

**LOCATING A COUNSELLING INTERNSHIP  
WITHIN A COMMUNITY SETTING**

**Sherine van Wyk**



**Assignment presented in partial fulfillment of the requirements  
for the degree of Master of Arts (Psychology) at the University of  
Stellenbosch**

**Supervisor: Professor A.V. Naidoo**

**December 2002**

## DECLARATION

I, the undersigned, hereby declare that the work contained in this assignment is my own original work, and that I have not previously, in its entirety or in part, submitted it at any university for a degree.

Signature

Date

## OPSOMMING

Hierdie navorsing ondersoek die behoefte van Sielkunde as professie om meer sosiaal relevante en gepaste dienste vir al die mense van Suid-Afrika te lewer. Dit bespreek die kritiek teen tradisionele sielkunde en die dringende behoefte vir 'n meer kontekstuele benadering om die negatiewe sielkundige verskynsels in die samelewing te begryp en verklaar. Die waarde van Gemeenskapsielkunde om voorkomende, kuratiewe en bevorderende geestesgesondheidsdienste aan gemeenskappe te lewer, word ook ondersoek. Verskeie modelle van gemeenskapsielkunde en die voorgestelde integrasie van geestesgesondheidsdienste by Primêre Gesondheid word bespreek. Die plasing van 'n voorligtingsielkunde internskap binne 'n gemeenskapsomgewing, naamlik, die Don en Pat Bilton Kliniek, Jamestown, word beskryf en geëvalueer.

## ACKNOWLEDGEMENTS

I am sincerely grateful to the community of Jamestown who opened their hearts to me in diverse ways and for the many lessons I have learned from them. The courage and dignity with which they live their lives are truly inspiring.

A sincere vote of thanks also goes to Professor Tony Naidoo for his generous and affirming support. Thank you for helping me to integrate theory and praxis and for facilitating the expression of my ideas.

I am also deeply grateful to my husband and best friend, Chris, and my three beautiful children for their constant support and helping me to understand that Windows are more than objects through which to view the world.

Thank you to USIKO for funding the internship and allowing us to take psychological services to disadvantaged rural communities.

*'Human existence cannot be silent, nor can it be nourished by false words, but only by true words, with which men and women transform the world. ...If it is in speaking their word that people, by naming the world, transform it, ..dialogue imposes itself as the way by which they achieve significance as human beings. Dialogue is thus an existential necessity.'*

**Paulo Freire (1996, p. 69.)**

## **LIST OF TABLES**

Table 1: Population of Jamestown	17
Table 2: Age distribution of Jamestown Residents	18
Table 3: Employment status of persons above the age of 15 years in Jamestown	19
Table 4: Monthly Income distribution in Jamestown	20
Table 5: Estimated rise in the Jamestown population	21

## **LIST OF GRAPHS**

Graph 1: Age distribution of Jamestown Residents	18
Graph 2: Employment status	19
Graph 3: Monthly Income distribution in Jamestown	20

## TABLE OF CONTENTS

Declaration	
Acknowledgements	
Summary	
Opsomming	
List of Tables	
List of Graphs	
1. Introduction	1
2. Literature review	1
2.1 Critiques levelled at mainstream psychology	3
2.2 Challenges to psychology	5
3. Community Psychology	6
3.1. Models of community psychology	9
3.1.1. The mental health model	9
3.1.2. The social action model	10
3.1.3. The primary health care model	11
3.1.4. The non-governmental organisations	13
4. Background to the internship	13
5. The aims and conceptual framework of the Jamestown project	14
6. A profile of the Jamestown Community	16
7. The intern, internship and client population	22
8. The spectrum of interventions	24
9. Discussion and evaluation	31
10. Recommendations and limitations	39
11. Conclusion	44
12. References	45
13 Appendices:	
Appendix A: Intake Interview Form	54
Appendix B: Process Notes	58
Appendix C: Poster made by Client	60

## **1. INTRODUCTION**

For decades there has been the realisation that the South African mental health services are vastly inadequate, inaccessible and inappropriate for the majority of the population. Progressive psychologists were at the forefront of highlighting the inequities in the system and initiated community-oriented services to meet some of urgent needs of the majority of South Africans (Freeman, 1991, 1998; Kriegler, 1993; Nell, 1994; Pretorius-Heuchert & Ahmed, 2001; Seedat, Duncan & Lazarus, 2001; Seedat & Nell, 1992; Swartz & Gibson, 2001). Community psychology in South Africa was a response to the oppressive system and sought to dismantle the structural inequalities and policies practised by the social and medical sciences. Through its activism it sought a more equitable and accessible psychology, which seeks to take relevant and appropriate services to people (Pretorius-Heuchert & Ahmed, 2001; Seedat, Duncan & Lazarus, 2001).

This paper is about a counselling internship at a primary health care setting, situated in a peri-urban area, which was initiated at the request of the community. In order to understand the context of the internship, the background to how the internship came about, a profile of the community, the aims of the internship and the conceptual framework will be discussed. The spectrum of psychological services and interventions rendered will be described and evaluated in order to draw out lessons that can inform future placements in similar contexts. The afore-mentioned will be discussed after the literature review.

## **2. LITERATURE REVIEW**

Mental health is fundamental to the total well-being of all individuals, societies and countries. According to Cowen (cited in Dalton, Elias & Wandersman, 2001) mental health encompasses physical and psychological health which is facilitated by the presence of social-emotional coping skills. Prilleltensky (2001) defines wellness 'as a favourable state of affairs, for individuals and communities, brought about by the presence of psychological and material resources' (p.750). Cowen (2000) states that "wellness" or "well-being" should be a matter of primary concern at all times, not only when it fails. The World Mental Health Report (1995) illustrated that despite world-wide improvements in health and living standards, mental health and the escalating mental ill-health have received minimal attention. Mental health has diverse meanings in different social contexts and there is no single definition that encapsulates its essence. The World Health Organization (2001)



states that it usually includes concepts such as 'subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence, and self-actualisation of one's intellectual and emotional potential, among others' (p.5). According to Desjarlais, Eisenberg, Good and Kleinman (1995), mental health is more than the absence of disease, it encompasses a general state of well-being where an individual fulfils his/her social functioning, realises his/her potential and contributes towards his/her community. The emphasis on the interrelatedness of biological, psychological and social factors broaden one's understanding of mental health. It further highlights the significance of the relationship between these factors and the role it plays in the development of mental illness (Brundtland, 2001).

The World Health Organization (2001) confirms this neglect of mental health. It estimates that world-wide about 450 million people suffer from mental illness and psychosocial problems due to substance abuse, yet only a small percentage of them receive the minimal basic treatment. For example, depression now ranks as the fourth leading cause of mental illness and it is predicted that one in four people will be affected by a mental disorder at some stage of their life (WHO, 2001).

Negative social factors such as unemployment, escalating HIV/AIDS incidence, crime, violence, alcohol and substance abuse touch all sections of South African society. These conditions have grave implications for the mental well-being of South African society. It is estimated that one in five South Africans suffer from a mental disorder that affects his/her social functioning. General practitioners estimate that twenty five percent of all their patients are ill due to psychological distress rather than biological causes. Adolescents are especially regarded as a high-risk group. Research indicates that annually at least twenty percent of this group think of injuring themselves (Mental Health Information Centre, 2002). The World Health Organization suggests that governments are responsible for the mental and physical well-being of their citizens and should formulate and implement policies to promote mental health. It regards the integration of mental health services into the health system as the more proven successful approach (WHO, 2001).

In South Africa, the provision of mental health services was characterised by overwhelming racialised inequalities. A distinct public/private dichotomy was the order of the day, with the state restricting itself to what was diagnosed as more serious disorders of "madness" and "mental retardation" (Foster & Swartz, 1997; Pillay & Petersen, 1996). According to

Freeman (1998), in the past, government mental health services largely focused on the custodial and medical care of people with severe psychiatric disorders. The broader aspects of mental health became the domains of the private, semi-private and non-governmental sectors. The deficiencies in the system were vast and the issues that needed redress are beyond the scope of this paper. However, the fragmentation of services, lack of intersectoral collaboration, inadequate co-ordination of funding, underservicing of the urban and rural disadvantaged communities, scant attention to psycho-social problems, the absence of prevention and rehabilitation programmes were some of the areas that demanded urgent attention (Freeman, 1990; Foster & Swartz, 1997). Further, traditional psychology's overwhelming silence about the structural inequalities and oppression in South Africa was seen as collusion with the prevailing systems of knowledge and power and was disempowering to clients (Ahmed & Pretorius-Heuchert, 2001).

## **2.1 Critiques levelled at traditional psychology**

Recent literature and policy makers maintain that drastic changes are needed in the provision of mental health services in South Africa and the Eurocentric, middle-class ethos which informs psychological praxis, warrants urgent transformation (Freeman, 1990; Freeman & Pillay, 1997; Pillay & Petersen, 1996; Pretorius-Heuchert & Ahmed, 2001; Seedat, Duncan & Lazarus, 2001). The shortage of psychologists, other mental health professionals and the unequal distribution of scarce resources result in the majority of the population being under-serviced (Freeman, 1990, 1998; Kriegler, 1993). Pillay and Petersen (1996) further highlight the inequities of the system in their study of the practice patterns of clinical and counselling psychologists. Their research indicated that most psychologists are in private practice and only cater for, approximately, twenty three percent of the population, mainly white and middle class clients. This implies that most of South Africans are dependent on the poorly funded public health system, as private psychological services are unaffordable and beyond their means (Freeman, 1998; Pillay & Petersen, 1996). Furthermore, the concentration of psychologists and mental health services in urban areas and the deprivation of rural and township communities of mental health services, compound the need for redress and equity (Freeman, 1990, 1991, 1998; Kriegler, 1993; Naidoo, 2000a; Pillay & Petersen, 1996).

Traditional psychology's preoccupation with the individual curative stance could be seen as a 'band-aid' approach to mental health, attempting to facilitate change within the client, but ignoring the real underlying causes. Watzlawick, Weakland and Fisch (cited in Dalton, Elias & Wandersman, 2001) regard this as first-order change. This refers to attempts to solve some aspects of a problem usually presented on the individual level. They contend that this focus usually leads to victim blame and that problems usually reappear, though, often in a different guise. The focus should be on second-order change, addressing the social systems or structures rather than the internal and behavioural processes of the individual.

Lewin's famous equation (quoted in Orford, 1992) is fundamental to the practice of psychology. The formulaic expression,  $B=f(P,E)$ , explains behaviour as 'the function of the person, the environment, and the interaction between the two' (p.5). Contrary to this, traditional psychology, in its research and practice, fundamentally immerses itself in the world of the individual and how to facilitate change within the individual, thus ignoring the latter part of this equation which is integral to one's understanding of the individual-in-context. Bronfenbrenner (1979) states that one would expect psychology to give equal emphasis to both sides of the equation, namely, 'the person and the environment, with special attention to the interaction between the two' (p.16). Orford (1992) contends that this approach, sometimes, shifts a gear into the domain of family or marital therapy. However, he argues that it is essentially still 'very personal, private and individualistic' (p.5). Laing (1971) in his critique of the medical model states that 'this model, when applied to a social situation, helps us to see what is going on about as much as do dark glasses in an already darkened room' (p.24). Freeman (1990) also maintains that 'this model does not do justice to the people being treated and to the complex social and psychological conditions which shape people's lives' (p.7).

People are historical and contextual beings, and according to Marsella (cited in Orford, 1992), the person and his/her context are a mutually influencing totality that is inseparable. Freire (1996) succinctly captures this situationality when he states that 'human beings *are* because they *are in* a situation' (p. 90). Similarly, the South African maxim, '*umuntu umuntu ngabantu*', which means that a person is only a person amongst other people, captures the situatedness of being (Higson-Smith & Killian, 2000). In his ecological model, Bronfenbrenner (cited in Dalton, Elias & Wandersman, 2001) uses the Russian nesting doll as metaphor to explain the nested, multiple levels and layers of relationships in society.

The individual, micro-, meso-, exo- and macrosystems are interdependent, reciprocal and understanding these multiple levels, is crucial to understanding the individual-in-society and the power it yields in shaping the lives of people (Riger, 2001).

Further critique against mainstream psychology is that its clinical, medical world-view fails to confront the fundamental causes of psychological distress and mental ill health. The myopic preoccupation with illness and the tendency to locate pathology within the individual, ignoring the broader socio-political conditions, result in a one-dimensional medicalisation of distress. Nell (1994) expounds this medicalisation of psychological distress and the dominance of biomedicine. He argues that in this colonisation, it arrogates for itself, both illness and healing, and subordinates other mental health professionals. He strongly advocates the resocialisation of distress and the divorce of psychology from the medical profession. Seedat and Nell (1992) concur that health professionals perpetuate a hierarchical system of power, based on technical knowledge and expertise. This stratification relegates patients and mental health workers to the bottom of the ladder, alienating them and rendering them powerless. For psychology to become an empowering and relevant force in the lives of especially disadvantaged communities, Whittaker (1995) suggested it has to radically transform itself from its 'theoretical straitjacket of positivist psychology' (p.44). Seedat and Nell (1990) proposed that it must 'first deal with its own disempowerment, produced by an authoritarian health-care system' (p.148) by adopting alternative pragmatic strategies.

