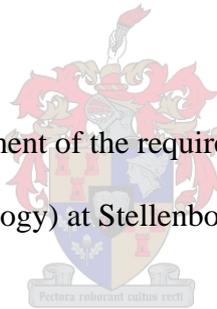


**PERCEPTIONS OF PSYCHOLOGY: THE VIEWS OF KEY INFORMANTS
AND PRIMARY HEALTH CARE SERVICE USERS IN A PERI-URBAN
COMMUNITY IN THE WESTERN CAPE**

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Thesis presented in partial fulfilment of the requirements for the degree of Master of
Arts (Psychology) at Stellenbosch Univeristy



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DECLARATION

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the owner of the copyright thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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ABSTRACT

The importance of delivering psychological services, particularly in disadvantaged communities is acknowledged by policy makers. Yet, little information exists about how communities view psychologists and psychological services. This study explores how key informants and primary health care service users in a peri-urban community in the Western Cape perceive psychologists and their profession. Focus groups were conducted with primary health care service users and in-depth interviews were conducted with key informants. Results were content analysed. These results indicate that this community's conceptualisation of psychology incorporates both Western and indigenous notions and concepts which are utilised simultaneously. Psychology is viewed positively as a profession that can aid individuals and groups in dealing with and resolving intra- and interpersonal problems and conflicts. Those with mental health problems are still subject to a great deal of stigmatisation. The fear of being labelled makes the utilisation of the services of a psychologist or other mental health professional highly unlikely in several instances. This problem is exacerbated by issues related to the availability of and access to such services, as well as the quality of available care. Nonetheless, these participants state that psychologists themselves can make a positive contribution to addressing these issues, starting with active involvement in communities and providing information regarding the nature and value of the work they do. This information is critical if we are to design and implement comprehensive intervention strategies that allow for meaningful and informed participation within communities.

OPSOMMING

Beleidvormers erken dat die voorsiening van sielkundige dienste in agtergeblewe gemeenskappe 'n prioriteit is. Tog is daar min inligting aangaande hoe gemeenskappe sielkundiges, die sielkunde en sielkundige dienste beskou. Hierdie studie ondersoek hoe sleutel informante en primêre gesondheidsorg verbruikers in 'n peri-stedelike gemeenskap in die Wes-Kaap sielkundiges en hul beroep verstaan. Fokusgroepe is met primere gesondheidsorg verbruikers gehou en in-diepte onderhoude is met sleutel informante gevoer. Resultate is deur middel van inhoudsanalise verwerk. Hierdie resultate dui aan dat hierdie gemeenskap se siening van sielkunde beide Westerse en inheemse idees en konsepte inkorporeer. Sielkunde word positief beskou as 'n professie wat persone en groepe kan help om intra – en interpersoonlike probleme en konflikte te hanteer en op te los. Tog word dié persone wat worstel met 'n sielkundige probleem gestigmatiseer. Die vrees van etikering maak die gebruik van sielkundige dienste in sekere gevalle hoogs onwaarskynlik. Hierdie probleem word verskerp deur kwessies wat verband hou met die beskikbaarheid en toeganklikheid van dienste, tesame met die kwaliteit van beskikbare dienste. Nieteenstaande, stel hierdie deelnemers dat sielkundiges self 'n positiewe bydrae kan maak in die aanspreek van hierdie kwessies deur te begin met aktiewe betrokkenheid in gemeenskappe en die daarstel van inligting rakende die aard en waarde van die werk wat hulle doen.

Hierdie inligting is noodsaaklik vir die ontwerp en implementering van omvattende intervensie strategieë wat betekenisvolle en ingeligte samewerking binne gemeenskappe moontlik maak.

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DEDICATION

I dedicate this work to every South African. May the time come when we live free and in peace with one another. May we be a nation blessed with prosperity, where each individual's needs are met, and where we live healthy and productive lives.

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CHAPTER 1

Introduction

1.1 Research Problem

Communities' health, including mental health has been a concern not only for professionals in the field but also national government (Department of Health, 2005; Freeman & Pillay, 1997). Several mental health professionals have questioned the relevance of psychology as it is mainly practiced today, given the fact that we find ourselves in an era of continued profound social and political change. Still, very little is known regarding how community members themselves view their mental health and well-being, psychology as a whole, and the contribution psychology can make to improve their quality of life. Thus, the purpose of this study is to explore the perceptions a specific community holds about psychology and psychological practice within the South African context. The literature suggests that the following issues are pertinent to this quest: the image of psychologists and psychological practice; links between personal problems (that is mental health) and social, political and economic conditions; utilization of helping services; a framework for relevant practice and the future role of the psychologist; and the relationship between psychological practice and political/social change in the South African context (Berger & Lazarus, 1987). Studies that have been done since that of Berger and Lazarus (1987) have proposed additional themes for consideration. These include: awareness of psychological service delivery; access to and availability of services; and the quality of available services (Mokgale, 2004; Pillay & Petersen, 1996; Pillay, Naidoo, & Lockhat, 1999). These will be systematically reviewed.

1.2 Rationale

Almost fifteen years have passed since a democratic society was established in South Africa. An essential element of the necessary transformation process inherent in such an occurrence has been re-organising policies and service delivery in all public service areas, including the mental health care system. Much of the focus in psychology has been on delivering services in communities, implying poor black communities, who have been marginalised and have not had access to psychological services. Still, little is known about what “the community” thinks of this professional service that has entered its sphere. This has yet to be explored systematically.

In order for change to be successful and relevant in our context the perspectives of both the providers and users of such services need to be assessed and afforded due consideration. As such, this study will focus on how key informants and service users in a specific community view psychology as a profession. In this manner one will be able to identify any stigmas and perceptions that may be relevant to the improvement and expansion of service delivery in this field.

We need to acknowledge that a skewed distribution of mental health resources in this country still exists, as most resources are focused on private, urbanised and institutional care. This is discussed in greater detail later in the text.

Admittedly, positive change and advances have been made in the delivery of appropriate, accessible and affordable mental health services in South Africa. However, the nature, availability, quality, and extent of these have yet to be adequately ascertained. Once we are aware of what perceptions not only key service providers but also those who utilise those services have of psychology as a profession, steps can be taken to address any

misperceptions and stigma still attached to the work we do. Admittedly, this is a lengthy process but it is hoped that this will help with the development of relevant and appropriate practices related to service delivery and the way in which these policies are implemented. In addition, it might assist in altering any negative perceptions that individuals, groups and communities have and influence help-seeking behaviour in a positive manner.

Little research has been done on the attitudes, knowledge and perceptions of society as a whole around the issue of psychologists and psychological practice, both internationally and in South Africa. The most significant study that has been done, the Berger and Lazarus study, specifically with a focus on the South African context, was conducted 20 years ago. It is time to repeat this study and extend on it as community psychological interventions have proliferated, yet we know very little about how communities experience these interventions and how they understand the role of psychology and psychologists. Leung and Zhang (1995) echo this sentiment. They argue that as an unknown entity psychology is often misunderstood. According to them, common beliefs and public opinions regarding psychology have no relation to its scientific nature and make no contribution to its advancement.

The current study aims to establish if, in fact, communities' perceptions of psychology have at all changed since the Berger and Lazarus study, as a positive attitude toward psychological services among service users is believed to be central to the overall success of psychological intervention programmes in communities.

This study will use a similar organisational frame as the one originally done by Berger and Lazarus (1987). Emergent themes were: the image of psychologists and

psychological practice; links between personal problems and social, political and economic conditions; utilisation of helping services; framework for a relevant practice and the future role of the psychologist; and the relationship between psychological practice and political struggles in South Africa. As previously stated, other possible themes to explore include awareness of psychological services, access to and availability of services, quality of services.

These themes will be detailed in the literature review which comprises chapter one. In chapter two, individuals' and communities' perceptions of mental health and illness will be explored according to the theoretical concepts of explanatory models and culture. Chapter three is a review of the method of data collection and analysis, as well as the limitations on this process. The results are presented in chapter five. Chapter six consists of the discussion of the results, followed by a brief description of the implications of the study as well as recommendations for future research. Finally, chapter seven is the conclusion which offers a summary of the study.

1.3 Nomenclature

A brief description of the key terminology used in this thesis is given below. These terms include: community; peri-urban community/ area; community counselling/ psychology; racism; minority group; key informants, primary health care; and service users.

1.3.1 Community

There is disagreement on what exactly the term community means, with several authors positing varied explanations. However, there are also several similarities. Lewis, Lewis,

Daniels and D'Andrea (2003) define a community as a group of people who have similar interests and needs. By viewing a community as a system they imply that it has unity, continuity and predictability. The components of a community – individuals, groups and organisations – are interdependent. A community also serves as a link between individuals and other communities and the greater society. Therefore, the community acts as a medium through which individuals can influence their world and through which society can relate norms and values.

Heitman and McKieran (2003) identify six elements of community. These are:

“membership (a sense of belonging and clarity of roles); common symbol systems (language, religious rituals, and national symbols); shared values and norms (from shared experience or handed-down beliefs); mutual influence of its members (based in communication); shared emotional bonds (a sense of personal connectedness); and shared needs and a shared commitment to meeting them (a sense of ‘us’ that transcends personal interest)”.

1.3.2 Peri-urban community/area

Peri-urban communities are regions that display some or all of the following interrelated characteristics: speedy and unplanned development that leads to, amongst other things, negative environment concerns and environmental degradation; uncertain and duplicated jurisdiction regarding issues of planning, land tenure and land transfer; residents' tenure is not always supported by a clearly defined and enforceable title; planning and building guidelines and regulations and the provision of urban services are not implemented; service infrastructure is unable to adequately address even basic needs; social

infrastructure does not meet fundamental needs; a considerable ratio of the residents fall within the lower income categories; unplanned settlements to serve the expanding rental market, with only the rental market meeting the demand; and a process of evolution which makes specific spatial definition impossible (Government of Swaziland, 1997).

Spatially, Rakodi (1999) defines a peri-urban community as:

... a dynamic zone, both spatially and structurally. Spatially it is the transition zone between fully urbanised land in cities and areas in predominantly agricultural use. It is characterised mixed land uses and indeterminate inner and outer boundaries, and typically is split between a number of administrative areas. The land area which can be considered peri-urban shifts over time as cities expand. It is also a zone of rapid economic and social change, characterised by pressures on natural resources, changing labour market opportunities and constraints, and changing patterns of land use. Intense rural-urban interactions give rise to numerous flows of capital/ investment, knowledge, energy, water, waste and pollution (p. 1)

Furthermore, Webster (2002) states that peri-urbanisation is a process where rural areas situated on the periphery of established cities become systematically developed and have urban characteristics in terms of physical, economic and social aspects. This development typically results in rapid social change as small agricultural communities are compelled to adjust to an urban or industrial lifestyle in a short amount of time.

1.3.3 Community Counselling/Psychology

According to Lewis, Lewis, Daniels and D'Andrea (2003), community counselling is a holistic helping framework that outlines intervention strategies and services aimed at enhancing the personal growth, well-being and mental health of all individuals and communities. Their model is based on the following assumptions:

- 1) People's environments may either nurture or limit them.
- 2) The goal of counselling is to facilitate individual and community empowerment.
- 3) A multifaceted approach to helping is more effective than a single-service approach.
- 4) Attention to the multicultural nature of clients' development ... is central to the planning and delivery of counselling services.
- 5) Prevention is more efficient than remediation.
- 6) One can use the community counselling model in a variety of human service, educational, and business settings (p. 20).

Others posit that community psychology is a branch of psychology which utilises other disciplines, such as sociology, anthropology and political science (Scileppi, Teed & Torres, 2000). This approach accepts that behaviour is contextual. Such behaviour is viewed from a system's perspectives, allowing multi-level intervention strategies aimed at the individual, family, group, institution and community. The focus is on the community. Thus, practitioners in this field must adhere to local cultural norms and

traditions and develop intervention strategies in collaboration with community residents and organisations.

Naidoo, Van Wyk and Carolissen (2004) view community psychology as a multi-dimensional system of intervention techniques that move past individualistic, victim-blaming approaches to a focus on groups, organisations and/or the entire community in a specific geographical area. These strategies mobilise community resources and strengths in order to foster capacity building and empowerment; working with communities to address needs and execute programmes they deem necessary and relevant. The aim is to enhance mental health, prevent mental health problems, and foster larger-scale systemic change.

1.3.4 Racism

According to Bhugra and Bhui (2002), racism is:

...an ideology or belief that helps maintain the status quo and, more specifically, it refers to the belief that one race is superior to other races in significant ways and that the superior race is seen as being entitled, by virtue of its superiority, to dominate other races and to enjoy a share of society's wealth and status. These advantages are related to health care, education, employment, wealth and power... (p. 112 – 113).

These authors further define *Institutionalised racism* as the “enforcement of racism and maintenance by the legal, cultural, religious, educational, economic, political, environmental and military institutions of society ...” (p. 115).

1.3.5 Minority group

According to the Wikipedia online dictionary (2008), a “minority or subordinate group is a sociological group that does not constitute a politically dominant voting majority of the total population of a given society”. Such a sociological minority does not necessarily constitute a numerical minority; it may include any group that is different from a dominant group regarding social status, education, employment, wealth and political power. Typically, "minority" refers to a socially subordinate ethnic group (in terms of language, nationality, religion and/or culture). The term "minority group" is often associated with civil, human and collective rights which is a major focus in contemporary global discourse. Every large society has ethnic minorities. In certain instances, these subordinate ethnic groups constitute a numerical majority, such as Black Africans in South Africa under apartheid. Members of minority groups are subject to differential treatment in their resident countries and societies, simply due to their membership of that specific minority group.

1.3.6 Key Informants

According to Roos, Taljaard and Lombard (2001), key informants are individuals who interact directly with others who experience problems in their day-to-day living. These are community residents or service providers whose status in the community affords them considerable knowledge of the community as a whole or a particular segment thereof (University of Illinois, n.d.). These may be professionals or members of the target group. Key informants can be drawn from any age group, socio-economic level, religious affiliation, educational level and ethnic group. They are individuals who both

comprehend and contemplate the situation. S/he is able to verbalise thoughts, emotions, opinions and perspectives regarding issues in a circumscribed region.

1.3.7 Primary Health Care

Primary health care (referred to as PHC hereafter) was first conceptualised by the World Health Organisation (1978) at The Alma Ata Conference. There, the following definition was formulated as:

...essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of both the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process (p. 2).

In the South African context, the services provided by PHC workers include the following: immunisation; prevention of transmittable and endemic diseases; maternity care; child screening; Integrated Management of Childhood Illnesses and child health care; promoting health, youth health services; counselling services; treatment of chronic

diseases and diseases of the elderly; rehabilitation; accident and emergency services; family planning, and oral health services (SA Government yearbook: health, 2003/2004). These are free and minimally paid services provided at public health facilities such as clinics and community health care centres.

1.3.8 Service Users

For the purposes of this study, service users refer to individuals and groups who utilise primary and mental health care services. These services include those provided by medical professionals and psychologists.

CHAPTER 2

Literature Review

2.1 Introduction

Several authors have commented on psychological practice within the South African context. Their views and critical analysis of our profession have led to large-scale change in the way that psychology is practiced today. However, the perspective of service users and those they interact with daily have not been adequately assessed. This chapter gives an overview of existing literature on psychological practice, that is its practice perspectives, and how it is viewed by professionals and service users alike according the following themes: the image of psychology, psychologists and psychological practice; links between personal problems and social, political and economic conditions; availability of and access to psychological service delivery; awareness of psychological services; utilisation of helping services; quality of services; and the relationship between psychological practice and socio-political change in South Africa; and a framework for a relevant practice and the future role of the psychologist.