## **2.2 Challenges presented to psychology**

The political changes of the 1990s and the establishment of a human rights culture have necessitated the transformation of all sectors of society. The discipline of psychology is compelled to engage in introspection in order to reflect on its role and chart its mission for a more relevant psychology (Freeman, 1991; Seedat & Nell, 1990). Kriegler (1993) calls for an affirmative action for psychology, which seeks to, transcend the petty rivalries between categories, play a leading role in the rebuilding of South African society and to promote healing and growth.

In his keynote address in August 2001 to the 7<sup>th</sup> annual congress of the Psychological Society of South Africa (PsySSA), the Minister of Education, Kader Asmal, laid down the challenge for the profession. He expressed the belief that psychology has a vital role to play in the healing of the psychological distress caused by oppression, racism, sexism,

ethnicity and fundamentalism. He challenged psychologists to reflect on a number of relevant issues with regard to training, the production of knowledge, critical aspects of language, accessibility and the promotion of well-being of all the people of South Africa. The key question which he raised is, 'Is psychology changing and more importantly does the profession want to change?' (Asmal, 2001). It is apparent that profession of psychology cannot continue with its old assumptions and practices. The dwindling resources and growing demands of the 21<sup>st</sup> century compel it to address these critical issues of accessibility, appropriateness and equity.

Therefore, psychology as a science and profession is challenged in its teaching, research and praxis to address the vast range of societal and psychological problems that confront South African society and above all, how to prevent them. Forty years ago Albee (cited in Dalton, Elias & Wandersman, 2001), already propounded that individualistic, psychotherapeutic and similar, professional interventions would never adequately satisfy all the mental health needs of society. Rappaport (cited in Orford, 1992) calls for a paradigm shift, new ways of thinking in psychology and for intervention at the appropriate levels. The growth of community psychology has been a response to explore alternative strategies to meet the escalating need for mental health services and implement a more proactive stance to mental health.

### **3. COMMUNITY PSYCHOLOGY**

Community psychology, in its philosophy and praxis, evolved to address some of the deficiencies inherent in orthodox psychology. It transformed the hypotheses related to understanding and treatment of mental health problems by de-emphasising the diagnosis of pathologies. It began to question the focus on changing the individual when the societal structures were detrimental to human development and sought to define problems in terms of ecological metaphors and multiple levels of analyses (Prilleltensky, 2001). In South Africa it aims to address the current challenges, namely, to provide access to services for the entire population, to adopt a more preventive stance, to involve communities in identifying needs, and in establishing and implementing programmes and services. Its primary goal is to promote mental health as part of the broader strategy of effecting social change at all levels of society.

Since the 1980s many initiatives emerged in order to address the critiques raised against mainstream psychology. These emerged under the broad umbrella of community psychology, utilising diverse labels such as “critical psychology”, “contextual psychology”, “progressive psychology”, “Afrocentric psychology” and “social psychology” (Naidoo, 2000a). These different paradigms underscore the complexities of formulating a single definition for community psychology. However, irrespective of their differing departure points, all these approaches aim to promote psychological well-being and improving the lives of individuals, communities and society (Pretorius-Heuchert & Ahmed, 2001). Orford (1992) contends that the practice of psychology in the community transcends the artificial boundaries of clinical, counselling, and educational and the diverse branches of applied psychology.

Community psychology is an approach that attempts to work with and across many disciplines. It is not a separate discipline, but rather an approach to psychology. Knowledge and practices from disciplines such as social work, anthropology, political science and sociology are integrated and utilised (Naidoo, 2000a). According to Dalton, Elias and Wandersman (2001), community psychology ‘concerns [itself with] the relationships of the individual to communities and society. Through collaborative research and action, community psychologists seek to understand and to enhance quality of life for individuals, communities, and society’ (p.5). This definition highlights the focus of community psychology, the well-being of the individuals as well as the community in which they are situated. They further elaborate their definition by presenting seven core values that extend from the micro-level to the macro-level of analysis, namely: ‘individual wellness, sense of community, social justice, citizen participation, collaboration and community strengths, respect for human diversity and empirical grounding’ (p.14).

Likewise, the principles of community psychology formulated by Orford (1992) capture the philosophy of community psychology. In essence he postulates that the community psychologist adopts a proactive stance, reaching out to communities, assessing needs and collaborates with them in developing preventive programmes. Services are located as near as possible, are not done *for* or *to* communities, but rather *with* them. Community psychology espouses to share psychology with residents through consultation, acknowledging that much psychological work is already being done within communities. In its research and action, it works from an egalitarian stance and strives for partnerships. Thus validating and tapping into the vast body of knowledge and expertise which exists

within communities. This approach is contrary to the medical model, which is disempowering to clients by making them passive recipients of mental health services. Rather, it challenges clients to become active in the therapy process and to draw on their inner resources as a precondition for change (Seedat & Nell, 1990).

From the above discussion, it is evident that prevention and empowerment are cardinal threads that are woven through the different theories of community psychology. Caplan (1964), in his seminal work on *Principles of Preventive Psychiatry*, distinguishes between primary, secondary and tertiary prevention. The focus of primary prevention is to prevent the onset of disorders, addressing the socio-environmental stressors and increasing people's resilience to such stressors. Once mental illness has been detected, secondary prevention aims to reduce the duration and severity of disorders through early, appropriate diagnoses and treatment. Tertiary prevention aims to restore an individual's social functioning by reducing the impairment of disorders through social rehabilitation and community based support structures. Secondary prevention encompasses primary prevention and likewise, tertiary prevention entails both primary and secondary levels of intervention. These levels of intervention are complementary and form part of an integrated approach.

The empowerment approach moves away from the medical stance of pathology and deficits towards the building of competencies (Lazarus, 1988). According to Zimmerman (2000), it is antithetical to the 'experts giving advice approach' or merely facilitating intrapsychic change. It is a process, a multilevel construct, enhances self- and mutual-help and defines competence in a number of ways. He maintains that 'the focus is on enhancing strengths and promoting health, rather than fixing problems and addressing risk factors' (p.58). It connects individuals, organisations and communities, providing them with opportunities to play an active role in gaining mastery over their lives. It encompasses personal and political power. Serrano-Garcia (cited in Lazarus, 1988) identified three major facets of empowerment, namely, the enhancement of personal power, growing the awareness of alternative strategies and accessing resources in society.

Lazarus and Seedat (cited in Seedat, Duncan & Lazarus, 2001) identify five core tenets that define the aims of community psychology within a South African context:

- (a) to make mental health services accessible to the entire population, especially previously disadvantaged urban and rural communities;
- (b) a shift in perspective in how the aetiology and development of psychosocial problems are explained and understood;
- (c) to address environmental stressors and contextualise social issues;
- (d) transform the practice of psychology and include prevention programmes and
- (e) redefining the role of the psychologist within a broader public health framework.

To implement the philosophy and aims, different models of community psychology have evolved.

### **3.1 Models of Community Psychology**

As discussed previously, there is no unified approach to community psychology. According to Seedat, Duncan and Lazarus (2001), it manifests universally in diverse orientations and models, usually adapts to suit local conditions and 'remains an incomplete project' (p.13). It is evolving and worldwide there is the expectation that it will grow and expand according to the needs of countries and their unique socio-political contexts (Wingenfeld & Newbrough, 2000). A few of these diverse models will be discussed briefly.

#### **3.1.1 The mental health model**

For this model, primary prevention is the underlying paradigm, focusing on early detection and large-scale health promotive interventions. Mental health services are integrated in the primary health-care framework and are provided in a geographical area, located as near as possible to where communities live. Accessibility, service delivery and cost-effectiveness are key factors. Through the curative, preventative and health promotive assumptions, the belief is that early detection could arrest the development of mental illness, thus reducing the incident rates and promoting positive health. There are close links between the secondary and tertiary levels for specialised areas of mental distress. Communities are actively involved in the establishment of services, taking ownership and playing a vital role in deciding what services they need.



Critique levelled at this model suggests that the mental health worker is still regarded as the expert, even though cognisance is taken of the impact of the broader social context. The focus is still on pathology in the individual and how to facilitate change and adjustment for him/her. The model is still rooted in the medical discourse and the power hierarchies are still operative. Although attempts are made to make services accessible, this model is essentially still individualistic by nature, whereas community psychology propagates broad social change on a macro-level. It is argued that despite the emphasis having shifted from treatment to prevention, any change that occurs is incidental and not transformative enough (Ahmed & Pretorius-Heuchert, 2001; Lazarus, 1988; Pillay & Lockhat, 2001).

### **3.1.2 The social action model**

The social action model dates back to the 1960s in the United States of America where communities campaigned against poverty, racism, absence of civil rights for minorities and protested against the Vietnam War. It is often regarded as one of the most revolutionary theories in community psychology and defines communities geographically as well as politically. According to social action theorists, there is a direct correlation between mental ill health and psychological distress, and the unequal distribution of power and resources within a society. Social action aims to organise communities to realise their inherent power as a collective and to conscientise them to the effects of the structural inequalities in their lives. It further identifies the various obstacles to empowerment in the lives of oppressed and marginalised groups. It facilitates the climate to challenge the vestiges of power within a society in order to bring about changes for individuals and communities (Ahmed & Pretorius-Heuchert, 2001; Lazarus, 1988; Dalton, Elias & Wandersman, 2001; Seedat, Duncan & Lazarus, 2001).

This model challenges those individualistic world-views that hold people accountable for their own fate and that fail to see connections between the individual and the societal forces. Joffe and Albee (cited in Orford, 1992) suggest that often symptoms of psychological distress are diagnosed as cognitive distortions. These then become the targets for therapeutic change and the suffering caused by injustice remains unchallenged. They argue that altering perceptions cannot alleviate feelings of powerlessness, rather, it is the social reality that needs to be changed. Kamin (cited in Nell 1994) suggests, "the solutions, if such there be, lie in the social, economic and political realms' (p.33). The psychologist in this model is not a neutral agent. Empowerment and social change are

central to this model. Thus, the mental health worker activates, organises, mobilises and conscientises oppressed groups to gain a more equitable access to resources and services. This compels social institutions to be more responsive to community needs, thereby enhancing the lives individuals and communities (Ahmed & Pretorius-Heuchert, 2001; Orford, 1992).

### **3.1.3 The primary health care model**

The World Health Organization (1978) declared that health is a fundamental human right and governments are responsible for providing the appropriate health infrastructure in order to meet this goal. It stipulated that primary health care (PHC) should be based on accessible, affordable, practically sound and socially acceptable health services to individuals and communities. There are three levels of intervention, namely, primary, secondary and tertiary levels.

PHC is the first point of contact with the health system for individuals, families and communities. It aims to bring health care as close as possible to where people live and work. According to Pillay and Lockhat (2001), this is the front-line level of dealing with primary health issues and PHC sites in South Africa usually includes primary health clinics, district hospitals, general medical practitioners and traditional healers. The secondary level would receive individuals from the PHC system who are in need of more specialised care or facilities. These would be at regional hospitals, larger day-hospitals and specialised mental health settings. The tertiary level services all individuals referred by the secondary level of care. These services would be located at academic hospitals at a provincial level, where the focus is on a specialist approach with minimal in-patient treatment. Individuals are referred back to the secondary and primary health sectors for follow-up and maintenance.

The Department of Health (2002) in its Health Sector Strategic Framework 1999 - 2004, has declared primary and community based health care as its primary objective, focusing on an efficient, preventive and promotive health care system. It aims to remove all barriers to health services and to transform the inequities of the past. It is cognisant of the growing demands on the health system due to poverty and unemployment. It acknowledges that mental health services have been neglected in the past and is an area that has to be addressed urgently. Its vision is to improve the mental well-being of all South Africans by incorporating appropriate mental health services, community care and psychosocial

rehabilitation within the primary health care framework. Areas that will receive special focus are:

- (a) children, adolescent and women's health
- (b) prevention of teenage pregnancies
- (c) HIV/AIDS treatment and prevention
- (d) violence against women, and
- (e) the prevention of smoking and substance abuse.

In this policy document the government states that it is aware that it has to take decisive steps in order to address the serious backlogs of the past. Areas that need special fast tracking include the training of primary health care nurses and community health care workers to identify and deal with mental health problems at the primary health care level. Due to the dwindling resources and ever-increasing mental health needs, it strongly advocates inter-sectoral collaboration with the private and non-governmental sectors, in order to render meaningful services.

The incorporation of mental health services holds many advantages of which the holistic approach to health, accessibility and early detection are paramount. However, Nell (1994) cautioned that the location of mental health services in the already 'heavily medicalised health care system found in South Africa' (p.37), could result in mental health services being regarded as secondary to health services. It could also hamper addressing the real underlying social causes of the psychological distress. Freeman (cited in Pillay & Lockhat, 2001) concurs that one runs the risk of the medical model engulfing mental health, thereby compromising genuine holistic care. Early detection of mental health problems could also go unnoticed due to inadequate training or over-burdened primary health care personnel (Pillay & Lockhat, 2001). The Department of Health in the Western Province, in its Draft Strategic and Service Delivery Improvement Plan (2002), states that rationalisation, growing patient numbers and lack of adequately trained personnel have impacted on staff morale and affected service delivery in certain areas. Thus, training and employing more appropriate primary health care personnel are crucial to the successful implementation of this model.

The policies and strategic frameworks formulated by the South African government illustrate their commitment to transforming the previously fragmented and racially divided health care system. Freeman (1998) states that this transformation involves a more

comprehensive approach to mental health, which includes prevention, promotion and rehabilitation. It intends to move away from the hospital-centred approach of the past and to address the needs of both urban and rural populations. Mental health services are proposed to be included in the primary health care system and form part of an integrated, holistic approach to health. Services will be located as close as possible to communities and community involvement and partnerships underlie the ethos of this level of intervention. This model ascribes to the tenets of community psychology that aims to empower communities through its active participation in the assessment of needs and establishment of services.

#### **3.1.4 Non-governmental organisations**

The philosophical and theoretical underpinnings of the non-governmental sector are diverse and somewhat different from the formal models of community psychology. However, they warrant inclusion in this section as they played a critical role in the provision of mental health services and the transformation of South Africa. Non-governmental organisations (NGOs) evolved and developed in direct response to the needs of communities and the paucity of services. They fulfilled a crucial role in the provision of services for children, the aged, women, advocacy and dealing with specific problem-areas. These included, amongst a host of others, violence, abuse, 'street children', alcohol and substance abuse, and trauma.

NGOs are closely aligned to communities and are at the coalface of addressing needs. Since the political transformation there has been attempts to rationalise this fragmented sector. However, they still have a vital role to play in the provision of services due to the limited government resources. It is expected that NGOs will have to respond to the changing context and adopt new strategies and frameworks. Moving beyond welfare and relief, to empowerment and community development, and closer collaboration with government on all levels (Parekh, McKay & Petersen, 1997; Pillay & Lockhat, 2001).

#### **4. BACKGROUND TO THE INTERNSHIP**

The reality of inaccessible and inappropriate services and the philosophy of community psychology formed the background of the Jamestown community project. The internship formed part of a broader community project that was established at the request of the

Jamestown community. The nursing manager of the Don and Pat Bilton Clinic, Sister R. Barnard, initiated contact with the university. She requested assistance with the rendering of psychological and developmental services at the local community clinic. She hypothesised that a large percentage of the caseload at the clinic was due to social factors, rather than biological or medical causes. She opined that medical treatment was merely symptomatic relief for social problems, such as, poverty, spousal abuse, high levels of unemployment, lack of recreational facilities, alcohol and substance abuse, teenage pregnancies and gangsterism (Naidoo, 2000b). This hypothesis corresponds with Kleinman's theory of the social origins of distress and disease and how it 'embodies peoples' experience of material conditions and social relation' (cited in Seedat, Butchart & Nell, 1991, p.145). He argues that the disempowered and those who lack access to resources are at high risk for somatisation. Seedat et al. (1991) make the assumption that in such societies many people erroneously believe that they are physically ill and are therefore treated inappropriately. Albee (1986) agrees that social factors such as poverty and degrading life experiences, powerlessness and low self-esteem, marginalisation and social isolation impact on social functioning and are the social origins of psychopathology. This initial contact started the process of rendering a 'seeking mode of service delivery' (Scileppi, Teed & Torres, 2000), attempting to provide proactive community programmes in collaboration with the community. The Jamestown Community Project (JCP) was launched in 2000 as a project of the University of Stellenbosch and the Jamestown community.

## **5. THE AIMS AND CONCEPTUAL FRAMEWORK OF THE JAMESTOWN COMMUNITY PROJECT (JCP)**

The paucity of accessible and appropriate services in disadvantaged communities and the dwindling resources necessitate all service providers in South Africa to collaborate and integrate this fragmented sector. Government acknowledges that it has to address the inequities of the past and seeks to build partnerships with important role players in this field to address the neglect of mental health (Department of health, 2002). The request of the community afforded the University of Stellenbosch such a unique opportunity to meet the needs of a rural disadvantaged community. It could also implement one of the core values in its mission statement, rendering service and contributing to the well-being of communities in South Africa (Naidoo, 2000a).

The philosophy of community psychology and systems theory formed the theoretical orientations that underpinned this project. Fundamental to this approach is the belief that people function within specific social contexts and social systems, and systemic change of the underlying social factors should be the primary focus of interventions (Orford, 1992). The JCP afforded Honours and Master level students the opportunity to gain firsthand experience of working within a community setting, gaining expertise and knowledge from the community and applying this in their interventions. This also created a setting where theoretical knowledge and community knowledge could be harnessed in a collaborative process to the advantage of both parties. The JCP has four primary objectives that aim to serve the community through development, participation and empowerment. These aims are:

- (i) to establish a prototype model for community partnerships
- (ii) rendering mental health services in the community and providing a learning/training site for university students
- (iii) developing preventive life-skills programmes and implementing a wilderness therapy intervention for youth at risk, and
- (iv) integrating the knowledge gained and contributing towards policy formation relevant to rural disadvantaged communities and youth at risk (Naidoo, 2000b).

Community participation formed an integral part of this project as, research indicates that community involvement is crucial to the success and sustainability of such endeavours (Petersen & Ramsay, 1993). The community leaders, important community role players, staff of the health clinic, principals of both the secondary and primary schools, church leaders, the Jamestown Executive Area Forum and the Stellenbosch municipality were all consulted and involved in the establishment of the project. Further, an advisory committee has been proposed to oversee the progress of the project (Naidoo, 2000b). Prilleltensky (2001) suggests that it is imperative that community voices be heard in praxis, not only in terms of information about needs and context, but also in terms of the process of collaboration. He lists self-determination and collaboration as two fundamental values that promote personal, collective and relational wellbeing.

## **6. A PROFILE OF THE JAMESTOWN COMMUNITY**

Jamestown is a peri-urban settlement situated approximately 7 kilometres south of Stellenbosch on the Stellenbosch/Strand road and approximately 40 kilometres from Cape Town. It was established in 1910 by a German, Rhenish missionary, Jacob Weber and a benefactor, James Rattery, hence the name Jamestown. It is renowned for its strawberry cultivation and the scenic vistas of the Stellenbosch and Helderberg mountains. In the past a large section of the inhabitants was subsistence farmers but the lack of resources, demands of sustainable, economically viable farming and competition from larger, well-resourced farmers, resulted in the decline of this enterprise (Kleinbooi, 1996).

Jamestown has the appearance of a middle-class socio-economic status when one drives through the village. However, behind this idyllic, pastoral veneer, one encounters extreme poverty, hardship, physical and emotional neglect, unemployment, alcohol and substance abuse, violence, spousal, elder and child abuse. However, it is an established and close-knit community where a sound sense of community prevails. An outstanding feature of this community is that everybody knows each other, are connected through kinship and familial bonds and during times of distress community support is visible. The church, of which there are a number of denominations offering numerous activities, plays an integral role in the life of this community and fostering the community spirit. Sport also plays an important role and especially the soccer club is a unifying agent in Jamestown. It has two pre-primary centres, a primary and secondary school. Current figures indicate that there are 702 primary and 859 secondary school learners enrolled at the schools (Personal communication, Principals, 26 February, 2002). Sixty to seventy percent of the children enrolled at the schools are bussed in from the surrounding farms where their parents are employed as farm workers.

The local primary health clinic was established on 29 March 1999 and provides comprehensive health services to the Jamestown residents as well as farm workers from all the surrounding wine estates and fruit and vegetable farms. Workers from twenty-nine farms, in a radius of approximately 10 kilometres, utilise the services at the clinic. It is managed by a nursing sister and aided by a nursing assistant and resorts under the auspices of the Stellenbosch Municipality. A general practitioner pays weekly visits to the clinic to attend to cases in need of expert care. The clinic focuses on preventative and curative treatment and services approximately 380 patients per month (Annual Report,

1999). A number of Non-governmental and welfare organisations, such as Child and Family Welfare, ACVV, Rape Crisis and Nicro are rendering social work services to the community. Patients in need of psychiatric services utilise Cloetesville Day Hospital, where a psychiatrist visits once a week and two psychiatric sisters manage the patient load. However, these services are located in the city centre of Stellenbosch and people have to incur transport costs in order to access these services. Liebenberg (2000) found in her study of services in the West Coast / Winelands Region that, although these services are available, they often are not accessible to communities due to monetary, transport and time constraints.

According to a recent census (Statistics South Africa, 1996), Jamestown has a population of 1 831, with a population distribution as indicated in Table 1. The settlement was created primarily for people classified as 'coloured' under the Nationalist government, however, since 1996 other population groups have settled in the community.

**TABLE 1. Population of Jamestown**

African/Black	51
Coloured	1683
Indian/Asian	6
White	1
Unspecified	90

Source: Statistics South Africa, Census 1996.

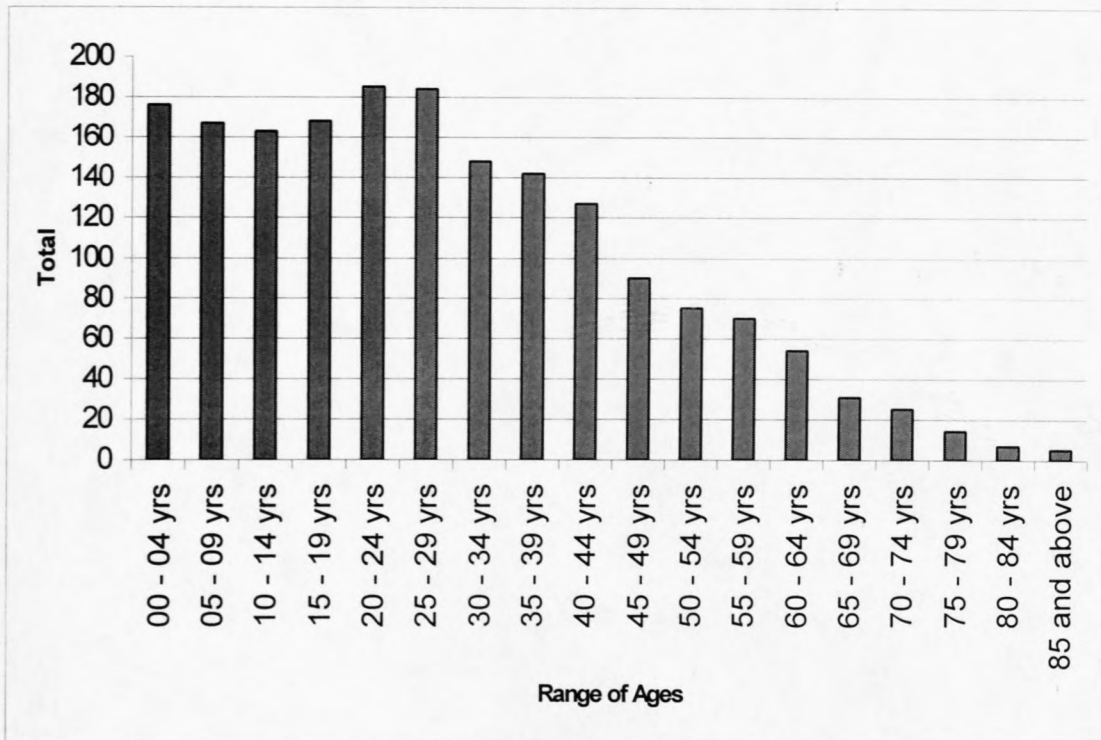
According to the census data, the majority of the population is under the age of fifty years, with a large number of pre-school and school-going children. There also appears to be a number of senior citizens. The age distribution is in displayed in Table 2 and Graph 1.



**Table 2 / Graph 1: Age distribution of Jamestown Residents**

00 - 04 yrs	176
05 - 09 yrs	167
10 - 14 yrs	163
15 - 19 yrs	168
20 - 24 yrs	185
25 - 29 yrs	184
30 - 34 yrs	148
35 - 39 yrs	142
40 - 44 yrs	127
45 - 49 yrs	90
50 - 54 yrs	75
55 - 59 yrs	70
60 - 64 yrs	54
65 - 69 yrs	31
70 - 74 yrs	25
75 - 79 yrs	14
80 - 84 yrs	7
85 and above	5

Source: Statistics South Africa, Census 1996.

**Graph 1: Age distribution of the Jamestown Residents**

Source: Statistics South Africa, Census 1996.