2.2 Image of psychology, psychologists and psychological practice

The views of professionals in the field and psychology students are the main focus of literature in this area. Certain findings indicate that psychology is widely conceived as focused on individual therapy with few viewing psychology as a science (Dollinger & Thelen, 1980; Aspenson et al., 1993). Cupchik, Klojner and Riley (1986) argued that students do perceive psychology as a “science, vehicle in the search for wisdom” and as a

“healing profession”. This view becomes more entrenched and their conceptualisation of the profession more abstract as they progress within the field. In addition, some researchers note that the general public have ideas of psychologists that are associated with brainwashing people, as having primary responsibility for their clients’ well being, and as being in control of the therapeutic relationship (Williams, 1986).

Stones (1996) aimed to conduct a survey to establish knowledge of psychological services. His participants included were divided into five categories: psychology and non-psychology university students; psychologists; general medical practitioners; members of the general public; and psychiatric hospital staff and clients in psychiatric hospital settings. He found significant differences between the respective samples, which he ascribes to the individual’s degree of knowledge regarding mental illness as well as the level of contact the individual has had with mental health professionals and the services they provide. In accordance with Cupchik et al (1986), Stones (1996) found that the higher the students’ training within the field the more positive his/her attitude towards the discipline. However, psychiatric treatment (for example institutionalisation) is increasingly frowned upon as the student advances within this field of study. Both psychiatric staff and clients held a positive view of psychiatric treatment but not psychological interventions, and believed that psychiatrists are best able to deal with mental health problems. General medical practitioners have slightly greater confidence in the effectiveness of psychological and psychiatric treatment than members of the public. Interestingly, in this regard, psychologists like students, have a less than favourable view of treatment practices.

Berger and Lazarus (1987) found that most individuals that they interviewed in community based settings in South Africa, had very little personal involvement with psychologists and were unfamiliar with the work that psychologists do. They attributed this to two things: the inaccessibility of psychologists to the majority of the population and the nature of their work. At the time of their study, psychologists did not work in disadvantaged communities, they did not actively promote themselves or the work they do and their services were viewed as expensive. Mokgale (2004) supports the notion of promoting awareness of psychologists and their work in communities. Mokgale (2004), like Berger and Lazarus (1987), suggested that psychologists were thought to work with 'mad' people and the middle class, and it was believed that they are ignorant of community issues and the concerns of the oppressed. Psychologists were viewed as handling severe problems and were to be consulted in the case of traumatic situations. This means that they were connected to the negative image of psychiatric institutions, which caused people to regard them with caution and even suspicion. Mokgale (2004) suggested that it would be helpful if psychologists did psycho-education regarding psychology in the communities in which they work and live.

Nevertheless, there were some positive views regarding the psychologist's role in individual counselling which was defined as "the development of a relationship with clients, listening and talking to them in order to help them work through personal experiences and problems" (Berger & Lazarus, 1987). However, the manner in which this was conducted was believed to be inappropriate for and inaccessible to the majority of the South African population. Informants indicated that although psychologists could

provide assistance and guidance, during the late 1980s and early 1990s the plight of the oppressed were not lightened by the psychologist's skills (Berger & Lazarus, 1987).

In addition, psychology's individualistic approach where the focus was to make people fit back into mainstream society was frowned upon. Here, already, a call was made that a context-sensitive framework should be incorporated more significantly.

Finally, psychologists were viewed in relation to the powerful and privileged classes in South Africa, and thus believed to have little comprehension of and appreciation for the concerns and realities of the oppressed and marginalised.

It is evident that socio-economic and political factors play a major role in how psychology is viewed by especially the general public. Therefore, it is important to evaluate how these factors affect people's psychosocial functioning and how psychology can address problems of living that arise from these factors.

2.3 Links between personal problems and social, political and economic conditions

Rock and Hamber (1999) cite several authors who contend that traditional, Eurocentric psychological practice locates psychopathology within the individual and does not consider the social context within which mental health and psychological problems arise (Anonymous, 1986; Bassa & Schlebusch, 1984; Berger and Lazarus, 1987; Dawes, 1985; Freeman, 1989; Hamber and Rock, 1993; Straker, 1988; Thomas, 1987; Vogelman, 1986; Vogelman, n.d.). Furthermore, according to Vogelman (1990), psychological interventions were thought to be associated with broader apartheid ideology. Govender (1989, cited in Vogelman, Perkel and Strebel, 1992) holds that "any analysis of human

behaviour cannot exclude an analysis of the dynamics of the social, political, economical and cultural context within which such behaviour occurs” (p. 5). Accordingly, psychologists should investigate the reciprocal interaction between the personal and the political. Within the South African context, the apartheid system and its residual racist, oppressive and harmful influence on the mental health and general well-being of a large portion of the population, even after it has been abolished, is considered by many to be our country’s most significant social problem (Vogelman 1986, cited by Rock and Hamber, 1999). According to Trivedi (2002), racism continues to influence the lives and social positions of the majority of black people. Institutionalised racism in particular (which remains a pervasive characteristic of society) affects “black people’s social, educational and employment opportunities, their economic situation and the way they are treated within public services” (p. 73).

Kosny and Ennis (1999) argue that it is imperative that social, cultural, and economic factors be considered when designing policies, programmes and models aimed at improving the health and well-being of both individuals and communities.

Health is associated with factors other than biological mechanisms and medical models, including a host of socio-cultural, physical, and psychological factors (Cohen & Sinding 1996, as cited by Kosny and Ennis, 1999). These multiple determinants of health include factors such as “income and social status, social support networks, education, employment and working conditions, physical and working environment, biology and genetic predisposition, personal health practices, healthy child development, gender and culture” (Cohen 1998; Women’s Health Strategy 1999, quoted in Kosny and Ennis, 1999). The findings of Kosny and Ennis’ 1999 study, although specifically geared

towards those factors influencing women's health in particular, may be generalised to communities as a whole. They discovered that health and, so too, mental health, does not occur in a vacuum. It is contextualised. Individuals are members of families and communities. Should the community suffer, the members' health is likely to deteriorate. Thus, despite the fact that access to services and quality health care can influence health, poverty and a lack of employment opportunities, which are social factors, are leading health determinants. Furthermore, people living in rural, peri-urban and geographically isolated areas frequently do not have access to basic services. Finally, social support plays a crucial role in health and well-being.

In addition, Kosny and Ennis (1999) list the following as social determinants of health: employment, social support, income distribution, discrimination, poverty, the environment, quality of housing, and access to education. Depending on their nature within the community, these factors may have either a positive or negative effect on community members' mental health and well-being.

In accordance with these findings, McKenzie (2002) argues that for ethnic minority groups (particularly those who are/ were severely marginalised), social factors (such as racism) can have a serious impact on the physical and psychological health. These effects occur on multiple levels, and are longitudinal and intergenerational. Furthermore, detrimental social factors negatively influences the individual and community, as well as social support, cohesion and efficacy.

In the Berger and Lazarus (1987) study, participants commented on an association between broader socio-political and economic structures and those issues that are usually viewed as personal problems or 'individual pathology'. Common psychological

problems such as anxiety and depression were attributed to basic conditions of poverty, unemployment, overcrowding and a lack of recreational facilities. These problems and the high incidence of alcoholism, crime and family conflict were considered to be people's reactions to stressful life situations and severely oppressive social circumstances. Kale (1995b) concurs with these findings. He contends that if symptoms such as elevated levels of substance abuse, crime and violence are indicative of mental health, it is safe to assume that the mental health of all South Africans has been impacted on significantly. Thus, it is imperative that these individuals, groups and communities receive services that cater to their mental health care needs. This means that the country must make such services available to its entire population and ensure that everyone has access to these services.

2.4 Availability of and access to psychological service delivery

Mental health service delivery is part of the general health service package of provincial health departments and local authorities (Department of Health, 2007; 2002). These services are provided in different settings by a variety of health service practitioners. With regards to communities, primary health care clinics are the first point of care utilised by most individuals. The complex nature of mental health care means that the staff of the clinics mainly do screening, emergency management and referrals of people who present with mental health problems. Furthermore, most provinces in South Africa have specialised staff who deal with community mental health. Their task is to support clinic staff and take over the care of those mental health service users who cannot be managed by primary health care staff.

Equity means securing access to quality health care for the entire population (Department of Health, 2007). This requires ensuring the even distribution of health care resources throughout the country, and within the national health care system. Specific attention needs to be paid to the needs of historically disadvantaged individuals and communities and the most vulnerable groups, that is, women, children, the elderly and people with disabilities. Ensuring such equity requires: “redistributing health expenditure to achieve equity – those with equal need should receive the same level of funding; redistributing health resources, in particular doctors and nurses; setting national norms and standards to judge that all people receive an acceptable quality of care; and monitoring progress.”

A large portion of the South African population has inadequate access to health services due to, amongst others, geographical, financial, physical, communication and sociological barriers (Department of Health, 2005). Identifying such barriers and implementing interventions to overcome them should help improve access for all.

Flisher, Fisher and Subedar (1999) argue that availability and access to mental health services for all can only be achieved if the disparities created by the apartheid government are taken into consideration. Apartheid was characterised by oppression and discrimination, making equitable distribution of resources a priority for the current democratic government. Admittedly, much has been done to bring primary health care to all people. Still, inadequate attention is given to the mental health of the whole population. This is evident in, for example, the budget afforded to the mental health care system, which is discussed in greater detail later in the section on the quality of available psychological services. According to these authors, the key to attaining equity in the public mental health care service is a comprehensive, community-based mental health

system that is integrated with other health care services. Currently, these services are least accessible to the most vulnerable population groups and are situated mainly in psychiatric hospitals rather than other levels of care. The locale of mental health care services may mean that many potential service users are unaware of the existence of such services and that they are available for their use.

2.5 Awareness of psychological service delivery

This is a category that did not form part of the original Berger and Lazarus (1987) study. However, they do make reference to the fact that key informants thought that few social services were available and that communities were generally ignorant of those that were. Mokgale (2004) states that level of education and exposure to the media primarily influence individuals' knowledge of psychological services. In her study, such knowledge extends largely to the awareness that such a profession exists and that psychologists' work involves helping people. It is important to note that those individuals with a solid knowledge of psychological services are those who possess a high level of education. These individuals had studied psychology at tertiary level and/or had been exposed to psychologists and the profession because they, family members or friends had made use of psychological services before. Those participants who did have some limited knowledge of psychologists did not seem to think they could be of any help, most likely due to an inability on the part of participants to identify the nature of problems that were clearly psychological. Still, it was also noted that although a large number of people still lack knowledge about psychologists and psychological services, increased exposure to the media (specifically television and newspapers) has remedied

this to a certain extent. This is evident in the fact that younger participants were better able to convey some understanding of who psychologists are and what they do. Thus, today communities have greater access to information than they did ten or twenty years ago. However, this awareness of psychological services does not necessarily mean that individuals, groups and communities will utilise these services.

2.6 Utilisation of psychological services

Several factors influence individuals' willingness to consult psychologists and other mental health professionals. Individuals often prefer to not seek outside assistance in resolving issues but would endeavour to find solutions to their problems themselves (Berger & Lazarus, 1987). This would likely entail an acceptance of the current situation, that is, no real attempt to improve their circumstances. Furthermore, basic material concerns are deemed to be of greater importance and people would more readily seek aid and advice in obtaining 'concrete' resources. Services are widely regarded as expensive and inaccessible. Still, professionals are regarded as a source of advice and problem resolution. This idea is supported by Mokgale (2004) who argues that although most people in rural communities do not consult psychologists they are likely to do so should their services be available in these areas.

The framework within which psychotherapy is practised is believed to be partly responsible for this lack of utilisation of psychological services (Berger & Lazarus, 1987). The cost of therapy and transport, the time involved, regularity of appointments and the language used are factors that prevent the majority of working classes from utilising this service and make it available to only a small portion of the population. Thus,

a large number of the populace approach individuals other than psychologists to help them resolve personal and family problems that may have a psychological component. Such support systems include religious leaders, family members, friends, social workers and medical doctors. Such consultation is related both to the nature of the concern and whether the person was considered trustworthy. These then are the individuals whom researchers generally come to regard as key informants.

The key informant approach is a tool that is often employed in the process of needs assessment (Lewis et al, 2003). Interviews with these individuals may provide important information regarding the community and can act as basis for the design of other assessment tools such as questionnaires that may then be put to community members themselves. It is widely believed that these individuals are a source of information given that they are “important role players in the gathering of contextual data since they provide detailed historical data, knowledge about interpersonal relationships and the cultural nuances of people life in a particular community (Roos, 2005). The author does not argue that the key informant approach is not a valuable resource in the research endeavour, but these individuals who are key informants are likely to fall within the middle to high socio-economic stratum of a community. As such, they may tend to look at the community from this perspective and not be able to give a genuine account of the community and communal life, particularly of those groups who are working class. Furthermore, psychological knowledge may also be contrary to local traditional and/ or religious beliefs and practices, which may make people exceedingly resistant to using such services (Leung & Zhang, 1995). Thus, utilisation is greatly influenced by the explanatory models people adhere to.

Pillay (1996) holds that people's health beliefs affect their response when they view themselves as ill, the way in which they prevent illness, sustain good health, diagnose symptoms and attend to inconvenient and/or chronic or recurring conditions. Such health behaviour could be divided into six major categories derived from a variety of models (Cummings, Becker & Maile, 1980). These categories are:

... accessibility of health care (for example individuals' ability to pay for health care and awareness of health services, and the availability of services); attitudes towards health (for example beliefs in the benefit of treatment and beliefs about the quality of medical care provided); threat of illness (for example the individual's perception of symptoms and beliefs about susceptibility to and the consequences of disease); knowledge about disease; social interactions; social norms and social structure; and demographic characteristics (p.137).

Furthermore, according to Findlay and Sheehan (2004) physical factors such as lack of appropriate services and distance from adequate assistance are important obstacles to obtaining mental health care for those who reside in rural and remote areas. Again, the issue of accessibility is a major predictor of whether community members will use the services available to them. Hugo, Boshoff, Traut, Zungu-Dirwayi and Stein (2003) note that ignorance and the effects of stigma may prevent potential clients from utilising appropriate services, and that broader community attitudes and beliefs influence individuals' help-seeking behaviour and successful interventions to promote and enhance mental health. Thus, there are several interrelated factors that influence whether or not an

individual will utilise certain services. All these factors have to be addressed if mental health care is to be appropriate, accessible and affordable for everyone.

It is thus clear that enhancing public awareness of both psychology as a profession and mental health is likely to reduce stigmatisation and stimulate greater use of available services and ensure advocacy for quality services.

2.7 The quality of available psychological services

The following quote succinctly encapsulates the importance of quality in service delivery: “.... quality is never an accident, always the result of high intention, sincere effort, intelligent direction and skilful execution, and represents the wise choice of many alternatives....” (Department of Health, 2007: p. i). This document states that the following problems with quality in health care, in both the public and private sectors have to be addressed:

... under-use and overuse of services; avoidable errors; variation in services; lack of resources; inadequate diagnosis and treatment, problems relating to the reallocation of funds from “better off” to “historically poorer” communities and facilities; inefficient use of resources; poor information; an inadequate referral system; disregard for human dignity; drug shortages; records not well kept; and poor delivery systems.... (p. 3)

These deficiencies jeopardise the health and lives of all service users, increase the financial burden of the health care system, and decrease productivity. These problems with the provision of quality care are probably related to the national health budget.

Annually, only 8% of the Gross National Product (GNP) is spent on the national health system, comprising both the private and public sectors and mental health care. Usually, 60% of the available funds are allocated to the private sector. This is problematic, and indicates a skewed distribution of resources, as only about 20% of the country's population utilise private health care. Accordingly, only 40% of the health budget is spent on the public health care sector which caters to 80% of the populace. Thus, although this is in line with the practice of other countries, it has a detrimental impact on the quality of care available within the public sector.

Those individuals and groups from the lower and middle socio-economic strata generally have poorer health outcomes and life expectancy than those in the high-income groups. This is mainly due to the fact that the latter group has access to greater quality and quantity care than the former (Department of Health, 2007).

As previously stated, most of the country's population rely on primary health care centres for medical treatment. However, the staff is often overworked and may not assume responsibility for the treatment of psychiatric patients (Kale, 1995b). Often, the psychiatric nurses can merely renew prescriptions and refer their patients.

Still, in this district where the current research was conducted, nurses bear the burden of psychiatric care (Psychiatric nurse: personal communication, June 26, 2006). While the nature of psychiatric nurses burdens are not always formally recorded in the literature, it is perhaps important to mention some of them here as the quality of care also depends on the job satisfaction of nursing staff who are primarily responsible for running primary health care clinics. Once screening is done at the primary health care clinic, nurses are responsible for identification, assessment, management and referral of psychiatric

problems. They prescribe medication, conduct monthly follow-ups and refer patients to the relevant institutions and organisations. Certified patients are referred to tertiary hospitals every six months. These nurses act as psychiatric consultants for the hospitals and clinics in their district. They see up to 60 patients a day, excluding new cases. The latter amount to 40 cases a month. Of these approximately five are referred to the doctor or psychiatrist. Due to time constraints resulting from inadequate staffing, patients receive practically no counselling. In addition, counselling is hampered by communication and confidentiality issues. For example, African patients are often unwilling to talk through a translator for fear that this individual will spread their story within the community. This barrier has been somewhat overcome by using HIV/AIDS counsellors in community clinics, where possible. Still, this is not an ideal solution. Nurses generally believe that all these demands have contributed too many nurses quitting their posts or burning out. She ascribes this to a lack of skills and/or inability to handle the massive caseload. Thus, improvements in mental health care are likely to have a positive effect on these mental health practitioners as well. More staff, care for the caregivers, and other professionals to lighten the load will improve the quality of care and thus the outcome for patients.

The quality of available care, with specific reference to South Africa, is closely related to continued change on social, political and economic level to redress injustice and discrimination of the past.

2.8 The relationship between psychological practice and socio-political change in South Africa

It is important to provide immediate relief from psychological distress (Berger & Lazarus, 1987). This may require the development of new coping mechanisms in order to challenge the origin of the individual's problems. To ensure the success of such an endeavour psychological intervention must be founded on a political orientation to problems and incorporate empowering the individual through "reflection and action". Such an approach would facilitate the analysis of problems within the wider socio-political context. The structure of a society determines how the elements function. As such, a society that addresses the needs of all the entire South African population was impossible during the apartheid era (Vogelman et al., 1992). During the apartheid regime, psychologists could not remove themselves from the oppressive political realities in South Africa and psychologists had to formulate their role and social responsibility in promoting social change in the country. Thus, these authors argued that they employ their "skills and insight to promote the democratic movement". Transformation, both within psychology and the overall social context, was proposed even prior to a democratic government was elected. According to Vogelmann et al. (1992), the struggle for a democratic psychology not only necessitated that it serve the interests of the majority of South Africans, but that it is also involved in the struggle for a democratic government and for "non-exploitive and non-oppressive social relations". Many psychologists, such as Vogelmann, argued that psychologists cannot be neutral in challenging oppressive societal structures. They too have personal values and beliefs that colour their world, personally and professionally, and their professional activities have

social consequences. It was proposed that mental health professionals incorporate political content into their work, participate in general political activity and provide consultation and training (Berger & Lazarus, 1987). As Berger and Lazarus' study was conducted at a time of extreme political unrest in South Africa, the limitations of psychologists and other mental health professionals were readily admitted. Nonetheless, it was suggested that should political and economic change not take place, we would forever be treating thousands of individuals with similar problems, essentially related to their oppressive, discriminatory environment.

Today, individuals, groups and communities are presenting with a variety of mental health problems directly related to socio-political and economic circumstances. Thus, although a democratic society has been established, the repercussions of apartheid are evident in the psycho-social and economic well – being of many South African citizens. The psychological profession needs to continue to reformulate its philosophy as well as practice principles and techniques in order to address these issues.

2.9 Framework for a relevant practice and the future role of the psychologist

Rock and Hamber (1994) assert that the psychology profession should define its role and function in South Africa. They propose a variety of recommendations and ideas that may act as basis for the design of policies that will lead to the establishment of a profile psychology profession within society. They hold that relevance extends beyond merely making the profession applicable to the majority of South Africans. A relevant framework would incorporate, amongst others, the level to which psychology can burgeon into an authentic profession (Raubenheimer, 1981), the degree to which the

profession can disengage itself from a Eurocentric orientation and embody Afrocentricism (Buhrmann, 1977; Holdstock, 1981; Kruger, 1981), illustrating the relationship between politics and psychology (Dawes, 1985), and the capacity to successfully address the needs of those of a low socio-economic and working class status (Whittaker, 1993).

For decades, South Africa's mental health care system was typified by racism, sexism and the fragmentation of services that are complicated by inadequacy, inefficacy and discrimination (Vogelman, as cited by Vogelmann, et al., 1992). Clinicians contended that services were inadequate, inaccessible, unaffordable, and contextually irrelevant.

The role that the psychologist needs to play in the present and future South Africa needs to take cognisance of the country's socio-political context (Mokgale, 2004).

Interventions should be designed and implemented with the specific socio-political environment and the empowerment of a particular community in mind.

Leung and Zhang (1995) hold that the evolution of psychology calls for lobbying within academic and government circles as well as active involvement in public policy-making.

Several authors have made recommendation of what the focus of what mental health care should be and have suggested a variety of elements which they believe a relevant and appropriate mental health framework must consist of (Bhui, 2002; Bhugra & Bhui, 2002; Petersen, 2000, 1998; Rock & Hamber, 1994). The Department of Health (2000) has also designed a set of norms and standards according to which mental health services should be provided. Vogelmann et al. (1992) argued that developing and implementing psychological training and practice that is relevant, appropriate, accessible and affordable requires attention to several factors. First, one needs to acquire an understanding of how

dismal working and living conditions in apartheid South Africa detrimentally affected people's mental health and still do. The enhancement of people's mental health and well-being requires both psychological intervention and broader socio-political transformation. Thus, mental health services should be culturally sensitive and shape care and treatment to fit the needs of each individual by taking cognizance of socio-economic and cultural background, lifestyle and individual preferences. Also, clinicians should be aware of why psychology was and is often perceived as irrelevant by a large portion of the South African population. This may elucidate past mistakes and provide suggestions to make psychology more meaningful. Another important element is that professional relationships with progressive organisations both within the community (such as civic, youth, and women's organisations) and the trade union movement need to be established. Such an endeavour will take time, and the suggestion that work done with these organisations be accomplished under their leadership requires acceptance. Furthermore, an in-depth, comprehensive value clarification exercise is crucial. The ideology and ideas of apartheid South Africa has to be critically assessed. This might leave psychologists with a better understanding of South African society and thereby leave them in a better position to deal with the reality of South African community life. Psychologists must also guard against viewing themselves as the exclusive "experts" on people's problems. Community members are also experts in understanding their conditions and should partake in the solutions to their problems. Still, the skills that psychologists possess should be acknowledged and such expertise should be introduced into the situation in an accountable way. It is also imperative that the inadequacy of psychological training in preparing psychologists to effectively manage many problems

encountered by the Black working class has to be recognized. Psychologists need to acquire flexibility and new skills and help guarantee that the next generation of graduates receives appropriate, relevant training (See also Bhui, 2002).

In considering a training that would be suitable for South African psychology, Lazarus (1986) has made some useful suggestions. These include the teaching of accountability; promoting a critical consciousness within the student to enhance self-awareness and characteristics necessary for community work - self-reliance, patience, flexibility; and enabling the student to make better use of inter-disciplinary resources. The success of training is determined by the amount of emphasis psychology departments place on broader community work and whether psychological training is such that students are able to *act* upon their understanding. "To facilitate optimism in action, students should be involved where possible in well-established projects or in newly-developed projects from the beginning." The fusion of "mainstream" psychology and alternative "community psychology" should be addressed within the framework of cultivating an integrated psychological practice that is sensitive to the needs of the majority of South Africans. The propensity to divide psychological practice into "mainstream" and "community" branches needs to be challenged. Rather, a transformed discipline as a whole should be focused on meeting the needs of the majority of the South African people (See also Petersen, 2000, 1998; Swartz, 1998). Another key concern when designing a relevant mental health care policy is that services must be designed based on users' needs. It is particularly important that those individuals who endure psychological distress participate in the planning, administration and supervision of services. In addition, individuals should be able to consult a general clinician/ healer (GP) of their choice, and

those individuals who have mental health problems should not be discriminated against in this regard. Primary health care staff should undergo sufficient mental health training, and service users should be involved in this process as educators. Furthermore, individuals who experience mental health problems must be adequately informed regarding treatment options and services. Finally, the public should have access to a variety of treatment and support alternatives. In accordance with this, Bhui (2002) contends that training and education should be targeted at health sector professionals, voluntary and independent sector professionals, and patients and carers. Such endeavours would include enhancing helpers' ability to recognise distress across various cultures and how it relates to existing psychological and psychiatric diagnosis; re-stating the function of community mental health care; and information to service users on how to more effectively access mental health care services.

Berger and Lazarus (1987) identify several areas within which psychological activity would yield positive results. These include: research; education and the dissemination of information; counselling; group work; and the training of non-professionals. They argue that the psychologists' approach to their work should be of greater importance than it just being a specific area of inquiry. Thus, they need to inform both the general public and organisations of the availability of their services. In addition, they should actively endeavour to clarify their work and destroy the negative connotations attached to psychologists and psychological practice. Thus, PHC mental health services should advance mental health and diminish the discrimination and social exclusion that coincide with mental health problems. They should also make attempts to establish a more equal helper-client relationship. Psychologists should also improve their credibility in order to

gain the trust and acceptance of the communities within which they practice. Speaking from a personal viewpoint regarding race and culture within psychological practice, Trivedi (2002) argues that the attitude and behaviour of mental health workers are empowering when they:

“...acknowledge and value our cultural differences; ...allow us to express our culture and spirituality in our own way; ...recognise and acknowledge that personal and institutionalised racism is a very real feature of black people’s every day lives; ...take responsibility for challenging racist behaviour and comments, whether from staff or other patients; recognise institutionalised racism within psychiatry and how it affects black people; ...recognise that some of our anger at oppressions within the psychiatric system (e.g. being sectioned, forcibly medicated) is very justified and a healthy response to injustice; ...make it ...business to find out about culturally appropriate services in the hospital/ community/ voluntary sector and help us to access them practically; and ...recognise the importance of our family and community to our well-being and our interdependence with them (p. 81).

Thus, it is important that present and future psychological training and service delivery is culturally sensitive, and that programme and policy design also be based on the needs and challenges of the people they aim to serve.

2.10 Summary

Individuals and groups have varied perceptions of psychologists and psychological practice. They tend to view psychology as a non-scientific profession focused on

individual therapy. The general public associates it with brainwashing and believe that psychologists are in control of the therapeutic relationship. It is a general belief that psychologists' services are expensive and thus they work with the middle (and upper) classes. Psychologists are perceived to work with 'mad' people and as such are associated with psychiatric institutions. Most individuals also believe that psychology and psychologists are ignorant of community issues and the concerns of the previously disadvantaged. Still, the image of psychology and psychologists is not entirely negative. Students, in particular, regard it as a science, a means of discovering truth and as a profession that facilitates healing. Also, in individual counselling, psychologists are able to build rapport and establish a relationship with clients that promote the sharing and resolution of personal experiences and problems.

The remnants of an oppressive society are deemed the most significant social crisis facing South Africa. Psychological interventions were widely thought to reflect Apartheid ideology, which is a vivid example of oppression and discrimination. Apartheid informed the social, political and economic conditions within the country. Health is contextualised and is affected by certain social determinants. These include income and social status, social support networks, level of education, employment and working conditions, physical and working environment, biology and genetic predisposition, personal health practices, healthy child development, gender and culture. Psychopathology and the high incidence of alcoholism, crime and family conflict are considered individuals' responses to stressful life situations and severely negative social circumstances. In most communities, few social services - particularly psychological services - are available and community members are generally unaware of those that are

available. Even if aware of psychological services offered in their community, individuals may still choose to find solutions to their problems themselves, by using tried and tested coping mechanisms. Utilisation of services is also affected by the fact that individuals believe these services to be inaccessible and expensive. For many, the practice framework of psychology makes using psychological services difficult. Important here are elements such as the cost of therapy and transport, the time involved in getting to and from therapy, and the therapeutic sessions themselves, the regularity of appointments and the language used. Other factors that influence utilisation of psychological services are contrary traditional beliefs, stigma and broader community attitudes and beliefs.

Utilisation is likely to improve if the psychology profession clearly defined its role and function in South Africa. The role that the psychologist needs to fulfil must consider and incorporate the country's socio-political context and history. It is imperative that we develop and implement psychological training and practice that is relevant, appropriate, accessible and affordable. The evolution of psychology necessitates lobbying within academic and government circles and active involvement in public policy-making. It is clear that mental health professionals be ignorant of social and political issues. They must integrate political content into their work, partake in general political activity and provide consultation and training. Psychological intervention must be based on a political orientation to problems and incorporate empowering the individual. This would facilitate the analysis of problems within the wider socio-political context.

A wide variety of suggestions regarding the framework of psychological practice have been made to ensure that appropriate and quality mental health care services are provided

to the South African population. Many of these proposals have been implemented. Still, it is imperative that such services are routinely reviewed to guarantee that the public benefits from psychological interventions. Therefore, obtaining the views of service users is essential in ensuring that psychological services address the mental health needs of all. Such views will include how individuals and communities perceive mental health and illness and how cultural influences affect this view. The following chapter explores the perspective of mental health held by community members according to theories on culture and explanatory models.

CHAPTER 3

Theoretical Overview

3.1 Introduction

Any endeavour to elicit current and potential service users' perceptions of psychology and psychological practice requires knowledge of how these individuals understand mental health and ill-health and the treatment thereof. A useful way to achieve such insight is to draw on the concept of explanatory models and culture in understandings of psychiatric conditions, which will be the focus of this chapter.

Arthur Kleinman (1978) defines explanatory models as 'the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process'. Thus, explanatory models are health beliefs held by service users and their families, as well as clinicians. Other leading theorists in this area include Cecil Helman (1982, 1984, 1990, 2001, 2003, 2004), as well as Kamaldeep Bhui and Dinesh Bhugra (2002a, 2002b, 2002c, 2003, 2007).

The importance of explanatory models becomes evident when working with people from different socio-economic strata. Low-income clients tend to assess and express their disorders in somatic terms (Kroenke, et al., 1994 as cited by Palinkis, 2000). When combined with the stigma often associated with the concept of 'mental' illness and restricted access to health care, the primary care provider or medical doctor, rather than a mental health specialist are likely to be the person they consult. However, a primary care practitioner's often limited comprehension of the client's explanatory models make the process of accurately diagnosing the problem and executing an effective intervention

difficult (Swartz, 1998). Furthermore, this variation in ways of seeing is also a concern particularly in those instances where the client's language, or culturally and socially influenced patterns of symptom expression differ from that of the practitioner. Implicit here is the distinction that can be drawn between illness and disease. According to Kleinman (1991:7), "*illness* refers to the patient's perception, experience, expression, and pattern of coping with symptoms, while *disease* refers to the way the practitioner recast illness in terms of their theoretical models of pathology" (italics in original text). Thus, without knowledge of other cultural beliefs and practices, mental health care professionals may easily fall prey to errors in diagnosis, resulting in inappropriate care and poor treatment compliance.

3.2 Culture and the formulation of mental health and ill-health

Any explanation of explanatory models requires attention to culture and how it relates to mental health.

3.2.1 The concept of culture

Helman (1994: 2-3) defines culture as

... a set of guidelines (both explicit and implicit) which individuals inherit as members of a particular society, and which tells them how to *view* the world, how to experience it *emotionally*, and how to *behave* in it in relation to other people, to supernatural forces or gods, and to the natural environment. It also provides them with a way of transmitting these guidelines to the next generation – by use of symbols, language, art and ritual (italics in original text).