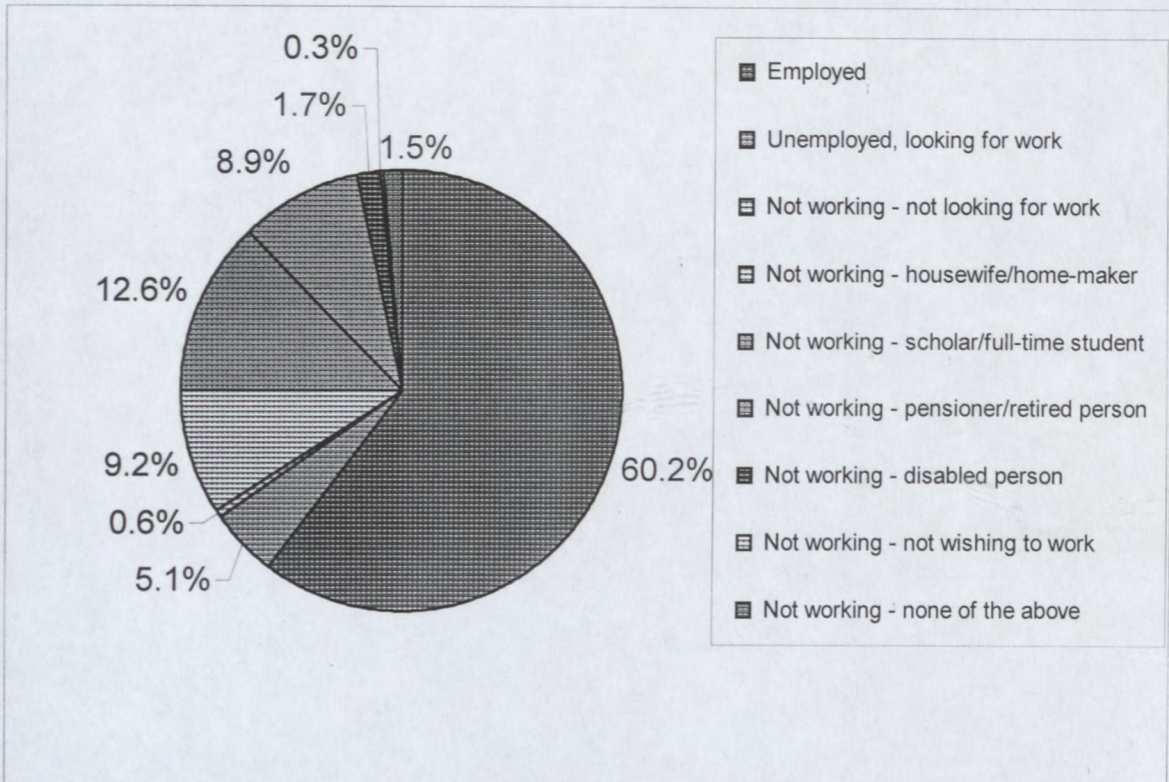
The data in Table 2 and Graph 1 indicate that a large section of the population are between the age groups 20-59 years, which is also the economically active group of a population. According to the Census 1996, the employment status in Jamestown (Table 3 and Graph 2) is as follows:

**Table 3: Employment Status of persons above the age of 15 years in Jamestown.**

Employed	802
Unemployed, looking for work	68
Not working – not looking for work	8
Not working – housewife/home-maker	123
Not working – scholar/full-time student	168
Not working – pensioner/retired person	118
Not working – disabled person	22
Not working – not wishing to work	4
Not working – none of the above	20

Source: Statistics South Africa, Census 1996.

**Graph 2: Employment Status**



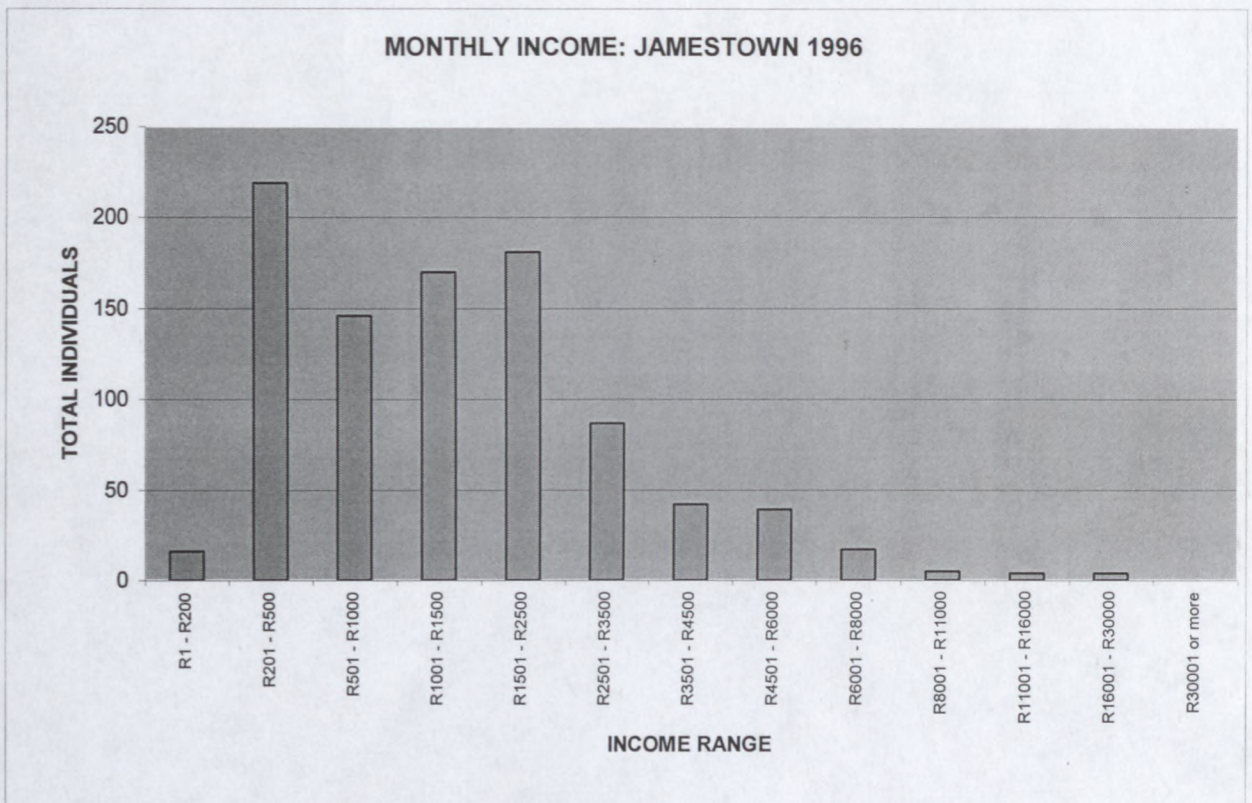
Source: Statistics South Africa, Census 1996.

While sixty percent of persons over the age of fifteen years in Jamestown appear to be employed (see Table 3 and Graph 2), the majority earns less than R2500 per month and a large section earns less than R500 per month (see Table 4 and Graph 3). It can be deduced that much hardship is prevalent in the community despite its middle class appearance.

**Table 4 / Graph3: Monthly Income Distribution in Jamestown**

R1 – R200	16
R201 – R500	219
R501 – R1000	146
R1001 – R1500	170
R1501 – R2500	181
R2501 – R3500	87
R3501 – R4500	42
R4501 – R6000	39
R6001 – R8000	17
R8001 – R11000	5
R11001 - R16000	4
R16001 - R30000	4
R30001 or more	0

**Graph 3: Monthly Income: Jamestown**



Statistics South Africa, Census 1996.

According to Statistics South Africa (1996) the following persons are excluded from the above Table 4 and Graph 3:

Persons with no income = 840

Unspecified = 61

It should be borne in mind that the 1996 Census data is merely a representation of one part of the Jamestown community, namely those that are resident in the area. Jamestown also has a 'hidden community' located in informal settlements and on neighbouring farms. As indicated earlier, since 1996 migration into Jamestown has increased markedly. The Stellenbosch Municipality (2002) estimates the rise in population to be as follows:

**Table 5. Estimated rise in the Jamestown Population**

1998	1999	2000
4798	4918	5035

A comparison of the 1996 Census data and the estimated figures in Table 5 dramatically alters the profile of the Jamestown community. The inward migration of unemployed workers from the surrounding farms, seasonal workers and people from other areas has resulted in the establishment of two informal settlements, namely, Kreefgat and Matops. The people living in the Matops settlement are residents from Jamestown who work on the surrounding farms or in Stellenbosch and because of the housing shortage, erected their own homes. Those residing in the Kreefgat informal settlement, are regarded as "inkomers", people who have no historical ties with Jamestown but who have now settled in the area. The lack of adequate housing, infrastructure and employment opportunities are some of the negative social factors with which this community struggles daily. Alcohol and substance abuse are prominent and the rise of shebeens has compounded the abuse of these substances.

This inward migration has affected the dynamics and interactional patterns along class and socio-economic lines and has 'us and them' overtones. This sometimes plays itself out in the classroom and on the school grounds amongst teachers and children. Many of the Jamestown residents regard the 'squatter camp' as a breeding ground for negative social forces and attempts for re-settlement have resulted in divisions along party political lines. Further, the Jamestown community also consists of a 'hidden community', namely all the workers who work on the surrounding farms. These workers are congregants of the local

churches, are serviced by the clinic and their children attend the schools in the area. The socio-economic conditions on these surrounding farms are also characterised by severe poverty, rampant alcohol and drug abuse and lack of recreational facilities for both parents and children. The prevailing social conditions have dire consequences in the lives of this and surrounding communities. It is an area that warrants urgent attention.

## **7. THE INTERN, INTERNSHIP AND CLIENT POPULATION**

### **The Intern**

Lifschitz and Oosthuizen (2001) contend that therapists are more than the theories that they subscribe to. They are shaped by their personal relationships and experiences. Rogers (1961) asserts that 'what is the most personal is [also the] most general' (p. 26). My interest in the Jamestown internship grew while I was completing a practicum at the Don and Pat Bilton clinic during the first year of the Masters programme (M1). The life issues with which the residents in Jamestown struggled, was a reflection of my own childhood. Having grown up in a similar community, who struggled with the same issues of poverty, violence and inequality, and having firsthand experience of the lack of and need for psychological services in such disadvantaged communities, evoked a deep sense of connection between myself, my roots and the Jamestown community. This interrelatedness motivated me to apply for the internship, acknowledging the 'age-old maxim....that the healer can only heal through [an awareness of] her or his own woundedness' (Lifschitz & Oosthuizen, 2001, p. 127). This heightened awareness of self facilitates personal transformation and creates a fertile therapeutic space for development and change in both the client and therapist (Mearns & Thorne, 1997).

Having completed a practicum at the clinic during the M1 year, I was relatively acquainted with the clinic, the social context and had a fair idea of the nature of the problems which clients presented. I expected that clients would readily avail themselves of the services, especially the two schools, where there appears to be a pressing need. My therapeutic style is that of an integrated approach, however, a person-centred style forms the basis of my orientation. I am guided by my own personality, philosophy and the personality style and needs of my clients. It is my belief that the relationship is critical for growth to occur in counselling (Mearns & Thorne, 1997; Rogers, 1961; Yalom, 1989), and the dialogical nature of this relationship is cardinal in the healing process (Angus & Halling, 2001; Freire,

1996). It affirms and validates the uniqueness of clients and their social contexts. Casement (1990) speaks about an 'open-minded approach' (p.14), where one focuses on the client and what works for that particular client. I am also aware of the impact of historical processes and how these influence social reality and clients' expectations of what psychology could or should offer them (Seedat & Nell, 1990). These authors suggest a more concrete and practical approach to therapy given the many social constraints that could affect the duration of therapy. Thus, I find that Reality Therapy and Solution-focused Therapy are modalities that I frequently use to help clients and myself make sense of what is happening in their lives.

### **The Internship**

The duration of the internship was for one calendar year, which extended from 1 January 2001 to 31 December 2001. The internship was located at the Don and Pat Bilton Clinic, was funded by USIKO and resorted under the auspices of the University of Stellenbosch, who provided the supervision. The internship was structured in such a manner as to provide training and exposure to a wide variety of clients in different settings. The clinic served as the primary base for the internship, from where services were also rendered to the schools in Jamestown. The Centre for Student Counselling and Development (CSCD) at the University of Stellenbosch also formed part of the internship where extensive supervision and training opportunities were provided, and peer consultation proved to be a valuable experience. Although the CSCD formed part of this internship, this research paper focuses mainly on the activities related to the community placement. Overall, this internship provided an ideal opportunity for training and exposure to remedial and prevention work in both, community and counselling psychology.

### **Client Population**

A broad spectrum of services was rendered to the Jamestown community, the schools and people from the surrounding farms. As awareness of the internship spread people outside the Jamestown area also utilised the services. These clients came from Kayamandi, Aids Action, the other community clinics in the Stellenbosch area, patients from Stellenbosch Hospital, children from Luckhoff and Cloetesville secondary schools, the Lindelane Place of Safety and the Dorothea Training Centre. Students at the university and colleges were counselled at the CSCD, the teaching staff at the schools in Jamestown and nurses in the

Stellenbosch area also availed themselves of the service. Clients came from all demographic and socio-economic groups and clients who were physically disabled were also counselled. The total number of clients seen from 1 January 2001 to 31 December 2001 was two hundred and twenty four and the ages ranged from pre-school children to senior adults (see Table 6).

**Table 6. Summary of age distribution of clients (N=224)**

<b>Ages</b>	<b>Number of Clients</b>	<b>Percentage</b>
Under 6 years	12	5,3%
7 – 12 years	24	10,7%
13 – 20 years	73	32,6%
Over 21 years	115	51,4%

## **8. THE SPECTRUM OF INTERVENTIONS**

Community psychology promotes the psychological well-being of individuals within the community and utilises a broad spectrum of interventions (Dalton, Elias & Wandersman, 2001). The spectrum of services rendered ranged from individual psychotherapy or counselling, group therapy, consultation, career counselling and to the presentation of workshops. Supervision and evaluation were conducted on a weekly basis with quarterly case presentations.

### **Individual psychotherapy and counselling**

The services offered varied according to the needs of the community and the different settings. These entailed individual psychotherapy and counselling, couples and family therapy and focused on individuals and families within their social context. It consisted of assessments, diagnostic formulations, therapeutic planning, therapeutic interventions, counselling or referral. Therapy extended on average over a period of five to ten sessions and more.