In other words, culture refers to the process of being and becoming a social entity, the norms and standards of a society, and the manner in which these are practiced, experienced and communicated. According to Helman (1994), most societies are divided into subcultures based on social stratification. As such, members within any given society will conform to the distinguishing cultural characteristics inherent to the socio-economic sphere within which they exist. One's cultural foundation has serious implications for several aspects of people's existence, which affect their attitudes and behaviour regarding health care. This explains discrepancies evident in the worldviews and so too explanatory models of mental health and illness of, for example, the rich and the poor. Thus, these cultural factors are mediated by individual, familial, educational, socio-economic and political factors which may distinguish certain individuals within a particular society (Helman, 2007; 1994). Hence, although discernable patterns exist, it is important not to generalise all behaviour and attitudes to all members of a given society. Societies are subject to individual differences and large-scale change. The latter refers to the dynamic nature of culture, which means that cultural patterns are constantly changing, growing and developing as people's understanding of societal regulations alter with time and varying conditions.

Themes central to the notion of culture is that it is a series of guidelines that inform how people perceive their world, experience it and behave within it. It is dynamic and contextual, and is influenced by both individual and group factors. Cultural factors relate to mental illness in several ways, such as determining what is seen as normal and abnormal within a given society.

3.2.2 Normal vs. Abnormal behaviour

Helman (1994) states that the social explanation of normality and abnormality are founded on communal beliefs within a cultural group regarding what comprises the ideal, becoming and correct way for persons to direct their lives in relation to others. Normality is ordinarily a multi-dimensional notion. The relevance of the person's behaviour, attire, posture, hairstyle, odour, gestures, facial expression, tone of voice and language used are all considered, when determining appropriate social behaviour. According to Dein (1997) perspectives on normal and abnormal behaviour vary widely from culture to culture and, within any given group, are determined by demographic factors such as age and gender, socio-economic status, and occupation. Still, there is no culture where individuals remain unaware of erratic, disturbed, threatening or bizarre behaviour (Dein, 1997; Foster & Anderson, 1978). This awareness is enhanced when such behaviour occurs without reason. In certain cultures these behaviours may be perceived as bad and therefore punishable, while in others they may be considered signs of illness necessitating treatment. Therefore, doctors and mental health professionals may be confronted with behaviours that in other societies may sometimes be acceptable, but that could be perceived as signs of mental illness in another (Dein, 1997). Witchcraft and possession states are illustrative of this. In many parts of the world these are culturally permissible ways of accounting for misfortune or expressing distress and are socially acceptable as such. Thus, normal and abnormal behaviour may be viewed as existing on a spectrum, with variations of acceptability operating for both of these categories (Helman, 1994). People's notions of normality and abnormality form the basis of what is considered mental ill-health and how this is presented to the world.

3.2.3 Cultural representation of mental health problems

According to Kirmayer, Young and Robbins (1994), medical anthropology accentuates how culture influences individuals' attempts to understand their symptoms and suffering. Causal attribution is an important cognitive process in this internal and interpersonal creation of meaning. Cultural diversity in symptom attribution influences the aetiology, course, clinical presentation and outcome of psychiatric disorders. Such differences in explaining the causes of common somatic symptoms may affect clients' proclivity to somatise or psychologise psychiatric disorders in primary care. Furthermore, Helman (1994) argued that most societies and cultures have entrenched frameworks for the understanding of symptoms, their organisation, genesis and treatment. When these are organised into a whole, they may be viewed as a 'folk illness'. This does not negate the reality of the experience or that it might also be considered a disease by clinicians but simply details how a society understands, and arranges specific phenomena.

Similarly, anthropological studies have revealed that psychological problems are viewed differently across cultures (Williams & Healy, 2001). This means that the ways individuals are treated in different cultures vary. Still, while anthropologists have identified different explanatory models concerning mental illness, similarities exist across societies that point to both the influence of culture and the inherent nature of the phenomena itself.

A major consideration in perspectives of mental illness is the matter of stigmatisation. According to Shepherd (n.d), in the majority of cultures such stigmatisation is particularly harmful as entire families, including the person with the mental illness, are

often subject to such treatment. This frequently results in resentment, fear and maltreatment of the mentally ill person.

Kleinman (1980: 7) also argues that a psychiatric diagnosis is basically an “interpretation of a person’s experience”. This interpretation is influenced by, and varies due to, several factors, such as the professional’s orientation, clinical expertise, the institutional environment and the professional’s characteristic cultural background. In addition, the client’s own lived experience may limit the clinician’s explanation of said experience. As the illness process is always mediated by the individual’s understanding of physical symptoms and issues related to the self, it is invariably a culturally shaped occurrence. Thus, as cultures vary, the way in which mental illness manifests differs from culture to culture. The observation of this variation in the presentation of mental ill-health has been termed culture-bound syndromes.

3.2.4 Culture-bound syndromes

Sadock and Sadock (2003) define culture-bound syndromes as

... signs and symptoms of mental distress or maladaptive behaviour that are prominent in folk belief and practice. Such patterns are informed by native cultural assumptions, sorcery, breach of taboo, intrusion of a disease object, intrusion of disease-causing spirit, or loss of soul (p. 529).

These authors hold that gauging these phenomena must begin with an acknowledgement of the varying perspectives, including views on health and illness that exist across cultures and are internalised by the members of different societies. In recognition of the

importance of heterogeneous cultural attributions and explanatory models in the psychiatric field, a guide on cultural formulation supplements the DSM IV (Aidoo & Harpham, 2001). It accentuates cultural factors associated with the psychosocial environment, that is, the “perceived causes or explanatory models that the individual and reference group use to explain the illness, and current preferences and past experience with professional and popular sources of care” (American Psychiatric Association, 1994). The Cultural Formulation aims to improve efficacy in using the DSM-IV classification of diseases, to consider cultural factors that may influence how illness is perceived and explained in lay people’s own phrases and concepts. This is supplemented with a glossary of culture-bound syndromes, such as amok, boufee delirante and zar. *Amok* refers to “violent and aggressive (even homicidal) behaviour following a period of brooding” (Swartz, 1998, p. 155). This frequently occurs in a state of disassociation and the individual does not remember what happened. Incidents of *zar* have been recorded in North Africa and the Middle East. This is a kind of spirit possession comprising dissociative episodes which are characterised by socially inappropriate behaviour. Primary examples of culture-bound syndromes from the South African context include amafufunyana and ukuthwasa (Swartz, 2007; Drennan, 2001). Amafufunyana is the best known indigenous illness presented to mental health care service providers. Traditional healers attribute this condition to spirit possession. Symptoms include listlessness, social withdrawal and loss of appetite, as well as auditory hallucinations and an altered state of consciousness. Amafufunyana is associated with schizophrenia as well as dissociative and adjustment disorders. Ukuthwasa commonly denotes a “calling by the ancestors to become a healer” (Drennan, 2001: p. 401). It is characterised by a sense and fear of

madness, dreams, social withdrawal, anti – social behaviour, and symptoms of anxiety. It mainly affects women and children, and is related to psychosis, emotional disorders and normality. Such concepts all illustrate psychiatric episodes as construed within a variety of cultural settings. The aim of these conditions being identified in different settings is to assist diagnosis in cross-cultural settings. The existence of such culture specific categories of illness has implications for culture specific treatment of psychiatric disorders.

3.2.5 Cultural aspects of treatment

The first stage of treating clients from different ethnic and cultural groups is to establish whether a problem exists and, if it does, to determine the nature and degree of said problem (Dein, 1997). This requires knowledge of the culture from which a client originates, as cultural factors influence what is deemed abnormal. This is particularly important in the South African context as the majority of mental health care professionals are white and unable to communicate in any of the African indigenous languages (Swartz, 2007). Thus, efforts have to be made to redress this lack of equity in the access to and quality of available mental health care.

Furthermore, it is important to note that a psychiatric diagnosis is not merely a marker for a set of signs and symptoms which exist in isolation. It denotes a social deed that underpins social relationships (Swartz, 1998). Furthermore, the diagnostic process forms part of a cultural scheme of relating with and understanding the world. Still, it does not enable the helper to elicit every aspect concerning the person's beliefs and lived experience within their world. Coll (2002) contends that it is important for the helper to

resolve incongruences between his/her and client's understanding of distress, particularly when they are from different cultural backgrounds. This prevents misdiagnosis and ensure long-term treatment benefits for the client.

According to the DSM-IV (1994) a helper who is unaware of the undertones of a person's worldview may mistakenly evaluate as psychopathology those common deviations in behaviour, belief, or experience that are distinctive of the person's culture. Therefore, it is also essential to establish how a client appears to be a member of his or her own culture, and a mental health professional is likely to benefit from eliciting the aid of significant individuals in the client's life. It may be decided that a mental health problem is not present and that the client manifests culturally appropriate behaviour, that is, behaviour that is acceptable within the context of that particular cultural setting. In this instance, a traditional healer may be a more suitable source of assistance than a clinician/healer.

The idea that competing treatment frameworks exist, have been given more credibility in the South African health context. It is understood that traditional healers are better able to address certain problems than Western practitioners. The World Health Organisation (WHO, 2003) defines traditional medicine as:

... health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain wellbeing

This definition indicates that there is recognition and acknowledgment of healing systems that may deviate considerably from the biomedical approaches mainly employed within psychological practice. According to Richter (2003), most South Africans tend to relate indigenous healing to herbs, remedies (that is muti) and advice obtained from sangomas and/ or izinyangas, as well as with deep-rooted spiritual elements. However, Kale (1995a) distinguishes between four types of South African indigenous healers: inyangas, isangomas, umthandazi and traditional birth attendants. The first refers to herbalists who have a comprehensive and vast knowledge regarding remedial herbs and medicine of animal origin. Most are male. Isangomas are concerned with divination. In contrast with inyangas, they are mainly female. These individuals identify the aetiology of illness by summoning the aid of ancestral spirits. Becoming an isangoma is a calling, not a vocational choice. The umthandazi are self-proclaimed Christians who practice as faith healers. They are members of traditional African churches and heal by means of prayer, the use of holy water or ash, and/or physical touch. Finally, traditional birth attendants are commonly older women who are respected in their community for their skills. They are most likely to practice in rural areas. These women seek the assistance of inyangas should their client experience birth complications. It is important to note that historically, colonialism had a powerful impact on the setting and practice of indigenous healers and those who seek their help, distorting the difference between herbalists and diviners (Richter, 2003). Despite this, the WHO (2000) estimates that approximately 80% of the African population seek the services of indigenous healers. This means that African healing systems can make a substantial contribution to the mental well-being of the South African people.

Still, regardless of several advances and long – standing healing traditions, no single healing system can boast of possessing a “cure” for serious mental illness (Swartz, 1998). Moreover, the responsibility of biomedicine (that is Western psychiatric and psychological practice) in managing mental illness is to apply the greatest effort as regards care within the milieu of their clients. Thus, one should not disavow alternate approaches out of hand, nor view other perspectives as inevitably more genuine than the biomedical system. The fact that clients will utilise alternative (that is traditional/indigenous) services have to be acknowledged, requiring similar recognition of said services. This is a positive course of action where collaboration between different services is possible (Swartz, 1998; Odenwald, van Duijl & Smith, 2007). However, this may often not be feasible as relations between various healing systems are strongly influenced by history and power relationships. Nevertheless, a respectful affiliation with other healing systems and ways of seeing serious mental illness does not denote merely agreeing that other healing systems are proficient. This is important as there is a tendency toward such acceptance (Swartz, 1996).

It is clear that within a context of competing diagnostic and treatment frameworks, it is important to examine the notion of how people understand their illness as many people do not adhere to explanatory frameworks invoked by western medical models. This has given rise to the idea that competing explanatory models, other than those suggested by Western medicine, also exist. It is therefore necessary to look at the notion of an explanatory model and the different kind of explanatory models that have been described in the literature. This is crucial as explanatory models apply not only to notions of health

and illness but also to notions of how laypeople understand psychology and psychologists.

3.3 Explanatory Models

Weiss (1997) contends that explanatory models are important as cultural beliefs and practices are infused in all facets of psychiatry as well as the cultural context within which meanings of illness are communicated. This necessitates a framework for the ‘operational formulation’ of explanatory models of illness. Ignoring clients’ explanatory models mean that clients and clinicians alike may not appreciate the importance of the client’s own understanding, even when they originate from similar socio-cultural backgrounds.

3.3.1 Definition of explanatory models

Kleinman (1973) defines explanatory models as:

“... understandings or explanations of episodes of illness and treatment, framed within the context of the cultural beliefs and norms of the given society, and employed by all engaged in the clinical process, and in the interaction between healer and client that is central to health care systems”.

Hargrave (2006) extends this definition to state that explanatory models of disease indicate a network of health beliefs that is used to describe the distinctive illness behaviours, culturally-mediated worldviews, and help-seeking behaviours exhibited by

ethnic groups. They incorporate beliefs about disease origin, symptomology, favoured treatment options, patterns of decision-making, and assessment of available treatment. Thus, the way in which clients view illness determines how they interpret abnormal experiences, how these experiences are translated into action (whether help-seeking or avoidance), their reaction to societies acceptance, or not, of this behaviour and the meaning of this experience (Lloyd et al, 1998).

Hence, explanatory models are explanations of incidents of illness, informed by culturally-mediated belief patterns regarding aetiology, symptomology and treatment, which influence relations between healers and mental health care service users.

Still, it is not a simplistic social process. Rather, it is a cultural phenomenon underscored by several factors.

3.3.2 Underlying Assumptions

The concept of explanatory models is underpinned by the recognition that client systems often rely on their own concepts and categories for illness, which may be at odds with those held by clinicians (Aidoo & Harpham, 2001). In other words, underlying the idea of explanatory models is the acknowledgment that individuals and their families may have their own insight into what constitutes illness, how that illness is experienced and what the appropriate treatment for that particular illness would be. Furthermore, Weiss (1997) asserts that individuals blame their distress on a myriad of factors, frequently citing societal conditions, relationship issues, witchcraft or sorcery, sin, or a broken taboo as the cause of their problem. This style of attribution, based on moral, religious and spiritual elements (amongst others) may differ greatly from the approach employed by

mental health care professionals. Aidoo and Harpham (2001) state that the varying perceptions exemplified by explanatory models can be related to the ethnographic terms 'emic' (beliefs of local communities) and 'etic' (beliefs of professionals outside local communities). Consequently, according to these authors, when exploring explanatory models, it is the distinction between 'local insider' and 'professional outsider' that is significant.

3.3.3 Client- healer Dichotomy

As stated above, the client and healer's view of the client's lived experience of their particular illness may vary greatly. This often has serious consequences for diagnosis and treatment. However, Weiss' (1997) also proposes that no clear dichotomy may exist in the relationship between local and professional ideas. He suggests that the medical ideologies of health professionals influence local beliefs about illness. This may be an implicit process resulting from clients' interactions with medical professionals, or may be attributed to health education and media depictions of health-related issues. Similarly, health professionals' beliefs can be affected by ideas common to members of that society, at least in so far as they recognise local explanations.

Aidoo and Harpham (2001) found that the greatest difference between the explanatory models of professionals and those of lay people is that the former group recognise a chain of causality, linking psychosocial factors to certain mental health problems such as depression. Conversely, lay people tend to express their situation or illness experience in

a narrative, experiential style failing to make a causal link between their circumstances and mental ill-health.

Helman (1994) concurs that healers and their clients have different perspectives regarding ill-health, despite sharing a cultural milieu. These perspectives are grounded in varying assumptions/suppositions, utilize contradictory methods of proof, and evaluate the effectiveness of treatment with dissimilar approaches.

These (expected) differences in understanding and treatment of illness necessitate determining the client's notions concerning illness and recovery, that is, determining what exactly their explanatory models are.

3.3.4 Assessing explanatory models

Kleinman (1980, p. 156) argues that clients' explanatory models of illness can be gauged by employing a mini-ethnographic approach that explores the client's concerns.

Questions asked during this process include 'Why me?'; 'Why now?'; 'What is wrong?'; 'How long will it last?'; 'How serious is it?' and 'Who can intervene or treat the condition?' This process will assist the clinician in gaining a better understanding of the subjective experience of illness, and in this way advance collaboration and improve clinical outcomes and client satisfaction. Bhui and Bhugra (2002) also suggest that the clients' complex view of their world and of their illness within that world results in a greater understanding of their illness, including its meaning to them and their expected recovery process. The proposed process is for client and clinician/healer to share information, a characteristic that differentiates indigenous health systems from Western biomedicine, which flourishes on esoteric knowledge being held by the professional.

During an exploration of explanatory models, the socio- anthropological construction of participant observation and open-ended conversations encompasses the accurate view of the client's world. Clinicians are deprived of this valuable insight when questioning is directed at making a diagnosis and introducing a treatment. Yet, such questions are the focus of a consultation, which results in neglect of the client's total experience of the illness.

Despite its usefulness in determining the client's perspective of their illness experience, relying indiscriminately and absolutely on explanatory models in the healing process could lead to problems in diagnosis and treatment. Thus, as with any other approach to understanding and intervening in people's lives, the explanatory model perspective has also been the subject of critical analysis.

3.3.5 Critique of explanatory models

Available data suggests a marked difference between the health beliefs of people who actually suffer from mental health problem and the broader community (Williams & Healy, 2001). This implies that a reformulation of beliefs may take place among people who develop a mental health problem, such as depression. This leads one to question the stability or fluidity of these beliefs. Such considerations are important as people may move between explanatory models and use one or more models that are useful to them at the time, causing errors in the preliminary diagnosis and associated treatment on the part of the healer. In other words, beliefs that are salient at the time of initial assessment may not be relevant throughout the entire treatment process. Thus, it is imperative that healers continuously assess the client's understanding of their illness-experience in order to

ensure optimal adherence to the agreed upon treatment. Lewis (1995) contends that people actively seek meaning for the experiences they face. However, Williams and Healy (2001) argues that during this process of making meaning individuals may ascribe to a variety of explanations concurrently, or may move rapidly between beliefs. The possibility of this movement reinforces the interpretation of beliefs as forming an exploratory map rather than an explanatory model. The notion that explanatory models may be idiosyncratic and subject to change due to individual and cultural influences is echoed by Pill, Prior and Wood (2001). Still, despite the possibility of variability explanatory models remain a useful means of reviewing people's perceptions of mental health and ill-health and the treatment thereof.

3.4 Conclusion

It is evident that we need to explore indigenous systems of healing and explanatory models which are customary to specific cultural groups (Bhui & Bhugra, 2002). In this manner an improved understanding of distress that resonates with the client's experience can be gained prior to attempts to map these to specific biomedical diagnostic categories and related care pathways (Patel, 1995). Any intervention strategy can then be based on a shared understanding, taking heed of the best clinical evidence as well as recognising and acknowledging beliefs that help people cope with misfortunes of all kinds. Thus, attending to explanatory models is an important facet in the development of psychological interventions as the focus of service delivery is shifting away from a concern with the individual to the provision of comprehensive services that address the needs of communities, particularly those whose mental health needs were neglected in

the past. In addition, explanatory models also inform mental health care service providers on how service users perceive them and their services, as views of what constitutes ill-health and the appropriate treatment modalities influence whether people will utilise accessible mental health services and demand quality of care. Thus, explanatory models are a valuable means of evaluating various aspects of the planning and provision of mental health care services, and informed the methodology of the research.

CHAPTER 4

Methodology

4.1 Context of the study

This study was conducted in a small, predominantly “coloured” community approximately 20 km outside Stellenbosch. While the community is historically coloured, the racial demographics are changing to incorporate Black African groups. This peri-urban community has an estimated 4000 inhabitants. It has a fairly young population as 42% of the community are under the age of 19 (Stellenbosch Municipality: Census 2006, Appendix 5). Of this total population under the age of 19, 21 % are of primary school-going age. The levels of formal education in this community are low. Ten percent of the population have had no schooling, 40 % have had some primary school education, 37 % have completed some stage of high school, and 2 % have some form of tertiary qualification. The dominant language in the area is Afrikaans. The other languages spoken by the inhabitants include English, IsiXhosa, IsiZulu, and Sesotho. The majority of the population (98 %) have a monthly income of between R0 and R3 200. Of this total, 66 % live under the poverty datum line, that is, they earn under R 354 per month (Frye, 2006). (See Appendix 5 on demographic data). It is therefore a predominantly Afrikaans, working class community.

The psychology department of the University of Stellenbosch has been involved in this community for the past 6 years. Students from this department were placed there for service learning. These included 4th year BPsych and 1st year Clinical and Community Counselling Masters students. Direct counselling was provided and prevention activities such as psycho – education workshops were presented. In addition, a group of BPsych

graduates implemented a community project in this community aimed at the primary school learners (grade 1 to 7). This project aims to provide a safe place for children to enhance their self – esteem and to stimulate the motor and cognitive development. In order to achieve this aim, the project incorporates community psychology principles such as prevention, empowerment, a psychological sense of community, social justice and utilising an ecological perspective of people’s functioning. Thus, it is expected that all participants – both key informants and service users will have a relatively accurate and diverse understanding of psychology as a profession.

4.2 Research Design

The aim of this study is to explore and gain a comprehensive, integrated and in-depth account of a small, previously disadvantaged community’s experience and perceptions regarding psychologists and psychological practice within the South African context. The researcher attempts to ascertain those views and beliefs that describe the individual’s subjective experience of the world in which s/he lives. Therefore, an exploratory and descriptive process is utilised. Although this inherently implies a qualitative study, quantitative data will also be gathered in order to gain a comprehensive contextual picture. In essence it will be an exploratory study incorporating qualitative methods.

4.3 Participants

This study essentially is an expansion of Berger and Lazarus’ 1987 study with community organisers. However, this study was two-pronged in that the views of potential clientele were also determined.

Two sets of samples were drawn from this target population. The sample categories were key informants and primary health care service users from the local community. With regards to the key informants, the fact that it is a very small community enabled the researcher to approach **all** the key informants who regularly interact with a wide variety of community members. This was a total of ten individuals. Of the ten potential interviewees, only six were interviewed. These included the school principal, sister in charge at the clinic, a religious leader, two community development workers, and a city council member. The average age of key informants was 48.

Convenience samples of primary health care service users attending the local clinic were requested to participate in the study. Permission for this process was requested and attained from the regional head of the department of health (See appendices 2a and 2b). On Mondays and Tuesdays predominantly antenatal clients attend the clinic while on a Wednesday predominantly clients with diseases of lifestyle attend the clinic. On each of these days, a small group of six participants were invited to attend a focus group on psychological service delivery. The average age of service users in the two focus groups was 39.

4.4 Methods of Data Collection

In-depth individual interviews and focus groups was utilised to gather data. Open-ended questionnaires, which served as guidelines for the key informant interviews and focus groups, were constructed. Individual interviews were used to elicit data from key informants. Focus groups were used to gather data from clinic users, as it was believed that the interaction inherent in such a situation would stimulate debate around the issue

(Kitzinger & Barbour, 1999). It was envisioned that three groups consisting of 6 clinic users each would constitute the focus groups. However, clinic users were reluctant to participate in the study. Therefore, only two focus groups, of six and seven members respectively, were successfully interviewed. A self-constructed questionnaire was used in both instances (that is for individual interviews and focus groups).

The researcher acknowledges both the advantages and disadvantages of the focus group method. A great benefit of this method is the depth of information that may be obtained. Focus groups allow for the generation of information by means of social interaction in the form of group discussion; informants can expand on the responses of others; all members of the group have the right to ask questions and clarify uncertainties; and the format does allow the researcher to use probes, prompts and questions (Fontana & Frey, 1994).

However, in such a group the researcher may have limited control and struggle to supervise the discussion; group effect may result in conformity; certain members may be marginalised; conflict may lead to the serious consideration of ethical issues; and it may be difficult to assemble the groups.

Still, despite these weaknesses focus groups provide the best medium for investigating people's experiences, perceptions, ideas and interests (Kitzinger & Barbour, 1999). The focus group approach provides participants with the opportunity to personally create problematic, frameworks and theories and to discover the meanings of these in their own language, and in a manner they are comfortable with. Furthermore, this methodology facilitates the researcher in exploring differing perspectives on specific topics as they manifest within a particular social milieu.

4.5 Procedure

Two groups, of six and seven members respectively, participated in the focus groups sessions. Each session lasted for approximately 1-1.5 hours. Individual interviews and focus group discussions were tape-recorded and transcribed.

An adapted self-constructed questionnaire (Mokgale, 2004) was compiled and used to obtain information from both the key informants and focus groups. This data was then transcribed. The researcher conducted the interviews in a safe, controlled space to ensure privacy and the enforcement of the ethical obligation of confidentiality. Particular care was taken to ensure that the information obtained is a true reflection of the participants' experiences and perspectives, as well as confirming that what was recorded was consistent with the participants' own thoughts and feelings.

4.6 Data Analysis

Participants' responses were content analysed and a qualitative descriptive account of responses drawn up. Content analysis is a "systematic, replicable technique for compressing many words of text into fewer content categories based on explicit rules of coding" (Stemler, 2001). According to Weber (1990), content analysis enables us to make inferences. In other words, the statements and descriptions of experience obtained from participants were analysed to discover the essence of their thoughts, feelings and actions regarding this particular topic of interest, and what meaning this has for them. As previously stated, the main priority of this research project was to determine the nature of clinic service users' experience of psychologists and psychological practice in the South African context. An understanding of how a certain community perceives psychologists

and psychological services, the essence of their experience with this service and what this experience, or lack thereof, means to the individual needed to be obtained. Content analysis provided an ideal medium with which to do that.

4.7 Reflexivity

The researcher was involved in practical work related to an undergraduate degree (BPsych) prior to the initiation of the research project. Thus, she became acquainted with certain members of the community, particularly those who require basic psychological counselling services. This interaction made it clear that misconceptions related to mental health services were still prevalent in the community, but also that community members are willing to consult mental health care service providers should these services be readily available and accessible. Thus, investigating service users' perceptions of psychological and other mental health care services is important to improved understanding of how these services are viewed and experienced by those they target.

4.8 Ethical considerations

Access to the community was facilitated by the department of psychology's six-year involvement with the community. This involvement has previously been described (see context of the study). Still, in line with ethical research practice, permission to conduct data collection in the local clinic was sought from the department of health (Appendix 3). The letter of permission obtained from the Department of health is enclosed as Appendix 4.

Informed consent was also obtained from the participants themselves. This verbal contract with participants entailed detailing that they were not coerced into partaking in the study, that they have no relationship with the researcher, and that they may withdraw from the study at any point during the process. Participants were provided with the information necessary for them to feel comfortable about partaking in the study. This included a detailed introduction of the researcher, and explanation of the aims and objectives of the study, as well as the methodology. Furthermore, it was mentioned that participation is voluntary and that any individual may refuse to answer questions s/he is not comfortable with. The study participants were informed that any and all sensitive and personal information provided will be protected and made unavailable to anyone other than the researcher. Such confidentiality will be ensured by, for example, restricting access to data, keeping the participants' background information separate from the results, and utilising a numbers code.

It was explicitly stated that information obtained in the study will be used exclusively for academic purposes. This respects the participants' right to privacy and support the ethical principle of confidentiality.

4.9 Limitations of the study

One limitation of this study is that it is restricted to a specific community. Furthermore, due to logistical issues fewer individual interviews and focus groups, than was anticipated, were conducted. This means that the scope of information gained may not be as comprehensive as it would have been had all potential participants been interviewed. In addition, focus groups were conducted on days with intervals in between, meaning that

the information obtained does not reflect these participants' views at a particular time. Finally, there is a clear lack of Black African participants. This was due to the fact that many of the community members who fall within this group do not utilise primary health care services frequently. In addition, those who were approached declined to participate or did not arrive for the interviews at the designated times. Still, despite these limitations, the study does provide valuable insights into the views of key informants and service users, regarding psychology and the contribution psychologists can make towards improving the mental health and well – being of communities as a whole.

CHAPTER 5

Results

5.1 Introduction

During the past twelve years, primary health care was introduced into this community. This includes mental health care provision, although the service is situated outside of the community. In addition, students from Stellenbosch University have also been involved in individual and group intervention in this context over the last six years. A group of graduates from the afore-mentioned institution also initiated a community work project here. However, despite these initiatives, findings from this study correspond with existing literature (Dollinger & Thelen, 1980; Lazarus, 1986; Berger & Lazarus, 1987; Vogelman et al., 1992; Aspenson et al., 1993; Kale, 1995b; Kosny & Ennis, 1999; Findlay & Sheehan, 2004; Mokgale, 2004). These results from the two sample categories are reported separately under headings derived from the questionnaire utilised in this research. Discussion of these findings follows in the next chapter.

5.2 Key informants

5.2.1 Image of psychology, psychologists and psychological practice

There is general consensus among these individuals that psychologists direct people in sharing their experience. Thus they help them express that which is bothering them. They are viewed as working with individuals, helping them to resolve their problems and feel better about themselves. These sentiments are reflected in the following quotes:

Sielkundiges is daar om mense leiding te gee om hulle probleme te verwoord en sodoende verligting te bring ...

Psychologists are there to guide people towards verbalising their problems in order to bring relief (from said problems)....

According to one participant, psychologists help to improve people's functioning. These include problems related to social adaptation, the self, marital relationships and children's learning and behavioural problems. Psychologists "give advice, support and assistance". There is a discrepancy among key informants about how the community at large views psychologists and psychological practice. Some stated that only a small percentage of the community have a misconception of what psychologists do, while others believe that a large number of people have a negative viewpoint.

... klein persentasie ... wanpersepsie ... vs ...nie 'n deurlopende ... neiging om met 'n sielkundige te praat ... van dienste gebruik te maak

... small percentage ... misconception ... vs ...not an overall... tendency to talk to a psychologist to make use of services...

According to informants, individuals who seek help are stigmatised and labelled as mad.

.....sy kop is nie lekker nie hang 'n etiket rondom die persoon wat hulp soek se nek.....

.... his head is not right ... hang a label around the neck of the person who seeks help

5.2.2 Links between personal problems and social, political and economic conditions

Key informants mentioned several socio-economic and political factors that are causally related to personal problems. The community has a high unemployment rate. This forces many children to leave school early in order to supplement the household income. Many parents abuse alcohol and other drugs. When intoxicated there is a lack of parental supervision and children engage in many vices, such as substance abuse and sexually promiscuous behaviour.

...Naweke is ma en pa dronk. As ma en pa 'tiep' drink die kind die kan ... daar's geen beheer nie ... kinders maak wat hulle wil... dit gee ook aanleiding dan bv. dat kinders hulle eie plesier soek.... drank raak hulle plesier, dan seks...

... On the weekend mom and dad are drunk. When mom and dad is 'sleeping it off' the child drink the wine... there's no control ... children do as they please ... this leads to , for example, children looking for pleasure ... alcohol becomes their pleasure then sex ...

Teenage pregnancy has become a means of generating an income through the child support grant the parent is entitled to. This often leads to increased school dropout rates. Many children live within an unstable family structure, characterised by parent switching (that is several partners who take on the role of father or mother) and several stepsiblings. One informant refers to the lack of economic development in this community which leads to a continuation of the cycle of poverty.

*... geen industrie ... ekonomiese ontwikkeling het agterwee gebly ... bring ...
sosiale probleme....*

*... no industries ... economic development was neglected ... brings ... social
problems ...*

Other causal factors include the dynamics around the spread of HIV/AIDS and other sexually transmitted infections (STIs), crime and gangsterism, domestic violence, death in the family, a patriarchal family structure, and post-traumatic stress.