The problems identified and presented by clients included, amongst others:

- Developmental assessments and Parent guidance
- Scholastic, emotional, behavioural and learning problems
- Encopresis and enuresis
- Career counselling, time management and study-skills
- Developmental and adjustment problems
- Parent-child relationship problems
- Family relationship problems
- Post-traumatic stress disorder
- Termination of pregnancy, options-, pre- and post-counselling
- HIV/AIDS, pre- and post-test counselling
- Survivors of rape, sexual molestation and abuse
- Bereavement
- Anger management, assertiveness and conflict resolution skills
- Dealing with racism and labour issues
- Eating disorders
- Gender identity disorders
- Dissociative disorders
- Substance abuse and substance-induced psychosis
- Personality and self-concept development
- Marital and couples problems
- Emotional and physical abuse
- Mood Disorders
- Anxiety Disorders

Themes that emerged in therapy included issues around family relationships, parent-child relationships, 'difficult children', parenting, appropriate discipline, the traumatic effects of rape and child abuse, emotional abuse, coping with trauma and the effects of violence. A recurring theme throughout this year was the effects of poverty and how these impact on the lives of clients and coping with the concomitant psychological distress. Thus, Bronfenbrenner's ecological model enhanced my understanding of the interaction between macro-level phenomena, such as, unemployment and poverty, and micro- and meso-levels of society, the individual and the family, and the ramifications thereof.



## **Group work and group therapy**

One of the fundamental tenets of community psychology is to work on multiple levels and in diverse settings within a community, thereby, attempting to effect systemic change, as well as change within the individual. During this internship, group work and group therapy were offered to a number of diverse groups, dealing with issues relevant to their contexts. I facilitated sessions with a group of primary health care practitioners who dealt with organisational and change issues, excessive workloads, burnout and coping with HIV/AIDS. The aim of this group was to create a safe space for the nurses to deal with, and explore openly the complexities and demands of their work.

Psycho-education groups were also presented to a group of mentors and mentees who are involved in a diversion/mentoring programme. This programme forms part of the broader Jamestown Community Project and is an example of a primary prevention mode of intervention - intervening with a group of young men who are regarded as a vulnerable or high-risk group. Briefly, this project focuses on the rites of passage of young men, the complexities thereof in a changing world and aims to connect young men with mentors from the community. These mentors serve as role models for the young men (mentees) in their adolescent phase, providing a supportive, mutually enhancing relationship and socially acceptable models of manhood (Naidoo, 2000b).

Adolescence is characterised by multiple changes, physically and socially, and demands and influences from outside the home become a significant variable during this developmental stage. Increased risk-taking features prominently during this stage and in poor communities there is a heightened exposure to negative social forces such as gangsterism, violence and substance abuse (Moffit, 1993). Flisher, Ziervogel, Chalton, Leger and Robertson (1993) have documented risk-taking behaviour among adolescents in the South African context. Prevention, one of the defining features of community psychology, seeks to render proactive services to prevent the onset of psychological ill health. Thus, this programme aims to intervene by empowering the mentees with social skills to deal appropriately with negative influences. In the group sessions with the young men (mentees) we dealt with issues around identity, self-image, status in the group, peer pressure, exploration and experimentation. Life-skills also formed an important part of these sessions. Further, I also facilitated sessions with the mentees where the meaning and value of the mentoring programme were explored.

Community psychology aims to enhance strengths and to help people to gain mastery over their lives. According to Zimmerman (2000), it endeavours to connect individuals within communities, to galvanise skills, knowledge and potential to the advantage of the entire community. The mentors are members from the community with diverse strengths and talents who volunteered to be part of the programme. Group work that I facilitated with this group included exploratory work and psychoeducation, thus sharing skills and knowledge, thereby building capacity (Orford, 1992). During the group process we explored the meaning of what it means to be a mentor, the demands of such a mentorship programme and the vicarious benefits that accrue from such an involvement. The psychoeducation involved sharing knowledge about the various developmental phases of the mentees and mentors, and the various tasks of each developmental stage.

### **Services rendered at the schools**

Schools are important sites involved in the development of young minds and for providing an environment where children can realise their inherent potential. Here they not only acquire academic knowledge, but also have the opportunity to learn skills that will be useful in the adult world. Schools are also integral in the development of self-concept (Dawes & Donald, 2000). The early identification of problems is one of the cardinal facets of community psychology and teachers are valuable community resources in this process. Children were referred by teachers for emotional and behavioural problems and identified for counselling and/or psychotherapy. Developmental, scholastic and psychometric assessments of school readiness, learning problems and poor scholastic progress were conducted. Play Therapy for younger children and Reality Therapy older children were offered. Concepts of Reality Therapy, such as, the three R's, reality, right and wrong, and responsibility (Thompson & Rudolph, 2000), were used as part of my therapeutic modality. Further, social skills training, developing and expanding an emotional vocabulary were issues that were addressed in therapy. Career counselling was also rendered to the secondary school learners. The following psychometric instruments and questionnaires were used:

- Junior South African Individual Scale (JSAIS)
- Senior South African Individual Scale-Revised (SSAIS-R)
- Beery Test for Visual-Motor Integration
- Bender Gestalt Visual-Motor Integration test
- Connor's Rating Scale

- Child Depression Inventory Scale
- Draw-a-Person Test (DAP)
- Kinetic-Family-Drawing Test (KFD)
- Beck Depression Inventory
- Beck Anxiety Inventory
- Thematic Apperception Test (TAT)
- Children's Apperception Test (CAT)
- Myers-Briggs Type Indicator (MBTI)
- Meyer Interest Questionnaire (MB10)
- Mental Alertness Test - Intermediate Battery
- Vocational Rank Order Test and
- Rotter Incomplete Sentence Test

## **Consultation**

Consultation formed an integral part of the internship and services were rendered to the schools, the clinic and the project leader of the mentoring programme. Caplan and Caplan (cited in Scileppi, Leed & Torres, 2000) refer to consultation as a process where the consultee would approach a consultant in order to gain expertise in providing a better service to his/her clients. They list three approaches to consultation, namely, the client-centred, consultee-centred or programme-centred approach. Consultee-centred consultation focuses on a consultee's shortcomings or difficulties in rendering service to a group of similar clients. Orford (1992) states that this relationship between consultant-consultee is voluntary and triadic by nature. The three parties involved in the process being the consultant, the consultee and the client.

A consultee-centred approach was used at the school and focused on the emotional demands of the teaching profession, early identification and management of behavioural and learning problems, and finding more creative solutions for class management. Innovative strategies for discipline, creating awareness by teachers of the developmental phases, having age-appropriate expectations of children, the social context of learners and how to create an atmosphere of pleasant learning were areas of consultation. The goal of consultation was to empower the educators to deal more effectively with their daily challenges and to enhance the teaching process.

At the clinic much “sharing [of] psychology” (Orford, 1992) took place, sharing knowledge, skills and creating a sensitivity to the social forces that impact on the lives of the patients. This consultee-approach enabled the health practitioners to render a more informed service to their patients. According to Swartz and Gibson (2001), the “real job for psychology in primary health care is to help nurses to be better nurses, and other practitioners to be better practitioners” (p.45). One could include teachers and the whole spectrum of service providers, to provide what Swartz and Gibson (2001) refer to as a more humane service to their clients.

Desjarlais et al. (1995) advocate the effective use of mental health resources in order to promote mental health amongst the population. Given the realisation that the current mental health structures do not adequately meet the needs of the majority of South Africans (Freeman & Pillay, 1997), consultation is an effective vehicle to spread psychological knowledge and skills. Dawes et al. (1997) suggest that capacity building in people, such teachers, nurses, mentors, project leaders and others, who are involved in rendering services to their communities, is critical for the promotion of mental health. These individuals are in the advantageous position of having firsthand experience and knowledge about the social contexts and play a vital role in the detection and prevention of psychological problems. Through consultation one creates the opportunity for such front-line workers to integrate psychological knowledge into their daily programmes, thereby facilitating mental health and the promotion of preventive and promotive care within communities (Gibson, 2000).

### **Networking and multi-disciplinary liaison**

Networking and forging working relationships with the organisations already operative in Jamestown were a priority. These included Stellenbosch Hospital, the non-governmental organisations, social work services, the school clinic, the various training centres in Stellenbosch and the managers of the surrounding wine estates. Close liaison and referral was established with the psychiatrist and psychiatric nursing sisters at the Cloetesville Day Hospital, which is the secondary level of intervention in the area. From here clients were referred to the appropriate tertiary institutions.

## **Centre for Student Counselling and Development**

As indicated in Table 7, Fridays were spent at the CSCD at the University of Stellenbosch where I formed part of the staff rendering therapeutic and career counselling services. Workshops were presented to peer and academic counsellors. Case discussions, group and individual supervision were also part of the programme. My presence at the Centre for Student Counselling and Development provided an opportunity for ongoing professional development with supervisors and peers that were not available at the primary setting.

### **Supervision and professional development**

Supervision forms an integral part of an internship, especially where an intern functions outside the structure of an established organisation. A structured programme of supervision and continuous evaluation were followed in order to meet the requirements of the Professional Board of Psychology. Direct individual and group supervision were offered on a weekly basis. Weekly case presentations, including video recordings, were presented to senior psychologists and fellow interns at the Centre for Student Counselling. A quarterly case presentation was made to the teaching staff at the Psychology Department that formed part of the quarterly evaluation. This culminated in a final oral case presentation, where an external examiner was present. A case was also presented to a group of external psychologists as part of the Continuing Professional Development of the Board of Psychology, rendered by the Centre for Student Counselling and Development. I had to arrange for an expert to offer expertise and knowledge of particular relevance to the case presented. As for the continued professional training, courses were attended in career counselling (Myers-Briggs Type Indicator), play therapy and crisis intervention. A joint presentation of one intervention at Jamestown was also made at the 7<sup>th</sup> Annual Congress of the Psychological Society of South Africa (Naidoo, Dunn & Van Wyk, 2001). A schematic summary of the weekly activities and training programme is presented in Table 7.

**Table 7. Activities of the intern**

<b>Day</b>	<b>Activity</b>
Monday	Individual psychotherapy and Counselling, Group work, Consultation in Jamestown
Tuesday	Counselling, Consultation at the school
Wednesday	Supervision ,Counselling at the clinic
Thursday	Counselling at the clinic, Group work
Friday	Counselling, Training, Supervision at the Centre for Student Counselling and Development

The allocation of time for the primary internship activities is presented in Table 8:

**Table 8. Allocation of time**

<b>Activity</b>	<b>%</b>
Counselling, psychometric assessments and consultation	75%
Group therapy, training and workshops	5%
Supervision, professional development and report writing	15%
Research: thesis and case management	5%

## **9. DISCUSSION AND EVALUATION**

The ease with which the service was established at the local clinic could be attributed to the direct involvement and enthusiasm of the community leaders and the collaborative relationship that existed between themselves and the representatives of the Department of Psychology. Research indicates that community projects succeed when there is direct involvement and ownership by the people who utilise the services and when programmes are responsive to community needs (Petersen & Ramsay, 1993; Prilleltensky, 2001). Mash and Mahomed (2000) concur that participation at local levels and a "bottom-up" rather than

a "top-down" approach is vital to the success of projects. Prilleltensky (2001) maintains that by asking people what they need prevents the imposition of inappropriate services on them.

Community needs shaped the internship and although no distinct model of community psychology was subscribed to, its philosophy and principles informed the internship. It presented the intern with a learning experience to exercise curative, as well as preventive and promotive strategies. Due to the existing need, individual counselling demanded most of the time, however, group and community levels of intervention were also focused on. Scileppi, Teed and Torres (2000) maintain that traditional approaches are not obsolete, but it is one of the many forms of interventions in the broad strategy of community psychology (Naidoo, 1996).

The service was located in the heart of the community and was accessible to most clients, however, some clients still had to walk far distances from the surrounding farms. The situation of the internship at the clinic located the service within the medical paradigm, and this association affected the nature of the client-therapist relationship. Rappaport (2000) asserts that 'settings tell stories' (p.7) thus, it appeared that most of the clients assumed that the service formed part of the medical hierarchy, ascribing expert status to the intern. Rappaport suggests that these entrenched narratives are internalised by both the providers and users of services and are counter productive to change. Seedat and Nell (1990) agree that the 'quick fix mentality is deeply engraved in clients [who are] exposed to the cumulative consequences of oppression' (p.146). Many clients revealed a stoic acceptance of their situation and uttered the beliefs that there is not much that could be done to change their lot. Riger (2001) states that the subjective interpretations individuals relate about their lives are shaped by the dominant cultural narratives. This 'radical fatalism' (Nell, 1994) contributes to clients' disempowerment and perpetuates the view of victimhood (Seedat, Butchart & Nell, 1991).

Despite the political and social changes that have occurred in South Africa, the legacy of the past continues to feature as an integral facet of contemporary South Africa. The sad reality is that for many clients nothing much has changed since the change to a more democratic system (Bond, 1994) and many appear to be trapped in a somewhat feudal relationship. Many find themselves to be the working poor and their whole world revolves around the farm where the farmer wields absolute power. Thus, for some the clinic is merely a perpetuation of the discourse of power vested in authority and influences how

clients define themselves within this context. However, my therapeutic style resisted the ascribed expert status, hopelessness, fatalism and expectation for 'magical cures' by challenging clients to discover their sense of personal agency. Seedat and Nell (1992) assert that psychology has to move beyond the curative and the relieving of symptoms. It should rather challenge clients to take responsibility for their own well-being. It should foster the notion 'that individuals are agentic, capable of negotiating and influencing, as well as being influenced by context' (Riger, 2001, p.75).