5.2.3 Availability of and access to psychological service delivery

Presently, psychological services are available to the community at the Cloetesville Day Hospital in Stellenbosch, and at the local primary school. Psychology students from the University of Stellenbosch provide services at the latter institution.

Although both services are free, accessing them presents a challenge. Community members have to pay for public or private transport. The only public transport system to Stellenbosch from this community is the Metrorail train service. A return ticket costs between R10 and R15. Private transport, such as a door – to – door taxi service or that of a neighbour or friend may be double or even triple this amount. The lack of financial resources experienced by many, if not most, of the community members makes this difficult.

...betaal nie vir die dienste nie, maar omdat die dienste in Stellenbosch is die mense kan nie daar uitkom nie ... a.g.v. ekonomiese toestande is daai dienste eintlik van geen nut nie ...

... don't pay for the services but because the services are in Stellenbosch ... the people can't get there ... due to economic circumstances those services really are of no use ...

Accessing services may be even more difficult for those people who live on the surrounding farms and fall within the municipal district of this community.

The issue of access also influences the utilisation of services. Social services are often available within communities, as was the case in this particular community. As key informant 1 indicated:

... die maatskaplike dienste het toe uiteindelik sielkundige dienste gelever...

.... social services eventually provided psychological services ...

5.2.4 Awareness of psychological service delivery

Key informants are uncertain whether community members are aware of the services available to them, although most agree that the community is much more aware of social services than they are of those provided by mental health care professionals.

They further argue that the community members are informed of such services by means of posters, informal talks (usually held at the clinic or sports clubhouse) and referrals

made by the clinic or school. Informants state that awareness can be improved by enlisting the aids of community organisations in disseminating information in a simplified manner in the main languages of the area. Psychologists themselves can assist in this process by being actively involved in the distribution of information regarding the services they provide.

.....psychologists avail themselves permanent basis ...

5.2.5 Utilisation of psychological services

According to informants, most people are likely to utilise services if someone else notices a need and makes a referral. In addition, a lack of support from significant others in the person's life tends to reinforce the stigma attached to mental illness.

...hoe kan jy vir my se ek moet na 'n sielkundige toe gaan? Ek is nie mal nie ... wat gaan die mense se...?

... how can you tell me I have to go to a psychologist? I'm not crazy ... what will people say ...?

Informants recognise that people first need to have ready access before they are likely to use services.

... mense wil eers sien daar is die kantore ... wil eers toegang he ... as iemand hier plaaslik is, sal mense meer gebruik maak van die dienste....

... people first want to see the office ... first want access ... if someone is here locally, people will make greater use of the services ...

There is consensus among key informants that the community will utilise mental health services should these services be available and accessible, and if people are aware of these services.

... people don't have money to go to places if it's not near..... bring the services closer to the community.... if I don't have money I say I'll go but then I don't....

In addition, it is felt that service utilisation will benefit from an assurance that privacy and confidentiality will be maintained. Certain participants from this group noted that people may not be aware that their particular experience constitutes a psychological problem. As such, they are unlikely to utilise the available services even if they have the resources to do so.

... nie ingelig as daar 'n omskrywing is van wat bedoel word met sielkundige dienste dan sal ... die stigma verbreek word.... mense ... verstaan nie wat bedoel word met sielkundige dienste.....

... uninformed ... if there is a description of what is meant by psychological services ... the stigma will be broken ... people ... don't understand what is meant by psychological services...

It was also noted that mostly those people who could afford to pay for mental health services, such as those who belong to a medical aid scheme, seek help for their particular problem.

.... slegs mense wat behoort aan mediese skemas .. dis mos nie net hulle wat ly aan depressie

... only people who belong to medical schemes ... it's not only them who suffer from depression ...

5.2.6 *Quality of available psychological services*

There is overall consensus in this participant group that the services they are aware of meet high standards of quality. According to clients, clients who utilised the services both at the school and at the day hospital report a high level of satisfaction with the services they received. However, it is indicated that transport to, and from, the places where services are situated remain a problem, even when they are utilised.

... vervoer is die problem ... probleem nie altyd van die sielkundige se kant a.g.v. werksomstandighede ... finansiële probleme kan hulle (diens verbruikers) nie elke keer gaan tot daar nie ...

... transport is the problem ...problem isn't always on the side of the psychologist ... due to circumstances at work ... financial problems they (service users) can't get there every time ...

This means that the intervention process is often aborted prematurely, leaving the issue unresolved and the problem is perpetuated.

... opvolgdatums so ver uitmekaar ... verloor belangstelling omdat hulle nou oor drie maande eers 'n afspraak het ... baie keer ... probleem is sielkundige lys is vol

... follow-up dates are wide apart ... loose interest because their (service users) next appointment is in three months ...often ... problem is ... psychologist ... list is full...

One key informant stated that they rely heavily on social services, which often have to take on the job of the psychologist. However, due to several limiting factors, problems are often only addressed on the surface. Again, the underlying psychological problem remains unresolved as demonstrated by the following quote:

... daar is gehelp, maar net op die oppervlak byvoorbeeld maatskaplike dienste was 'n middel maar dit was net oppervlakkig ... die werklike probleme is nie aangespreek nie...

... there was help, but only on the surface ... for example ... social services was a means but it was only superficial.. the real problem wasn't addressed ...

Key informants argued that one way to improve the quality of services is to have greater collaboration between social and psychological services. In addition, services should be

situated within the community and the scope of the problems that are addressed broadened.

5.2.7 Relationship between psychological services and social and political change

Participants in this groups felt that psychologists can contribute to the empowerment of the community and affect social change. This could be achieved by becoming actively involved in communities and addressing pertinent issues. This should entail interaction with small and big groups about how to facilitate their own growth and development. One participant suggested that psychologist should focus on individuals who are central in the family system. The belief is that such an approach will have a ripple effect, that is affecting increased well-being for one person will have a positive influence on those this individual interacts with on a regular basis. Another participant indicated that psychologists can make a major contribution to improving education, parenting and children's development.

5.2.8 Framework for a relevant practice and the role of psychologists

Key informants contended that psychologists should be involved in raising awareness regarding social issues such as HIV/AIDS. It is reiterated that psychologists have to provide quality services to uplift and empower the community. This may be achieved by, for example, working with parents and children and enabling them to live at an optimal level despite their socio-economic circumstances.

...tekort aan werksgeleenthede maak dat armoede gee aanleiding tot maatskaplike en sielkundige probleme ... aangesien ekonomiese toestande 'n gegewe is, is sielkundige dienste ... 'n groot en ernstige behoefte

... lack of job opportunities means that poverty ... gives rise to social and psychological problems ... since economic circumstances are a given, psychological services ... a big and serious need ...

Several key informants emphasise the need to involve parents when a child is the primary client. It is felt that parents need to take responsibility for their children's well-being, but often need to be reminded of this duty.

... as ek sien dat kinders sielkundige hulp of berading benodig, dan verwys ek die ouer met die kind ... sodat die ouer kan opgevoed raak, dat die ouer moet beseef "Ek het 'n verantwoordelikheid teenoor my kind" ...

... when I see that a child needs psychological help or counselling, I refer the parent with the child ... so that the parent can be educated in order to help the parent realise "I have a responsibility towards my child ...

Psychologists should also present programmes where they help develop the skills of primary figures in the lives of community members, especially those of children and adolescents. An example is empowering teachers to better manage children with behavioural problems.

Sielkundiges is nodig ... onderwysers het nie tyd ... kundigheid ... om na sulke kinders om te sien nie ... kind ... skree vir hulp en dis waar die sielkundiges inkom ... dat hy (the child) kan oopmaak ...

Psychologists are needed ... teachers don't have time ... expertise ... to look after these children ... child ... screams for help and that's where the psychologist comes in ... so that he (the child) can open up ...

Key informants also suggested that psychologists provide counselling, both within an individual and group context. Finally, psychologists have to do research that will benefit the community and give feedback to the community about such investigations.

5.3 Focus groups

5.3.1 Image of psychology, psychologists and psychological practice

Focus group participants stated that one consults a psychologist when one “has many problems”, such as domestic violence and children who are involved in substance abuse

... ouers gaan maar gebuk onder die kinders en die huwelike ... jong kinders wat laat op straat is ... gesinsgeweld ... kinders onder ouderdom laat by 'taverns' ... verkrag ... vermoor ..' tik' (methamphetamine) ... jy as ouer ... bekommer ... dis hoekom die kliniek so vol is ... ouers is oorstres

... parents suffer from problems with their children and marriages ... young children who are out late ... domestic violence ... underage children in taverns ...

*raped ... murdered ... 'tik' (methamphetamine) ... you as parent ... worried ...
that's why the clinic is so full ... parents are stressed ...*

According to this group, the psychologist is someone you can talk to about traumatic events in your past and present, who will help you overcome the negative consequences of that trauma. A psychologist is someone you can trust with your problems. The issue confidentiality is reflected in the comment of one participant who states that a psychologist “keeps your secret”

... kan die sielkundige vertrou

... can trust the psychologist ...

One focus group member holds that a psychologist addresses those problems that are situated in the person's psyche or spirit.

*... sielkundige daar ... om te help ... geestelike probleem ... jy kan dit nie verwerk
...*

...psychologist there... to help ... psychological problem ... you can't resolve ...

This problem needs to be put out in the open, otherwise the person may resort to desperate acts such as suicide, as is illustrated by this quote:

*... sommige kere ... omdat jy nie iemand het om mee te gesels oor die problem ...
selfmoord ...*

*... sometimes ... because you don't have someone to talk to about the problem ...
suicide ...*

In addition, a psychological problem is said to have the potential to affect significant others in your life. Thus, the psychologists will have to counsel all involved in that system.

*... ma en pa en kinders moet almal beraad word ... dat die wortel van die kwaad
daar uitgehaal word ... baat nie net die een gaan counselling kry ... een sieke steek
mos die ander een aan ...*

*... mother and father and children must all receive counselling ... so that the root of
the problem can be removed ... doesn't help if only one is counselled ... one sick
person will infect another...*

Despite focus group participants' positive view of the psychology, many seek the assistance of other professionals within, and outside of, the helping professions.

*... die meeste van die tyd doen die kerke maar ons sielkundige werkons gaan na
die suster by die kliniek...*

*.... most of the time the churches do our psychological work ... we go to the sister
at the clinic*

This participant group indicated that some community members are open to the idea of consulting a psychologist should they have a problem. However, there is also a great many who believe that you have to be mad to seek the help of a psychologist.

... van die gemeenskap het 'n verkeerde opvatting ... hulle dink jy's mal ..

... part of the community has a misconception ... they think you're mad ...

5.3.2 Links between personal problems and social, political and economic conditions

Causal links between psychological problems and socio-economic and political factors were identified. Problems were attributed to a lack of finances due to a high unemployment rate within this community.

... werk is baie skaars ... jy wil, maar jy kan nie ... geestelike lewe is geknak ...

... work is scarce .. you want to, but you can't ... spiritual life is broken ...

Other causal factors include substance abuse (among adults and children/ adolescents), domestic violence, and child abuse and neglect.

...getwis tussen die man en vrou ... raak die kinders ... hulle verstaan nie waaroor dit gaan nie ... kinders kry emosioneel seer ... begin steel ... raak betrokke by verkeerde dinge ... kry mos nie wat hulle moet he in die huis nie ... daar is nie finansies ...

... quarrelling between husband and wife ... affects the children ... they don't understand what the conflict is about ... children are emotionally scarred ... start stealing ... become involved with deviant acts ... don't get what they need at home ... there isn't any money ...

This participant group also emphasised that their community lacks a sense of unity.

... die een gee nie vir die ander een om nie ... nie ondersteuning van mekaar nie ... jy kan niemand vertrou nie ... jy moet eintlik 'n sielkundige kry vir wie jy kan vertrou ...

... people don't care about one another ... no support from each other ... you can't trust anyone ... you need to find a psychologist who you can trust...

The development of mental health problems is thus thought to often originate and be exacerbated by the absence of infrastructure and support when facing certain difficulties.

5.3.3 Availability of and access to psychological service delivery

Focus group participants reiterate the fact that psychological services situated in Stellenbosch presents a challenge to community members, as described below:

... net met die trein ... maar daar's nie elke week of elke maand geld ... ons 'hike'...

... only with the train ... but there isn't money every week or every month ... we hike ...

Thus, although services are available, the location makes accessing these services difficult, as both private and public transport often proves too expensive. Participants concur that an ideal would be to have a psychologist working within the community.

... hier moet ander week sommer 'n sielkundige kom ...

... a psychologist should come here next week without any further ado ...

5.3.4 Awareness of psychological service delivery

There is a pervasive uncertainty about whether the broader community are aware of the services that are available to them. Participants feel that such awareness would be reflected in a high level of service utilisation.

... dienste in Stellenbosch ... mense weet nie ... dan sal baie al hulle optog soontoe gemaak het ...

... services in Stellenbosch ... people don't know ... otherwise many would have already made their way there ...

Due to this unawareness, religious leaders are approached to help resolve issues that could be considered the realm of the mental health professional.

...die meeste van die tyd doen die kerke maar ons sielkundige werk ...

... most of the time the churches provide psychological services ...

Focus group participants indicated that no-one actively creates awareness of said services.

... ons word nie ingelig ... ons leer maar onself ...

... we aren't informed ... we teach ourselves ...

They propose that awareness of available psychological services can be achieved through the distribution of pamphlets and posters, as well as information sessions. Psychologists themselves should be involved in the latter strategy.

... plakkate ... mense kies om ... survey te doen ... pamflette ... by die skool ... polisiestatie ... sielkundiges ... laat mense weet wat hulle doen ... met die gemeenskap praat....

... posters ... choose people to do a survey ... pamphlets ... at the school ... police station ... psychologists ... let people inform people about what they do ... talk to the community ...

5.3.5 Utilisation of psychological services

Focus groups participants are uncertain about whether community members will voluntarily consult a psychologist, that is without being referred. However, there is a

concurrent belief that, if psychological services are available and easily accessible, they will be utilised due to the anonymity and confidentiality inherent in such a situation.

... sal van die diens gebruik ... veral die moeders ...

... will make use of this service ... especially the mothers ...

... 'n sielkundige sal hier moet instap ...

... a psychologist will have to come here ...

Participants also argued that it is easier to trust someone from outside their realm of existence who is unlikely to have any preconceived notions of who you are.

... daar is 'n spesiale persoon met wie ek heeltemal oopmaak ...

... there is a special person with whom I am completely honest ...

Participants also held that service utilisation would be facilitated if services were situated out of the eye of the broader community. Suggestions for the location of such services were the

... clubhouse (a facility on the local sports field) ... school hall and clinic...

It was further suggested that help-seeking behaviour can be promoted by employing community members to create awareness of services and helping to convince people of the value of such services.

... ons kry die lering en dan dra ons die lering oor ...

... we become educated and then we educate others ...

5.3.6 Quality of available psychological services

The quality of the services provided by the students was questioned. Particular reference was made to the depth and breadth of their work.

... twee studente by die skool ... hoeveel ure werk hulle met die kind, hoeveel kinders bereik hulle...

...two students at the school ... how many children do they reach ... how many hours do they work with a particular child...

Participants refrained from commenting in the quality of the services provided by the Day Hospital as they were unaware of this service. However, they did mention that the referral process was of poor quality as the individuals who are approached for assistance rarely provide feedback.

... nie goed genoeg nie ... hulle belowe jou maar hulle kom nie terug nie ... dan sit jy met die kommer ... met daai problem ...

... not good enough ... they promise you but they don't come back to you ... then you sit with the worry ... with that problem...

It was felt that an improvement in the quality of services could be achieved through mass protest action launched against those responsible for making services available.

5.3.7 Relationship between psychological services and social and political change

These participants contended that psychologists can help empower communities and help bring about social change by assisting the community in taking responsibility for its own welfare.

.... ons kry die lering en die lering dra ons uit ...

This means that they have to teach the community the necessary skills to help themselves and others. In this way, a cycle of helping will be established whereby psychologists help some people who, in turn, help others who now have the ability to help even more people.

... sielkundige beur ons op ... jy word so gou herstel aan daai wond ... ek gaan na die volgende persoon wat dit ook oorgekom het ... kan alweer daai persoon ook optel ... daarvandaan beveg on misdad en ... al die verkeerde dinge hier ... taverns maak ons toe ...

... psychologist ... comforts us ... you heal from that wound so quickly ... I go to the next person who has a similar problem ... can now uplift that person .. from there we fight crime ... all that's wrong in our community ... shut down the taverns ...

5.3.8 Framework for a relevant practice and the role of psychologists

It is suggested that psychologists be actively involved in creating awareness of pertinent psychosocial issues, such as HIV/AIDS, STIs and alcohol and other substance abuse. They should be involved in group work, and help create a psychological sense of community. Participants indicated that attention should be paid to both parents and children, aiding the former to effectively discipline their children and promote their growth and development.

*... parenting programme ... vrouegroep stig ... almal die 'abused women' ...
'HIV/AIDS support group' ... gesinsgeweld ... huwelike ... drankprobleme ...*

*... parenting programme ... establish a group for group for women .. all the abused
women ... HIV/AIDS support group ... domestic violence ... marriages ... alcohol
abuse problems ...*

They should also target children separately, focusing on development and prevention programmes. Psychologists also have to network with other role players to ensure a well-organised system of service provision where each part knows what its function is and what the roles of the other parts are.

Success in any of these endeavours will require winning the community's trust.

*... jy moet regtig iets doe nom eers die vertrouwe van die mense te wen ... sukkel lank
... moet eers 'n 'bond' het ...*

*... you must first do something to win the trust of the people ... struggle long ...
must have a bond first ...*

It is evident that communities have an overall positive view of psychologists and psychological practice in general. This is conducive to the acceptability and voluntary utilisation of psychological services. However, continued widespread stigmatisation of psychological problems is a barrier to the utilisation of psychological service delivery. This is exacerbated by the inaccessibility of services, the cost of services and the cost of transport to attain such services as they are mostly situated outside of communities, particularly in rural and peri-urban areas. Several authors have commented on these issues and have suggested solutions to these challenges. In the following chapter these are systematically reviewed in relation to participants' responses.

CHAPTER 6

Discussion

6.1 Introduction

In the previous chapter participants' views on psychologists, psychological practice and related issues were described. This chapter will focus on whether their views coincide with, or diverge from, those presented by other authors and on the nature of those similarities and differences. The implications of this study as well as recommendations for further research are also presented.

6.2 Image of psychology, psychologists and psychological practice

Key informants view psychologists as being focused on helping individuals resolve personal problems, by helping them share difficulties in living. Thus, they help improve people's functioning by addressing issues related to the self, relationships and children. This supports the idea that psychology is mainly concerned with individual counselling (Dollinger & Thelen, 1980; Aspenson et al., 1993). This notion of psychological intervention being aimed at individuals may explain why none of the participants, both key informants and service users, indicated the community project active in the community as a psychological project for 4 years already, despite the fact that it was established by psychology graduates. The effects of trauma, physical, emotional and spiritual, are also thought to be the domain of the psychologist. According to service users, psychologists are individuals who heal wounds inflicted on the spirit/psyche by assisting people in venting dormant emotions that cause distress. Thus, participants have a strong belief in the value of talking therapies as opposed to pharmacotherapy, which

was not mentioned by either key informants or service users. The psychologist advises and supports, and maintains confidentiality. They represent a safe haven, devoid of judgement or ridicule. However, participants also stated that much of what they understand under psychological services is provided by spiritual healers and members in other helping professions, such as social work. This indicates that participants perceive the realm of healing as not being exclusive to psychology and that others can provide a similar service, even if by different means and methods. Medical professionals such as nurses (particularly in local clinics) and doctors are also often consulted, mainly due to the fact that people in low income communities frequently express distress by means of somatisation (Kirmayer, Young & Robbins, 1994; Kroenke, et al., 1994 as cited by Palinkis, 2000). This supports the theory of Williams and Healy (2001), who argue that people view mental illness and problems and, so too, the treatment thereof, on a continuum. Thus, communities' beliefs about, and attitude towards psychology, may be flexible and subject to change based on socio – cultural variables. As Swartz (1990) argues, culture is dynamic and peoples beliefs, attitudes and behaviour is modified by social, economic and political transformation. Therefore, in accordance with Mokgale's (2004) findings, it appears that communities' views of psychology have altered marginally, even if improved understanding continues to co - exist with more traditional ideas. According to participants, many community members remain unaware of the true nature of the psychologist's job and continue to view those who seek the help of a mental health professional as "mad". Thus, the stigmatisation of mental ill-health remains a barrier to effective service delivery. This finding supports that of Mokgale (2004) and Berger and Lazarus (1987) who found that ignorance regarding the scope of

psychological service delivery lead communities to believe that psychologists work exclusively with serious mental illness, and that their services are only available and accessible to the higher socio – economic classes.

Often, consulting a psychologist voluntarily is facilitated by that specific *individual's* positive view of this service. This distorted view of psychologists is in accordance with the findings of the Berger and Lazarus study (1987). These authors found that people's unfamiliarity with the work of psychologists can be attributed to the fact that they do no work within the community, often meaning that their services are inaccessible as well as an expenditure many community members can ill-afford.

6.3 Links between personal problems and social, political and economic conditions

Participants identified several negative psychosocial issues within their community that negatively affect their quality of life. These include: teenage pregnancy; substance abuse; promiscuity, HIV/AIDS and other STIs' crime, gangsterism and violence; patriarchal family structures; child abuse and neglect; and domestic violence. Such phenomena form part of a cycle of debilitating socio-economic and socio-political circumstances. The community concerned also has a high unemployment rate. One of the reasons provided for this are people's low level of education, which is often due to their dropping out of school to help supplement the household income. Thus, many of the community members do domestic work, are employed as farm workers on surrounding farms and/or are tradesmen. According to participants, lack of economic development in the area also contributes to people's limited income. The result is an

inability to adequately provide for the family's needs. This may give rise to interpersonal conflict which, in turn, affects the child. Parents may vent their frustrations on their children who, conversely, may blame their parents for what they lack. This may be especially relevant in cases where parents spend what little income they have on alcohol. Parental alcohol and other substance abuse means that there is a lack of supervision for children. When this is compounded by child abuse and neglect, children often seek love, acceptance and material rewards elsewhere. This may result in alcohol and/or drug abuse, as well as sexual contact and involvement in criminal activity at an early age. According to Berger and Lazarus (1987) and Kosny and Ennis (1999), such psychosocial problems are community members' response to stressful life events and severely oppressive and/ or detrimental social circumstances. The latter remains relevant as residual consequences of apartheid continue to affect the lives of a large portion of the population. Kale (1995b) contends that if these phenomena are viewed as symptoms of distress, the mental health of all South Africans have been negatively affected by the country's political history. This history also has implications for the availability and access to psychological services.

6.4 Availability of and access to psychological service delivery

The only psychological services (at primary health care level, apart from minimal psychology student interventions available to this community, are situated at the Day Hospital in Stellenbosch. According to Flisher, Fisher and Subedar (1999), psychological services are mainly available in psychiatric hospitals, making them inaccessible to the most vulnerable populations. Given the economic circumstances of the majority of the

community, accessing these services presents a challenge, as many community members lack the financial resources to do so. Community members must use public transport, a situation which they seem keen to avoid. Private transport would also have to be hired at exorbitant rates and many people resort to hiking to Stellenbosch. The latter option, apart from being time-consuming, is also dangerous. The Department of Health (2002) has a comprehensive health care plan that incorporates mental health care service provision in the form of the Mental Health Care Act. In other words, psychological services have been made available to communities to some degree. Regarding the primary health care setting, nursing staff are concerned with identification, emergency management and referral of psychological problems. Such referrals are made to secondary health care service providers that are situated outside of the community, which has implications for the availability of and access to services for those in rural and peri-urban areas, who often do not have the resources to access these services despite their availability. Thus, these findings substantiate the view expressed in The Draft Charter of the public and private health sectors of South Africa (Department of Health, 2005) that a great many South Africans have inadequate access to health services, and therefore also mental health care services, as a result of geographical, financial, physical, communication and social obstacles.

As previously stated, students from the University of Stellenbosch also work in the community as part of their practical training. However, this is not a sustained programme, specifically due to the recent dissolution of the BPsych degree. There is now a void, at least to some degree, of psychological assistance that may not be filled for some time. Still, a degree of assistance remains in the form of clinical/community

master's students from the above-mentioned academic institution, as well as the Watergarden community project that was initiated by a group of BPsych graduates. However, the periodic nature the former intervention (students are there for limited periods) and the community's lack of insight into the fact that the Watergarden project constitutes a community psychology initiative negatively affects the awareness community members have of the psychological service available and accessible to them, and subsequently also the utilisation of psychological services.

6.5 Awareness of psychological service delivery

The views of key informants and service users differ considerably on the issue of awareness of mental health services. The former mostly believe that community members are aware of the psychological services available for their use. According to them, information related to these services is transferred by means of posters, informal talks and referrals. Service users, on the other hand, hold that they are ignorant of available services. They also indicate that they doubt whether the greater community knows of these resources. They argue that such information is not disseminated and, in fact, propose those mechanisms of distributing information indicated by key informants as a means to create and enhance the community's awareness of psychological services they could potentially utilise. Thus, in accordance with Berger and Lazarus (1987), in general, communities remain unaware of the psychological services available to them, despite changes in the distribution of these services. Furthermore, these findings concur with those of Mokgale (2004), who argue that there is a positive correlation between awareness of psychological services and the individual's level of education and exposure

to the media. Thus, key informants' greater awareness of psychological services can be attributed to their overall higher level of education and exposure to media and public campaigns.

Both groups feel strongly that psychologists should be personally involved in the dissemination of information in order to ensure utilisation of these services. This is in accordance with Berger and Lazarus (1987), who contend that psychologists cannot remain neutral in socio – political and economic issues, and should be actively involved in the provision of consultation and training. Such involvement must entail information regarding not only the availability of their services but also the nature and extent of these services.

6.6 Utilisation of psychological services

Services available to this community are mainly utilised as a result of referrals. Most of the participants - both key informants and members of the focus groups - expressed doubt as to whether people will use these services voluntarily, that is without referral. Reasons given for this includes fear of stigmatisation and the fact that they may be unaware that psychological intervention can help resolve their issues. Thus, stigmatisation of mental health problems has a negative impact on the utilisation of services of mental health professionals. This problem is compounded when those who want to access services are unable to do so due to a lack of availability of these services. This lack of availability refers to both the location of mental health care services (which is often in state hospitals and day hospitals) and whether individuals are able to obtain appointments when they do attempt to utilise these services. Thus, although members of rural and peri – urban

communities do not utilise psychological services, they may be willing to do so should these services be readily available to them (Berger & Lazarus, 1987; Findlay & Sheehan, 2004 and Mokgale, 2004). It appears that participants believe that a ready flow of finances or reserve funds, such as those available in the form of a medical aid scheme, promotes service utilisation. Again, the idea is created that these service users view psychological services as for the higher social classes who can more easily afford the cost of therapy and transport, and the time involved (Berger & Lazarus, 1987).

The issue of confidentiality was raised again at this point, but this time in a contradictory manner. Earlier, focus group participants indicated that the community would benefit from having a psychologist in their midst. However, they now hold that services need to be as far away from the 'prying' eyes of the community as possible, without negatively influencing the accessibility of services. Thus, it seems that community members are confronted with a real dilemma: they either have to utilise services openly and risk exposing the existence of a problem to all, or not seek help and keep their "secret" despite the distress it engenders. Thus, in accordance with Mokgale (2004) and Hugo et al. (2003) educating communities at large about the value of psychological services will help reduce the stigma attached to mental health issues, and in this way make accessing the services of a mental health professional more acceptable. The quality of services may also play a role. For example those who have utilised psychological services may relate to others that the quality of services they received were inadequate, making others less willing to spend time and effort on a service they now believe to be incapable of assisting them resolve the personal conflicts and problems.

6.7 Quality of available psychological services

Where the quality of services is concerned, there was disagreement both within the key informant group and service users' focus groups. Some key informants indicated that the quality of services available (specifically at the Day hospital) is high and that they receive positive feedback from those individuals who utilise these services. Others argued that people's problems are merely addressed at a superficial level. This view is supported by the personal communication with a psychiatric nurse at the Stellenbosch Day hospital (2006). Time constraints due to inadequate staffing results in clients receiving only limited counselling. This situation is further complicated by issues of communication and confidentiality. Thus, as argued by Kale (1995b), the staff responsible for psychiatric care is often overworked and may not assume responsibility for the treatment of clients. They often merely renew prescriptions and refer clients to tertiary care should the need arise.

Focus group participants did not comment on this issue as they had no personal experience with these services or knew anyone who had. However, concerning the students, doubt was expressed regarding the depth and scope of the intervention they offer. Thus, it is evident that the quality of services provided to communities must be improved.

It is difficult to gauge the quality of services when the intervention process often is not concluded. This phenomenon, specifically regarding those who reside in rural and peri-urban communities, may again be attributed to the cost of therapy and transport, the regularity of appointments, and the language used (Berger & Lazarus, 1987 and Findlay & Sheehan, 2004). It is acknowledged that evaluating a system or process when all the

necessary elements are not considered, brings the validity of such an evaluation into question. Still, it is evident that the availability of and access to services could have a positive influence on quality, if only with regards to providing a sustained treatment plan that does not only focus on pharmacotherapy, but that addresses the individual as a coherent entity. Focus group participants suggested that merely demanding improved service delivery will prove successful in changing current circumstances. This implies that communities wish to enforce their rights to comprehensive PHC. However, this is not so easily attained. Perhaps more should be done to inform them of the current situation as well as the reasons as to why PHC (including mental health care services) are structured as it is.

6.8 Relationship between psychological services and social and political change

Despite what appears to be a mainly negative perspective, participants did acknowledge that psychologists can contribute to the establishment and maintenance of social change. Service users stated that psychologists should address socio-political issues, help communities take ownership of their own welfare and facilitate a cycle of reciprocal helping. They further explained that psychologists can make a positive contribution to especially the growth and development of the community. Thus, psychological interventions should take cognisance of communities' socio – political circumstances and focus on the empowerment of that community (Mokgale, 2004). According to service users, this should entail establishing a sense of community cohesion and ‘brotherhood’. It appears that these community members in particular, speak to the awakening of a spirit of Ubuntu, where people become concerned with the welfare of themselves and others.

This means that the community as a whole should work towards healing itself, by focusing on individuals and groups, and in this way initiate and maintain a cycle of helping that will affect all positively. All participants feel that psychologists can make a valuable contribution to such a process, and should incorporate this into their overall practice.

6.9 Framework for a relevant practice and the role of psychologists

A number of suggestions were made regarding what participants believe the role of the psychologist should entail. Participants indicated that psychological practice must incorporate research, skill development, individual counselling, attention to child development issues, addressing stress-related issues and facilitation of community participation and collaboration. Thus, participants make several pertinent suggestions that have also been proposed by several authors over the last few decades (Lazarus, 1986; Berger & Lazarus, 1987; Vogelmann et al., 1992; Leung & Zhang, 1995; Mokgale, 2004). Particular focus is placed on the well-being of children, with participants emphasising the need to provide services and initiate programmes that will facilitate the growth and development of all children into optimally functioning individuals. Socio-economic issues also need to be addressed. These include issues related to HIV/AIDS, poverty and unemployment, and violence, all issues that are receiving increased attention from several sources. Thus, psychologists also need to investigate these and other issues and provide relevant and useful feedback, as well as strategies to address said issues.