Working within a multidisciplinary context presented a holistic approach to the service. Collaboration presented much opportunity for learning and at the same time sensitising the medical staff to the social origins of distress. Educating staff and clients about the role of medication in psychotherapy, and that it is not necessarily the first strategy to deal with social problems, was of primary importance. This resulted in a good working relationship and much consultation between the intern and the medical staff and the appropriate referral of clients. Research indicates that appropriate interventions enhance self-determination in clients and are cost-effective by reducing client loads at clinics (Nell, 1994). The proposed introduction of mental health services into primary health care necessitates that psychology makes its voice heard in the provision of appropriate services for patients and clients. Pillay (2001) asserts that the medical profession has to be taught that patients are more than diseased bodies and have to be treated holistically. He states that many of the psychosocial aspects of disease are often undetected because of the exclusive concern with pathology and postulates that it is a folly to equate health care with medical care.

The paucity of mental health services for children holds grave implications for South Africa. The consequences of poverty are endless and result in physical and emotional deprivation and cognitive and psychological problems (Hamber, Masilela & Terre Blanche, 2001). Because of the lack of access for disadvantaged children to mental health services, many underlying problems are undetected and consequently develop into more complicated states, affecting academic progress and emotional development (Barbarin & Richter, 2001; Pillay & Lockhat, 2001). Many of the referred children daily suffer the consequences of poverty, alcohol abuse (foetal alcohol syndrome), poor parenting styles, physical and emotional neglect, abuse and lack of academic stimulation. The presence at the primary school afforded the opportunity to render consultative services to teachers. Creating an awareness of the impact of poverty and the necessity for early detection of learning problems. The undetection of such problems has a compounding negative effect on the



child's scholastic progress, which in turn affects the child's self-image and –worth. For example, a learner who had repeated Grade 1 three times, was assessed to be mentally retarded, and the appropriate placement resulted in great relief for the parents. In assessments of Grade 7 learners it was found that some of the learners were functionally illiterate, had numerous learning problems but had been promoted from one class to the next. These cases were brought to the attention of the senior staff and the importance of early assessments and remediation was stressed, and how it could be implemented across grades. Essentially, the education system has failed these learners and could hold serious implications for their future development and possibly limit their vocational options (Desjarlais et al., 1995). The generic diagnosis of 'behavioural problems' was deconstructed and other ways of looking at these were explored. Creative ways of addressing a challenge such as visual-motor integration deficits in the daily programme and its long-term implications for scholastic progress were addressed.

It is an indictment against our society that very limited mental health services exist in disadvantaged schools that could render proactive and appropriate services timeously. The undetection of learning and emotional problems, usually manifests in behaviours for which children are blamed and rejected, and by implication, blames children for being poor and socially disadvantaged. Dawes et al. (1997) state that despite the rhetoric of "children being our future", services for children's mental health still remain the "Cinderella of South African social services" (p.193).

The group facilitation with the nurses revealed many concerns related to the integration of mental health services into the primary health care and how this will impact on the already overburdened staff. There appears to be a lack of clarity of policies, an absence of co-ordination between policy and implementation and nurses feel that these are just foisted upon them. A statement by one of the participants captures these feelings of overwhelm when she stated: "*It is expected of us to be mini-doctors, now they want us to be mini-psychologists also*". Flisher, Fisher and Subedar (1999) expound on these issues raised by the group. They highlight a number of impediments encountered thus far in pilot projects where mental health services are integrated into primary health care. Training in communication skills was effected in order to facilitate positive interaction with management. Further, a forum was established where nurses could find mutual support, share the complexities of their daily tasks and generate their own solutions.

The psychoeducation programme, presented to the young men involved in the rites of passage programme, was interactive and experiential. It focused on life skills training, exploring identity and relationship issues, connecting young men with their communities and their history through the mentoring programme. Desjarlais et al. (1995) advocate that adolescents, especially those from poor communities, should be considered a priority in the planning of mental health services. According to Dawes et al. (1997), poverty, limited education and marginalisation of young people are powerful predictors of negative emotional and psychological outcomes. They propound that the social demands and developmental changes in the adolescent render them vulnerable to negative psychosocial outcomes. This is compounded in poor urban areas, where negative social conditions, poverty, violence and crime abound. Such environments provide limited scope for the development of a positive sense of self and the establishment of good relationship bonds. This renders adolescents vulnerable to disconnection from their communities and susceptible to the brotherhood of gangsterism, where the sense of belonging is fulfilled. This traps especially young men in a lifestyle of crime and violence. Dawes et al. (1997) contend that life skills programmes promote resilience within young people at risk to deal with the social pressures of modern living.

Gibson and Swartz (2001) highlight valid concerns that confront interns when moving outside the known and traditional ways of applying psychology. They state that these often evoke feelings of disempowerment and frustrations with interns. However, the reality of South Africa is that mental health services need to be taken to the people and one has to find creative ways of confronting the issues which community placements present. Lifschitz and Oosthuizen (2001) deconstructed the traditional ways of rendering therapy and show how interns can render meaningful services when they are attuned to the community and their needs. The experience at Jamestown was that many clients are constrained by time, money and distance. Visiting the clinic is costly and usually means loss of income and transport expenses. Bedridden and hospitalised clients necessitated that therapy be moved outside the office or clinic walls to where clients found themselves. Creative arrangements could be made to meet clients at venues convenient for them, thus ensuring continuity in therapy. Flexibility and creativity are essential ingredients in community work. Lewis, Lewis, Daniels and D'Andrea (1998) speak about 'reaching out', breaking with the traditional ways of doing therapy and moving beyond the walls of the consulting room into the homes and work places of clients, should they express the need for this.

## Evaluation

Orford (1992) states that programme evaluation is one of the most frequent research tasks in community psychology. He states that often there is confusion about what is meant by evaluation and he distinguishes between formative and summative evaluation. Formative evaluation is process-oriented and looks at the operational aspects of a programme, how it could be developed and enhanced in order to facilitate the likelihood of the programme reaching the stated goals. Summative evaluation focuses on the effectiveness of programmes in reaching the initial goals. Orford (1992) lists a number of functions of programme evaluations, namely, clarification of the aims, have it reached the target audience, how does it function in practice, what are the outcomes and the costs of the programme. Similarly, Dalton et al. (2001) use a four-step model for programme evaluation, namely, identifying goals, process, outcome and impact evaluation. They state that goals reflect what a programme intends to achieve. This model is a useful tool to evaluate the services rendered at Jamestown.

The primary goal of the internship at Jamestown was to render psychological and developmental services to the community. This need arose out of the lack of appropriate, available and accessible mental health services for the population in this peri-urban area. The available services are not easily accessible due to long waiting lists and people usually have to incur financial costs to travel to these services. This initial aim was organically expanded as the internship became established and later included consultation to the medical staff and teachers at the schools. Locating the internship within the community facilitated accessibility. Simultaneously, the internship would also serve as a learning site for the intern in the training to become a psychologist and provide an opportunity for the university to render community service. The target population was the community of Jamestown as well as the people working on the surrounding farms. Participants came from all the demographic, age, gender and socio-economic groups in South Africa. The learners of the primary school in Jamestown were a specifically targeted group because of the negative social conditions to which these children are exposed.

Intervening at multiple levels is central to community psychology. This internship facilitated a systemic mode of intervention because I could work with the children, parents, grandparents, teachers, principals and medical staff. This cross-fertilisation of skills and knowledge across different levels facilitated the therapeutic processes with many clients. An important facet of intervening at the different levels is that one has to be creative in

adjusting to the different levels of context of clients and the professional staff. In consultation one has to be aware of the emotional needs of consultees. This was often my experience with the professional staff, many of whom needed time to deal with their own challenges and time had to be allocated for it. Thus, the emotional needs of consultees are important factors in the consultation process and should be allocated for.

According to Dalton et al. (2001), outcomes should be specific, measurable, realistic and attainable. The chief intended outcome of the Jamestown internship was to provide accessible services, to build social competencies across all age groups, maximising existing strengths and to develop new capacities to promote resilience and mental health amongst the community. The intervention with the young men is what Orford (1992) refers to as 'high-risk type prevention' (p.157), where one identifies vulnerable groups and builds resilience through imparting knowledge and skills. It also intended to provide opportunities for growth and healing through the therapeutic and group interventions, thus promoting empowerment.

The second step in Dalton et al. (2001) model is the evaluation of the process. According to them, this has a number of functions of which monitoring, accountability and the impact of the programme are some of the important aims. The nature of the internship, the activities, time allocated and instruments used in the process has already been discussed in this paper. Lessons learned from all the interventions presented are that most of the participants expressed relief at having this service on their doorstep and were enthusiastic to use the services offered. Feedback from clients, the principals of the schools and the medical staff indicate that these services were meaningful to the community. Riger (2001) states that when evaluating programmes one normally asks whether programmes have reached the stated objectives. She suggests an alternative approach, one should ask what a programme looks like from the participants' point of view. This could be regarded as a limitation of this internship, very little quantitative measures were used to measure the satisfaction of clients, notwithstanding the positive qualitative feedback given by community leaders, teachers and clients. If one could use the regularity with which clients returned for their scheduled follow-up appointments as a gauge to measure satisfaction, then the internship was relatively successful in meeting clients' needs. The feedback from the group work, both the therapy and psychoeducational groups, highlighted the impact group learning and support can have for the members in imparting skills, knowledge and building

resilience within the group members. It also contributed to developing a sense of belonging and a sense of community in the groups themselves.

A number of critical lessons were learned from this community. Swanepoel (1992) states that 'a community is a unique living entity and, like people, it continuously changes physically and psychologically' (p.11). In communities there is a web of unique patterns of relationships, networks and structures and it is vitally important to acquaint oneself with these and the dynamics operating within it. The success of the internship could be attributed to the initial spadework that was done, from the ground level, by the project leaders and the multiple role players in the community. This obviated 'experts' from coming in and imposing what they thought the community needed. Collaboration is an essential ingredient for success that could be transferred to other programmes. Psychology as a profession cannot function independently, one needs to establish networks with the different resources in the community. Thus, as an intern, it was imperative to establish ties with the different institutions and important role-players in the community. I had to be accessible and be 'present' in the community in different ways and in different contexts and roles.

Further, communities have unique ways of dealing with trauma and healing and one has to understand this and tap into this source of community knowledge in order to enrich one's therapy. In the Jamestown community religion plays an integral role and clients often used this medium to make sense of the world and their life-situations. Religious metaphors became a useful tool and often facilitated the therapeutic process.

Areas of interventions that were planned but which never materialised were plans to establish a teenage mother group, group career counselling for matriculants, the establishment of a trauma-debriefing group at Stellenbosch Hospital and to render parent guidance at the pre-primary school in Jamestown. The screening of the teenagers for the group work started and those interviewed expressed interest in joining. However, the timing of the planned intervention could have influenced it not coming into fruition. It occurred during August and the rainy conditions prevented many from coming to the clinic. Many plans and discussions were held with the principal of the pre-primary centre but promises of planned parent evenings never materialised. On reflection I could have volunteered to do the planning and contacting parents myself. Group career counselling was also planned for the high school but ill timing and the full school programme prevented

this from happening. Further, the fact that most students are bussed in restricts most interventions to school hours, which limits what can be done during the school day.

The failure of the trauma-debriefing group to get off the ground could be regarded as a prime example of what Prilleltensky (2001) cautions against, the imposition of inappropriate services due to lack of consultation with all stakeholders. Health officials decided that the need existed for medical personnel who were constantly exposed to trauma to be part of such a group. Despite the sincerity of the intentions, the need for such interventions to evolve from the participants and to be shaped by them, were manifested in the resistance to the intervention.

The value of such a community setting for an internship resides in the exposure to such a diverse client population from all sectors of the community and the opportunity to work in a multidisciplinary setting. The seeking-mode orientation, where the nursing sister identified symptoms early, facilitated therapy by preventing the progression of issues presented by clients. The holistic approach provided a valuable service to the participants and also afforded me the opportunity to look at problems from different vantage points. It provided much insight into the different cultural narratives that can operate within a community and the resilience of communities to deal with negative social factors such as poverty and violence. Rendering therapeutic services to people who are deprived of such services was immensely rewarding when one sees growth and change occurring. For example, when clients feel empowered to start challenging the power bases in their lives (employers) that wanted to determine when they should attend therapy. Also, when teachers implement shared knowledge in their daily programme despite having twenty-five years of teaching experience. Another example is when a survivor of incest is prepared to speak out on a national radio programme to promote awareness and prevention. These examples make psychology a worthwhile profession.

## **10. LIMITATIONS AND RECOMMENDATIONS**

One of the limitations in rendering service in the Jamestown community was the fact that many of the clients still had to cover far distances. Clients were also sometimes restrained by employers and with appropriate visiting times to the clinic. The programmes at the school were also limited to school hours as most of the children are bussed in from the surrounding farms. The operating hours of the clinic also presented somewhat of a

limitation as it restricted the hours that clients could be seen. Contact with farm managers was also difficult to arrange which stifled the expansion of the services on to the farms.