6.10 Summary of findings

This specific community holds particular views of psychology. They see psychologists as focusing on individualised, curative and reactive work as opposed to them having a preventative approach. The general consensus is that psychologists employ talking therapies to help individuals manage intra – and interpersonal conflicts and problems. Members of communities also seem to believe that there is little scope for group and community intervention. In fact, none made mention of the community project that was launched in their community approximately 4 years ago. This may either be due to an inability to identify this as a psychological intervention or the fact that, to them, psychologists mainly work with individuals. In other words, individuals' constructions of psychological help will allow them to look only for the kinds of services that they assume are psychological, in their environment. This will, as it has in this community, allow community members to see only what they believe is psychological help. Furthermore, participants indicated that psychological services can be provided by other professionals (for example social workers and primary health care staff) and “para-professionals” (for example spiritual leaders). Thus, people's perception of psychology incorporates diverse ideas on mental illness and the treatment thereof. However, a degree of stigma is still attached to the action of consulting a psychologist. This may account for the sense of anonymity participants feel need to be a core part of utilising these services. As in many other rural and peri – urban communities, this one is characterised by detrimental socio – economic and political circumstances. There is a belief that psychologists can and should address psycho-social and socio-economic issues, which

may help break the cycle of poverty and related problems within which many of our communities are caught.

It seems imperative that we work towards bringing services to communities, as many communities lack the resources to access available services due to spatial, monetary, and social barriers. The issue of utilisation of services is complicated by the fact that communities are often unaware of the services available to them. Regarding this, there is general consensus among all participants that psychologists themselves should be involved in the distribution of information regarding the availability of their services and what said services entail. Utilisation is also negatively affected by the stigma still attached to psychological service utilisation and the lack of resources to access services. Thus, again the argument is made that psychological services should be made more readily available to and within previously disadvantaged communities.

The quality of available services was brought into question, mainly due to the issues of availability and access, as well as the scope of the services that are provided within the community (specifically with relation to the students operating within the community). Participants argued that psychologists can make a positive contribution to the establishment of social change by addressing socio – political issues, empowering people to take ownership of their own health and well-being and helping them create a psychological sense of community. Counselling, skills development, child development issues and socio – economic concerns should also be addressed.

All these views indicate that key informants and service users' perceptions of psychology is not necessarily a separate, distinctive pattern of thoughts and beliefs. Rather, Western

and indigenous theories and concepts seem to operate together to form a unique picture of psychology as it is by members of communities today.

6.11 Implications of the study

It is evident that there is still extensive stigma around psychological services and those who use it. This stigma relates to the belief that psychological services are for those who are ‘mad’ or who can afford such care. Thus, although community members may recognise their problems as having a psychological component, fear of stigmatisation and the inaccessibility of care due to financial constraints makes accessing such services (where they are available) problematic. Furthermore, despite policy changes and the provision of primary health care services, mental health care appears to have been neglected. This is exemplified by community members’ lack of awareness of the availability of such services to them, and the inaccessibility of psychological services. The latter has serious implications for the utilisation of such services.

6.12 Recommendations for further research

Stigmatisation remains a major barrier to the effective and timely provision of psychological services. Thus, it is important to provide psycho – education about the nature of psychological practice and how it can contribute to the welfare of individuals and communities. Communities own views in this regard need to be obtained in order to ensure that the assistance provided is holistic, appropriate and acceptable for that particular group of people. Furthermore, greater insight is needed regarding what can be done to improve attending to local ways of understanding so that interventions are more

appropriate and take into consideration how popular views of psychology can be incorporated or dispelled.

CHAPTER 7

Conclusion

Traditional and modern beliefs regarding mental health issues are merged and may exist on a continuum through which people move in order to manage psychological issues, often seeking the assistance from other professionals and para – professionals. Thus, although psychologists plan and implement innovative and relevant intervention programmes they are still an unknown entity to many communities – a veritable stranger in disguise. As such, it is crucial that we expand communities' understanding of what psychology is and who psychologists are. This is likely to involve a large – scale psycho – education strategy. Psychologists themselves must be involved in such an endeavour; actively disseminating information in a simplistic manner; educating individuals, groups and communities; providing the information in the main languages of the area within which they work; and using the various organisations, committees and stakeholders that function within specific communities.

Furthermore, there is a place for psychology in the process of social, political and economic transformation which, in turn, influences cultural beliefs and practices. Therefore, increased exposure to, and improved understanding of, psychological practice is likely to engender greater utilisation of services where and when available, and empower people to campaign and advocate for appropriate, acceptable, accessible and affordable psychological services to be made available to them.

Again, it becomes evident that mental health practitioners need to be aware of the various ways in which people can, and do, interpret and experience mental illness, wellness, psychologists and psychological services, the factors that effect their help – seeking

behaviour, as well as how such beliefs and practices can change over time. We need to engage in a dialogue with the public about all the issues relevant to their health and well – being if we are to render a service that promotes the mental health of all South Africans.

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APPENDICES

Appendix 1

This constitutes the interview guideline for both key informants and focus group participants.

Date of Interview: _____

I am conducting interviews on perceptions of psychology in the community for my Masters degree. I would appreciate your assistance in answering the questions. The interview will last for about an hour.

BIOGRAPHICAL INFORMATION

Age: _____

Gender:

Male	Female
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Marital Status:

Single	Married	Divorced	Widow	Widower
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Language: _____

Level of Education: (no of years) _____

Occupation: _____

INTERVIEW GUIDELINE

Broad guidelines for questions

1. Have you ever heard about psychologists? Can you tell me everything that you have heard about this profession?
 - What do you think about psychologists, in general?

- Would you advise others to visit a psychologist? Explain.
- What do you think psychologists do?
- If you or a family member were to visit a psychologist would you want others to know about it? Why? Why not?

2. What do you think may cause a person to develop a psychological problem?

Please elaborate.

- Do you think people's personal (psychological) problems may be related to social, political and economic conditions? Explain your answer.

3. How aware are people about psychological services offered in your community?

Please explain.

- Is there a place in your community that offers information about where to go for psychological help?
- How is this information transferred?
- How useful and accurate is this information?
- What do you think can be done so that people are more aware of the mental health and psychological services that are available in the community?
- How can psychologists themselves contribute to this?

4. Do you think that psychological services are needed in this community and that they will be used? Can you tell me more about your ideas about that?

- How do you think people in the community would feel about going to a psychologist?

5. What can you tell me about the availability and access to services in your community?
 - Where in your area do people with serious psychological problems go for help?
 - Are the services accessible?
 - Are these services affordable?

6. How do you feel about the quality of the services that are available in your community?
 - What type of services is offered at the place where you can go to when you have a psychological problem?
 - Are these services adequate?
 - How can they be improved?

7. What would say is the relationship between psychological services and social and political change in South Africa?
 - Do you think that psychologists can contribute to social and political change?

8. What, in your, opinion, are the psychological needs of your community?
 - Who would be the appropriate person to assist in meeting each of those needs?
 - If you were to have psychologists in your local clinic, what type of services would they need to render?

- How do you think psychologists could contribute to the health and well being of your community?
- Do you think more psychologists should be sent to work in your community?

Appendix 2

Hierdie is die onderhoud riglyne vir beide sleutel-informante en fokus-groep deelnemers.

Datum van Onderhoud: _____

Ek voer onderhoude rakende die gemeenskap se persepsies van sielkunde vir my Meesters graad. Ek sal dit waardeer as u die volgende vrae sal beantwoord. Die onderhoud sal naastebly 'n uur duur.

BIOGRAFIESE INLIGTING

Ouderdom: _____

Geslag:

Manlik		Vroulik	
--------	--	---------	--

Huwelikstatus:

Onaetroud		Getroud		Geskei		Weduwee		Wewenaar	
-----------	--	---------	--	--------	--	---------	--	----------	--

Taal: _____

Vlak van Opvoeding (aantal jare): _____

Beroep: _____

ONDERHOUD RIGLYNE

Breë riglyne vir vrae

1. Het u al ooit van sielkundiges gehoor? Kan u my alles vertel wat u omtrent sielkundiges weet?

- Wat dink u oor die algemeen van sielkundiges?
- Sal u ander aanraai om 'n sielkundige te besoek? Verduidelik.
- Wat dink u doen 'n sielkundige?

- Sou u wou hê dat ander moet weet dat u of 'n familielid 'n sielkundige besoek? Hoekom? Hoekom nie?

2. Wat dink u kan veroorsaak dat 'n persoon 'n sielkundige probleem ontwikkel?

Brei uit asseblief?

- Dink u mense se persoonlike (sielkundige) probleme is verwant aan die sosiale, politiese en ekonomiese omstandighede waarin hulle woon? Verduidelik?

3. Hoe bewus is inwoners van die sielkundige dienste wat in u gemeenskap beskikbaar is? Verduidelik asseblief.

- Is daar 'n plek in u gemeenskap wat inligting verskaf rakende waarheen individue kan gaan vir sielkundige hulp?
- Hoe word hierdie inligting oorgedra?
- Hoe bruikbaar en akkuraat is hierdie inligting?
- Wat dink u kan gedoen word sodat mense meer bewus is van beskikbare sielkundige dienste?
- Hoe kan sielkundiges self 'n bydrae lewer in hierdie proses?

4. Dink u dat sielkundige dienste nodig is in u gemeenskap en dat hierdie dienste benut sal word? Kan u my meer vertel rondom u idees hieroor?

- Hoe dink u sou die mense in u gemeenskap daarvoor voel om 'n sielkundige te besoek?

5. Wat kan u my vertel aangaande die beskikbaarheid van en toeganklikheid tot dienste in u gemeenskap?

- Waarheen gaan die mense in u gemeenskap indien hulle sielkundige hulp nodig het?
- Is hierdie dienste toeganklik?
- Is hierdie dienste bekostigbaar?

6. Hoe voel u oor die kwaliteit van die dienste wat wel in u gemeenskap beskikbaar is?

- Watter tipe dienste lewer die instansie(s) waarheen u kan gaan indien u 'n sielkundige probleem het?
- Is hierdie dienste voldoende?
- Hoe kan hierdie dienste verbeter word?

7. Wat sou u sê is die verhouding tussen sielkundige dienste en sosiale/politiese verandering in Suid Afrika?

- Dink u sielkundiges kan bydrae tot sosiale en politiese verandering? Hoe?

8. Wat, volgens u, is die sielkundige behoeftes van u gemeenskap?

- Wie sou die aangewese persoon wees om elk van hierdie behoeftes aan te spreek?
- Watter dienste sou 'n sielkundige werksaam in u plaaslike kliniek moes lewer?
- Hoe dink u kan sielkundiges bydrae tot die gesondheid en welstand van u gemeenskap?

- Dink u dat meer sielkundiges in u gemeenskap moet kom werk?

Appendix 3

Psychology Department
Private Bag X1
Matieland
7602
2006-05-26
Fax: 022-4872927

Sister Carien Bester
Regional Director of Health
Westcoast Winelands

Dear Sister Bester

Request for permission to do research at the [REDACTED] Primary Health Care clinic

For the past four years we have been engaged in service delivery in the [REDACTED] community. We have been working predominantly within the school and at times we have seen referrals from the clinic. Some of our Bpsych students that have recently graduated have also launched a project ([REDACTED]) aimed at providing scholastic, emotional and social support to school-aged children in the community.

We would like to request your permission for us to conduct a study that has arisen out of this context. We are keen to enquire what key informants and clinic service users in the [REDACTED] community think of psychologists and psychological services. We also want to establish how psychological services could be more accessible in primary health care contexts. This kind of information is directly relevant to the development of psychological services at primary health care level. We would therefore like to interview (in focus groups), three sets of approximately 6 participants each, at the beginning of July.

We are aware of the incredible pressure under which Sister [REDACTED] works as we have established a fairly good relationship with both her and Sister Denise Johnson over the years. We will therefore use approximately one hour of her time (in total) over a period of a few weeks.

We are able to provide you with a research summary on completion of the research.

Should you have any queries, you are welcome to contact us.

Yours faithfully

Ronelle Carolissen

**Lecturer/Clinical psychologist/ Research supervisor
student**

Bianca Fortein

Masters (research)

Appendix 4



STELLENBOSCH
STELLENBOSCH • PNIEL • FRANSCHHOEK
MUNICIPALITY • UMASIPALA • MUNISIPALITEIT
HEALTH SERVICES • GESONDHEIDSDIENSTE

FAKS/FAX

Aan/To:	MS URSULA HARTZENBERG	Van/From:	MS DENISE JOHNSON
Faks/Fax:	(021) 808 3584	Tel:	(021) 808 8439
Tel:	(021) 808 8466	Datum/Date:	1 JUNE 2006
Insake/Re:	RESEARCH	Bladsye/Pages:	1 (Dekblad ing./Incl. cover)

BOODSKAP/MESSAGE

You are referred to the above and a facsimile from Ms Ronelle Carolissen as received on 10 May 2006.

Permission is hereby granted to do research at Klipmuts PHC Clinic.

Regards,

p HEAD: HEALTH SERVICES
n HOOF: GESONDHEIDSDIENSTE

JH/vab

Appendix 5

Demographic Data

Citizenship

South Africa	3 948
SADC countries	0
Rest of Africa	0
Europe	3
Asia	0
North America	0
Central and South America	0
Australia and New Zealand	0

Population Group

African	1 066
Coloured	2 808
Indian	6
White	70
Total	3 950

Age

0-4	459
5-9	435
10-14	399
15-19	391
20-24	353

25-29	370
30-34	369
35-39	373
40-44	269
45-49	186
50-54	112
55-59	57
60-64	59
65-69	52
70-74	33
75-79	24
80-84	3
85+	6

Gender by Age

Males

0-4	235
5-9	228
10-14	224
15-19	192
20-24	190
25-29	182
30-34	171
35-39	192
40-44	137

45-49	72
50-54	76
55-59	29
60-64	27
65-69	20
70-74	23
75-79	6
80-84	6
85+	0
Total	2 010

Females

0-4	227
5-9	213
10-14	172
15-19	178
20-24	182
25-29	191
30-34	188
35-39	191
40-44	118
45-49	101
50-54	47
55-59	35
60-64	39

65-69	27
70-74	12
75-79	9
80-84	6
85+	3
Total	1 939

Language

Afrikaans	3 069
English	21
isiNdebele	0
isiXhosa	764
isiZulu	9
Sepedi	0
Sesotho	83
Setswana	0
SiSwati	0
Tshivenda	0
Xitsonga	0
Other	0

Marital Status

Civil/Religious	837
Traditional/Customary	60
Polygamous	0

Living together	434
Never married	2 458
Widow/Widower	93
Separated	27
Divorced	39

Disability

Sight	132
Hearing	36
Communication	12
Physical	54
Intellectual	21
Emotional	9
Multiple	24

Highest level of education obtained by over 20 year olds

No schooling	391
Grade 1/sub A	145
Grade 2/sub B	135
Grade 3/standard 1	213
Grade 4/standard 2	217
Grade 5/standard 3	256
Grade 6/standard 4	263
Grade 7/standard 5	334
Grade 8/form 1	444

Grade 9/form 2	318
Grade 10/form 3/NTC I	280
Grade 11/form 4/NTC II	143
Grade 12/form 5/matric/NTC III	285
Certificate with less than grade 12	3
Diploma with less than grade 12	6
Certificate with grade 12	42
Diploma with grade 12	6
Bachelor's degree	6
Bachelor's degree and diploma	3
Honour's degree	0
Higher degree (Master's or Doctorate)	0
Not Applicable	459

Individual monthly income(R)

None	2 390
1 – 400	191
401 – 800	595
801 - 1 600	502
1 601 - 3 200	192
3 201- 6 400	54
6 401 - 12 800	24
12 801 - 25 600	0
25 601 - 51 200	3
51 201 - 102 400	0

102 401 - 204 800	0
204 801+	0

Annual household income (R)

None	116
1 - 4 800	28
4 801 - 9 600	133
9 601 - 19 200	234
19 201 - 38 400	253
38 401 - 76 800	136
76 801 - 153 600	28
153 601 - 307 200	0
307 201 - 614 400	0
614 401 - 1 228 800	0
1 228 801 - 2 457 600	0
2457600+	0