The location of the internship within a medical setting brought with it the perception that the internship formed part of the medical context. Although the perceptions of clients were dealt with, the clinic setting, to a large extent, influenced the internship. As Seedat and Nell (1990) illustrated, a 'quick-fix mentality' could be counter-productive to meaningful therapeutic intervention, as some clients seem to think that medication is the answer to all problems. One client captured this perception when she stated, "*as long as I have my tablets, then I can cope with many things*". Thus, the concern that Nell (1994) expressed with regard to the medicalisation of distress is valid and should be an area of discussion. Given the government's commitment of the integration of mental health services into the broad health framework, one has to consider, whether the powerful medical system will not again limit and overshadow the valuable role that psychology can play in the mental health of all South Africans. This is an area that the profession has to deal with urgently. The education of society on the role that psychology can play in the development of South Africa is one of the most pressing tasks.

The absence of psychologists and other mental health professions from disadvantaged communities has resulted in a lack of awareness of what this profession can offer communities. Stevens (1999) contends that using psychological services in most black communities is essentially a new experience. People also appear to be stuck in the notion that psychologists are for helping 'mad' people, an understanding that a number of clients shared in therapy. Dealing with the stigmatisation became a focus in therapy (see Appendix C). This limits the willingness of people to utilise psychological services and it is the task of the profession to educate the public about the value of psychology. The presence of psychologists at schools will go a long way in combating this stigmatisation. Here children will be exposed not only to the curative side, but also to the preventive side of psychology. The teaching of social skills such as problem solving, conflict-resolution, sensitivity training and communication skills are skills that are necessary for healthy social development and the promotion of good interpersonal relationships.

The primary limitation was the lack of training that I had in community psychology and its processes. My training was still schooled in the traditional paradigm of individual counselling, albeit that the counselling training focuses on prevention and promotion

aspects and sees clients as equal partners in the therapeutic process. In order to grasp the multiple interwoven levels of society one has to have a thorough theoretical framework in order to appropriately conceptualise what clients present in counselling. Failing this, one could easily fall in the trap of the traditional one-dimensional conceptualisation of problems, merely identifying pathologies and ignoring strengths and potential. Training in preventive work, such as psycho-education and life skills, how to do appropriate needs assessments, how to establish processes and connect with existing structures are fundamental to community work. Community building and development should also form part of the training.

Good supervision and consultation with the broader Jamestown Community Project leader facilitated my understanding and ways of working within the community. Learning how to tap into the resources of the community was a meaningful learning process and how to do this effectively, should be an area of training. Appropriate training in community psychology is fundamental to be effective and to optimally utilise the opportunities for learning from communities. The training of a psychologist should equip them to deal with the realities of South Africa in order to play a meaningful role in the development of the country.

Supervision, as one of the cornerstones of psychology training, should provide a safe space for interns to reflect freely on their experiences in the community, positive as well as negative ones. It should be process oriented and not merely a checklist of problems encountered in the internship, providing space for self-reflection, -discovery and -learning. Appropriate supervision can promote the efficient rendering of services by the supervisee, by focusing on the personal wellness and self-care of the intern.

The integrated approach which Gibson and Swartz (2001) advocate appears to meet some of the demands for the South African situation and needs to be expanded. Community psychology should be *the approach* that is taught at universities and not be an extension of the traditional approaches (Naidoo, Shabalala & Bawa, in press). It is simply the reality of South Africa that the individualistic therapeutic models have not addressed the overwhelming need for mental health services. These cannot be adjusted to resemble community psychology. The approach to psychology needs to be radically changed so that the resource can be equitably distributed amongst all the people of South Africa.



The proposed integration of mental health services into the primary health sector is an area that needs monumental clarification and training. Flisher, Fisher and Subedar (1999) highlight some of the numerous issues that need to be explored. Some of which revolve around training, staff morale, clarification of goals and definitions, budgetary and financial considerations and the elevation of the prevention and promotive aspects of mental health.

The internship provided a valuable entrance into community psychology as well as traditional ways of practicing psychology. The spread between the school, clinic, the mentoring programme and the Centre for Student Counselling and Development exposed me to a broad spectrum of clients, a variety of issues with which they deal with daily and also the opportunity to work on multiple levels of intervention in a community. The diverse settings presented me with a blank slate to creatively explore ways of doing psychology at such a setting, however, the lack of structure could result in isolation from peers and supervisors on a daily basis and has the potential to be disempowering (Gibson & Swartz, 2001). Peers and supervisors play an integral role in the life of an intern and should be dealt with when community placements are considered.

Furthermore, the location of the internship at the clinic inadvertently biased the internship towards a community mental health model, which essentially still focuses on individual, curative work and can trap the counsellor in the 'expert' mode. Given the complexity of the South African situation and the profound impact historical social forces has had on this society, one has to question whether the mental health model is the socially appropriate model for this context. Also, one has to ask whether this model does not merely perpetuate the status quo, by the mere treatment of the symptoms, while the covert systemic problems remain unchanged.

The focus of community psychology is to challenge those societal structures that are detrimental to human welfare and the promotion of mental health (Prilleltensky, 2001), and not merely treating the symptoms of psychosocial distress. Much of the psychological distress encountered during this internship is a direct consequence of structural issues such as poverty and unemployment, thus the focus should be on how to address these issues 'upstream'. For change not be incidental, the targets for intervention should be those forces that perpetuate mental ill health and unjust societies (Albee, 1986). This is an area of critique against community psychology, although it has played a meaningful role in changing the face of psychology internationally, it has not been successful on all fronts.

One of the areas that have been neglected is the promotion of social justice (Prilleltensky, 2001). He calls for community psychologists to refresh their memories with the founding values and goals of community psychology in order to chart its road ahead. He lists two goals, namely, eliminating those oppressive social conditions that promote psychological distress and the promotion of mental health as central to community psychology.

For psychology to be relevant in the lives of especially disadvantaged communities and to promote social justice, one wonders whether the social action model is not more suited to this context. Especially when one considers the legacy of the inequitable distribution and access to material resources in this society, the growing disparities between rich and poor, the slow pace at which fundamental change is occurring and the need for people to reclaim their power lost through years of oppression. On another level, the ease with which western and Eurocentric models have been adopted has been the main critique against traditional psychology in South Africa, thus the profession should be engaged in evolving models that will facilitate the conceptualisation and addressing the issues of South Africa.

Stevens (1999) identified two stumbling blocks to the growth of a socially relevant theory and application thereof. These are the conscious resistance from conservative sections of the profession and the liberal section's unwitting resistance to change and the adherence to theories and the concomitant training methods that entrench the myopic conceptualisation of psychological distress. Despite the rhetoric of training more black psychologists in relevant theories and praxis, the pace of change has been exceedingly slow. Stevens (1999) critically engages with issues such as training, the ambiguities within trainee psychologists, challenges that impact their ongoing professional development and their dilemmas of praxis.

On reflection the internship provided a valuable opportunity for me to engage with the numerous theories that were floating through my head and helped me to shape my own professional identity. As an intern, I constantly struggled, and still do, with questions such as, *am I doing therapy correctly, am I being effective, is what I am doing meaningful to my context*, and a host of others. I constantly had to deal with the uncertainties of not knowing and struggle to make sense of what clients present within my own theoretical orientation. Casement (1990) contends that this uncertainty is a healthy basis for questioning what we as psychologists are trying to do. He maintains that the dialectic between 'the search for certainty and a need to remain open to the experience of still not-knowing, can become the

source of a patient's greatest potential for change and creativity' (p.16). As the year progressed I became more quiet in the realisation that there is no one way of doing therapy and that one has to draw heavily on one's own personal theoretical orientation. The importance of the client-counsellor relationship (Yalom, 1989) and the importance of naming one's social reality (Freire, 1996) have become my mainstay. Acknowledging and dealing with my own impotence against the powerful social influences of the broad macro-structures that promote mental ill health, is an important area that was dealt with in supervision. Ultimately I discovered that one has to distill all these different theories into a personal, contextual orientation that will be meaningful for both client and counsellor.

## **11. CONCLUSION**

The question 'can psychology assist in the promotion of the health of black working people?' that Whittaker (1995) posed, is as relevant now as it was then. Psychology needs to answer the rallying call to play a more meaningful role in the lives of all the people of South Africa. It has the expertise to promote healing and transformation and to 'deal with the psychological scars wrought by apartheid' (Asmal, 2001, p.1). Stevens (1999) contends that the discipline has started to debate and explore alternatives that should significantly transform the discipline at a structural level. He argues that contextual issues should not be an addendum to the individualistic models, but should be the approach used to conceptualise psychological distress. Further, he concurs with Kriegler (1993) that the strict boundaries should be transcended and there should be an attempt to work across disciplines in order to develop a more relevant praxis and to extricate psychology from its stifling paradigms. Areas that need to be scrutinised and interrogated are the insularity of the profession itself (Hook, 2002), the production of knowledge and the training of psychologists. Furthermore, the profession has to raise its voice and speak out against the growing inequities and disparities in the social context of South Africa. Theory should contextualise the socio-political and historical forces operant in South Africa, how this impacts on mental health or ill health. Community psychology as an approach and the training programmes therein, should equip new psychologists to deal with these challenges and the changing contexts and needs of all South Africans appropriately.

## **12. REFERENCES**

- Albee, G.W. (1986). Toward a just society. Lessons from observations on the primary prevention of psychopathology. *American Psychologist*, 41(8), 891-898.
- Angus, C., & Halling, S. (2001). The healing power of the psychotherapeutic relationship: A dialogical perspective. Paper presented at PsySSA National Conference, August 2001.
- Annual Report, (1999). Department Health Services, Stellenbosch Municipality.
- Asmal, K. (2001). Keynote address by the Minister of Education. *PsyTalk*, 4, 1&4.
- Barbarin, O., & Richter, L.M. (2001). *Mandela's children: growing up in Post-apartheid South Africa*. New York: Routledge.
- Blokland, L.M. (1993). *Psychotherapy training: The Mamelodie experience*. Unpublished Master's thesis, University of South Africa.
- Bond, P. (1994). RDP versus World Bank. *International Viewpoint*, 257, 16-17.
- Brand, H. (1999). Psychological counselling in disadvantaged communities: Outreach programmes at the Centre for Student Counselling, University of Stellenbosch. Unpublished paper, University of Stellenbosch.
- Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge, MA: Harvard University Press.
- Brundtland, G.H. (2001). Message from the director-general of the World Health Organization. In *The World Health Report: Mental health: new understanding, new hope*. Retrieved February 20, 2002 from the World Wide Web: <http://www.who.int/whr/2001>.
- Buch, E. (2000). The health sector strategic framework. *South African Health Review*. Retrieved March 7, 2002 from the World Wide Web: <http://hst.org.za/sahr/>

- Caplan, G. (1964). *Principles of preventive psychiatry*. United States of America: Basic Books, Inc.
- Casement, P. (1990). *Further learning from the patient. The analytic space and process*. London: Routledge.
- Dalton, J., Elias, M., & Wandersman, A. (2001). *Community psychology: linking individuals and communities*. United States Of America: Wadsworth.
- Dawes, A., & Donald, D. (2000). Improving children's chances. In D. Donald, A. Dawes, & J. Louw (Eds.), *Childhood adversity* (pp.1-25). Cape Town: David Philip.
- Dawes, A., Roberston, B., Duncan, N., Ensink, K., Jackson, A., Reynolds, P., Pillay, A., & Richter, L. (1997). Child and adolescent mental health policy. In D. Foster, M. Freeman, & Y. Pillay (Eds.), *Mental health policy issues for South Africa*, (pp.193-215). Cape Town: MASA Multimedia.
- Department of Health, (2002). Health Sector Strategic Framework 1999 - 2004. Retrieved February 25, 2002 from the World Wide Web: <http://196.36.153.56/doh/doc/index.html>
- Desjarlais, R., Eisenberg, L., Good, B., & Kleinman, A. (1995) *World mental health: problems and priorities in low-income countries*. New York: Oxford University Press.
- Flisher, A., Fisher, W., & Subedar, H. (1999) Chapter 25: Mental Health. *South African Health Review*. Retrieved March 02, 2002 from the World Wide Web: <http://hst.org.za/sahr/>
- Flisher, A., Ziervogel, C., Chalton, D., Leger, P. & Robertson, B. (1993). Risk-taking behaviour of Cape Peninsula high school students. Part II. Suicidal behaviour. *South African Medical Journal*, 83, 474-476.

- Foster, D., & Swartz, S. (1997). Introduction: policy considerations. In D. Foster, M. Freeman, & Y. Pillay (Eds.), *Mental health policy issues for South Africa*, (pp.1-22). Cape Town: MASA Multimedia.
- Freeman, M. (1990). The challenges facing mental health care in South Africa. In M. Freeman (Ed.), *Mental Health Care for a new South Africa and rural community mental health care*, (pp. 3-11). Johannesburg: Centre for the Study of Health Policy, University of the Witwatersrand.
- Freeman, M. (1991). Mental health for all - moving beyond rhetoric. *South African Journal of Psychology*, 21, 141-147.
- Freeman, M. (1998). Mental health service change. *South African Medical Journal*, 88 (6), 742-743.
- Freeman, M., & Pillay, Y. (1997). Mental health policy - plans and funding. In D. Foster, M. Freeman, & Y. Pillay (Eds.), *Mental health policy issues for South Africa*, (pp. 32-54). Cape Town: MASA Multimedia.
- Freire, P. (1996). *Pedagogy of the oppressed*. London: Penguin Books.
- Gibson, K., & Swartz, L. (2001a). Psychology, social transition and organizational life in South Africa: "I can't change the past - but I can try". *Psychoanalytic Studies*, 3 (3/4), 381-392.
- Gibson, K., & Swartz, L. (2001b). Becoming a community clinical psychologist: Integration of community and clinical practices in psychologists' training. *South African Journal of Psychology*, 31(1), 29-35.
- Gibson, K. (2000). Working with troubled children. In D. Donald, A. Dawes & J. Louw (Eds.), *Addressing childhood adversity*, (pp.223-243). Cape Town: David Philip.

- Hamber, B., Masilela., & Terre Blanche, M. (2001). Towards a Marxist community psychology: radical tools for community psychological analysis and practice. In M. Seedat, N. Duncan & S. Lazarus (Eds.), *Community psychology: Theory, method and practice*, (pp. 87-106). Cape Town: Oxford University Press.
- Higson-Smith, C., & Killian, B. (2000). Caring for children in fragmented communities. In D. Donald, A. Dawes & J. Louw (Eds.), *Addressing childhood adversity*, (pp. 202-224). Cape Town: David Philip.
- Holdsworth, M. (1994). *Consultation and training challenges at the Mamre community health project*. Unpublished Master's thesis, University of Cape Town.
- Hook, D. (2002). Introduction: A 'social psychology' of psychopathology. In D. Hook & G. Eagle (Ed.), *Psychopathology and social prejudice*, (pp. 1-18). Cape Town: University of Cape Town Press.
- Kleinbooi, K. (1996). Urbanisation and land reform projects: area case study of Jamestown. Unpublished paper, Department of Sociology, University of Stellenbosch.
- Kriegler, S. (1993). Options and directions for psychology within a framework for mental health services in South Africa. *South African Journal of Psychology*, 23, 64-70.
- Laing, R.D. (1971). *Politics of the family and other essays*. London: Tavistock Publications.
- Lazarus, S. (1988). *The role of the psychologist in South African society: In search of an appropriate community psychology*. Unpublished doctoral dissertation, University of Cape Town.
- Lewis, J., Lewis, M., Daniels, J., & D' Andrea, M. (1998). *Community Counseling: Empowerment strategies for a diverse society*. Pacific Grove, CA: Brooks/Cole Publishing Company.

- Liebenberg, L. (2000). *Low-income women and mental health care: An exploratory Study of non-governmental mental health services in the West coast/ Winelands region of South Africa*. Unpublished Master's thesis, University of Stellenbosch.
- Lifschitz, S., & Oosthuizen, C. (2001). Discovering Agape: forming and re-forming a healing community. In M. Seedat, N. Duncan & S. Lazarus (Eds.), *Community psychology: Theory, method and practice*, (pp. 87-106). Cape Town: Oxford University Press.
- Mash, B., & Mahomed, H. (2000). Participatory development of a minimum dataset for the Khayelitsha District. *South African Medical Journal*, 90 (10), 1024-1027.
- Mearns, D., & Thorne, B. (1997). *Person-centred counselling in action*. London: SAGE Publications.
- Mental Health Information Centre. The mental health information centre. Retrieved February, 21, 2002 from the World Wide Web: <http://www.mentalhealthsa.co.za/>
- Moffitt, T. (1993). Adolescence limited and life course persistent antisocial behaviour: A developmental taxonomy. *Psychological Review*, 100(4), 674-701.
- Naidoo, A.V. (1996). Challenging the hegemony of Eurocentric psychology. *Journal of Community and Health Sciences*, 2(2), 9-16
- Naidoo, A.V. (2000a). Community psychology: Constructing community, reconstructing psychology in South Africa. Inaugural Lecture. University of Stellenbosch.
- Naidoo, A.V. (2000b). The Jamestown Community Project: Project Funding Proposal. Department of Psychology, University of Stellenbosch.
- Naidoo, A.V., Shabalala, N., & Bawa, U. (In press). Community psychology. In L. Nicholas (Ed.), *Psychology: An Introduction*. Cape Town: Van Schaik Publishers.



- Naidoo, A.V., Dunn, M., & Van Wyk, S. (2001). Taking the class into the community: The application of a community consultation intervention as part of a Masters course in counselling psychology. Paper presented at PsySSA National Conference, August, 2001.
- Nell, V. (1994). Critical psychology and the problem of mental health. *Psychology in Society*, 19, 31-34.
- Orford, J. (1992). *Community psychology: Theory and practice*. Chichester: John Wiley & Sons.
- Parekh, A., Mc Kay, A., & Petersen, I. (1997). Non-governmental organisations. In D. Foster, M. Freeman, & Y. Pillay (Eds.), *Mental health policy issues for South Africa*, (pp. 122-131). Cape Town: MASA Multimedia.
- Petersen, I., & Ramsay, S. (1993). Mental health and development in a shack settlement: The case of Bhambayi. *Psychology in Society*, 17, 35-50.
- Pillay, A. (2001). Psychological symptoms in recently diagnosed cancer patients. *South African Journal of Psychology*, 31 (1), 14-18.
- Pillay, A., & Lockhat, R. (2001). Models of community mental health services for children. In M. Seedat, N. Duncan & S. Lazarus (Eds.), *Community psychology: Theory, method and practice*, (pp. 87-106). Cape Town: Oxford University Press.
- Pillay, Y., & Petersen, I. (1996). Current practice patterns of clinical and counselling psychologists and their attitudes to transforming mental health policies. *South African Journal of Psychology*, 26 (2), 76-80.
- Pretorius-Heuchert, J.W., & Ahmed, R. (2001). Community psychology: past, present, and future. In M. Seedat, N. Duncan & S. Lazarus (Eds.), *Community psychology: Theory, method and practice*, (pp. 17-36). Cape Town: Oxford University Press.

- Prilleltensky, I. (2001). Value-based praxis in community psychology: moving toward social justice and social action. *American Journal of Community Psychology*, 29 (5), 747-778.
- Rappaport, J. (2000). Community narratives: Tales of terror and joy. *American Journal of Community Psychology*, 28(1), 1-24.
- Riger, S. (2001). Transforming community psychology. *American Journal of Community Psychology*, 29(1), 69-79.
- Robertson, A.C. (2001). Reflections on the Phelophepa train experience. *PsyTalk*, 4, p.5.
- Rogers, C. (1961). *On becoming a person: A therapist's view of psychotherapy*. London: Constable.
- Scilleppi, J.A, Teed, E.L., & Torres, R.D. (2000). *Community psychology: A common sense approach to mental health*. New Jersey: Prentice-Hall.
- Seedat, M., Butchart, A., & Nell, V. (1991). Family therapy in Primary Health Care: Skills training and outcome evaluation. *Contemporary Family Therapy*, 13(2), 143-163.
- Seedat, M., Duncan, N., & Lazarus, S. (2001). Community psychology: Theory, method and practice. In M. Seedat, N. Duncan & S. Lazarus (Eds.), *Community psychology: Theory, method and practice*, (pp. 3-14). Cape Town: Oxford University Press.
- Seedat, M., & Nell, V. (1990). Third world or one world: Mysticism, pragmatism, and pain in family therapy in South Africa. *South African journal of Psychology*, 20, 141-149.
- Seedat, M., & Nell, V. (1992). Authoritarianism and autonomy. Conflicting value systems in the introduction of psychological services in a South African primary health care system. *South African Journal of Psychology*, 22, 185-193.

Statistics South Africa, Census 1996.

Stellenbosch Municipality (2002). Population density. Unpublished document, Stellenbosch Municipality.

Stevens, G. (1999). Racism and cultural imperialism in the training of black clinical psychologists in South Africa: Identity, ambiguity and dilemmas of praxis. In N. Duncan, A. van Niekerk, C. de la Rey & M. Seedat (Eds.), *Race, racism, knowledge production and psychology in South Africa*, Chapter 6. (pp. ?). New York: Nova Science Publishers.

Swanepoel, H. (1992). *Community development. Putting plans into action*. Cape Town: Juta & Co. Ltd.

Swartz, L. (1998). *Culture and mental health: a Southern African view*. Cape Town: Oxford University Press.

Swartz, L., & Gibson, K. (2001). The 'old' versus 'new' in South African community psychology: the quest for appropriate change. In M. Seedat, N. Duncan & S. Lazarus (Eds.), *Communnity psychology: Theory, method and practice*, (pp.37-50). Cape Town: Oxford University Press.

Thompson, C., & Rudolph, L. (2000). *Counseling children*. (5<sup>th</sup> ed.). Belmont, CA.: Brooks/Cole.

Western Province, Department of Health (2002). Draft Strategic and Service Delivery Improvement Plan. Retrieved February, 25, 2002 from the World Wide Web: <http://196.36.153.56/doh/links/index.html>

Whittaker, S. (1995). Psychology and mental health care in deracialised South Africa. *Journal of Community and Health Sciences*, 2(1), 43-45.

Wingenfeld, S., & Newbrough, J.R. (2000). Community psychology an international perspective. In J. Rappaport & E. Seidman (Eds.), *Handbook of community psychology*, (pp.779-810). New York: Kluwer Academic/ Plenum Publishers.

World Health Organization. (2001). *The world health report 2001. Mental health: new understanding, new hope*. Retrieved February, 02, 2002 from the World Wide Web: <http://www.who.int/whr/2001>.

Yalom, I. (1989). *Love's executioner and other tales of psychotherapy*. New York: Basic Books.

Zimmerman, M. (2000). Empowerment theory: psychological, organizational and community levels of analysis. In J. Rappaport & E. Seidman (Eds.), *Handbook of community psychology*, (pp. 43-63). New York: Kluwer Academic/Plenum Publishers.

## **APPENDIX A:**

# DON & PAT BILTON CLINIC

## JAMESTOWN

INTAKE INTERVIEW
------------------

### Biographical Details

Name of Client: .....

Date of Birth: ..... Age: .....yrs.....mths

Address: .....  
.....

Marital Status: .....

Denomination: ..... Telephone: .....

Academic Qualifications: .....

Occupation: .....

Family description and relationships: .....  
.....  
.....

Social support network: .....  
.....

Presenting problem in Client's own words: .....  
.....  
.....  
.....

Problem onset / Development: .....

Solutions that have been tried: .....  
.....  
.....

Previous treatment at psychologist / psychiatrist: .....

.....

.....

.....

Medical History: .....

.....

Medication: .....

.....

Hospitalization: .....

Family history of psychiatric illness: .....

.....

**Mental Status Examination:**

Appearance: .....

Demeanor: .....

Mood: .....

Thoughts: .....

Speech: .....

Rapport: .....

Suicide attempts / thoughts / plans: .....

Physical symptoms checklist:

Depression:

- \* poor appetite / weight loss
- \* insomnia
- \* low libido
- \* anhedonia
- \* lack of energy

Anxiety:

- \* tremor
- \* palpitations
- \* excessive sweating
- \* shortness of breath
- \* nausea / diarrhea

Other physical symptoms: .....

.....

**SUMMARY AND EVALUATION:** .....

.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....

**DIAGNOSIS / INTERVENTIONS:**

.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....



## **APPENDIX B:**

**DON & PAT BILTON CLINIC**  
**PROCESS NOTES**

Client .....

Date.....

**Goals for session** .....

.....

.....

.....

.....

.....

**What was achieved**

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

**Remarks / Themes / Interactional Patterns**

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

**Planning for next session**

.....

.....

.....

## APPENDIX C:

EERSTENS Sielkundige hulp is NIE vir **“MAL”** mense nie.  
Sielkundige Hulp is vir enige persone op aarde  
Sielkundige Hulp is vir persone met Huweliks probleme.  
Kinders kan ook sielkundige hulp kry

PERSONE WAT ABUSE WAS, JY Kan vir niemand vertel nie, want jy is bang kom  
Gesels met Die Sielkundige  
Liefdes teleurstelling en jy kan vir dit kom nie kom Gesels met die Sielkundige  
Sj is Daar om Jou te Help

AS JY Verkrag was en dit voel soos Nagmerries kom Gesels met die  
SIELKundige SJ Kan Help  
Baie mense wat stress het, wat gespanne is, Senuweeagtig  
Kan ook met die

Baie mense Voel Die lewe is nie meer die moeite werd nie, altesaam  
te veel vir jou kom Gesels met die Sielkundige  
Soms wil Baie Selfmoord Pleeg, omdat Dinag Raak te veel vir Hulle dinge  
Kom Gesels.

Wat miskien gebeur het of wat ook al die geval mag wees kom Gesels  
met Die Sielkundige. JY Sal nooit WER aan self moord dink nie.  
AS JY ver Bitterd is Teen oor iemand kom Gesels met die Sielkundige  
Daar Baie mense wat nie kan vergewe nie jy leef met Haat dit vreet jou op binne in jou  
Die Sielkundige kan jou daarmee Help.

Daar's Nog Baie Soorte probleme wat knop noem, maar jy weet waarmee, jy werstel die  
Sielkundige is daar om jou te help.  
AS jy iemand tragies of skielik aan die dood afgegee het en jy kan nie oor die Geliefde Sedoeloor kom  
nie kom Gesels met Die Sielkundige

JY Sal niks verloor nie, jy sal net as n nuwe mens hier by die kliniek uit stap.  
ad'seen julle wat julle verneder en nie trots is nie. Dit is ook nie n Skande nie!! om na n  
Sielkundige te kom nie. Die Sielkundige sal met jou n afspraak reël. Vir Verdere inligting: Gesels met  
SHIREN VAN WYK

VAAK GEBRUIK VAN DIE SIELKUNDIGE IN DON & RAT  
Sr. R. Barnard