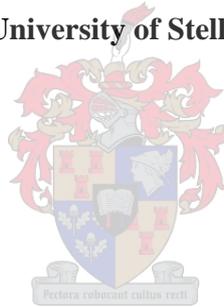


**THE INTEGRATION OF PSYCHOLOGICAL SERVICES INTO  
PRIMARY HEALTH CARE (PHC) IN SOUTH AFRICA:  
TENSIONS IN THEORY, POLICY AND PRACTICE**

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## **DECLARATION**

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

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Signature

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Date

## **Abstract**

This literature review follows the early origins of the integration of psychological services into Primary Health Care (PHC) to its promulgation by law under the new dispensation in South Africa post-1994. With a recent re-commitment in 2008 by government to PHC for health service delivery, the biomedical orientation of PHC is inherently problematic as the location for psychological services and runs contrary to a comprehensive discourse of care as envisioned locally and by the World Health Organisation (WHO). With such shifts in policy at a macro level and in a context in which the relevance of psychological theorising and praxis is under scrutiny, this review has highlighted that a bottom-up approach is necessitated; specifically one that will facilitate a convergence between policy, theory and practice, with its foundations informed by research.

## **Opsomming**

Hierdie literatuuroorsig begin by die vroeë beginpunt waar sielkundige dienste by Primêre Gesondheidsorg (PHC) ingelyf is, en volg die gebeure tot waar nuwe wetgewing hieroor in die nuwe post-1994-dispensasie in Suid-Afrika uitgevaardig is. Met die regering wat homself in 2008 herverbind het tot PHC vir gesondheidsdiensverskaffing is die biomediese fokus van PHC vir sielkundige dienste inherent problematies, omdat dit in teenstelling met 'n omvattende diskoers oor versorging staan, soos dit plaaslik en deur die Wêreldgesondheidsorgorganisasie (WHO) in die vooruitsig gestel word. Met makrovlakverskuiwings in beleid en in 'n konteks waarin die toepaslikheid van teoretisering en praktyk op die gebied van die sielkunde onder die loep is, beklemtoon hierdie verslag dit dat 'n onder-na-bo-benadering nodig is; spesifiek een wat 'n sameloping tussen beleid, teorie en praktyk sal fasiliteer, en wat gegrond is op navorsing.

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## **1. Introduction : The Winds of Change**

With the transition in South Africa in 1994 from an apartheid state to a democracy—many changes have taken place in the country, particularly with regards to the delivery of health care services to the previously marginalised and historically disadvantaged populations. In this regard, the vision of a national comprehensive health care system based on the principles of universal Primary Health Care (PHC) was conceptualised, including the integration of mental health care into the PHC system (Petersen, 2000). According to Hills and Mullett (2005) PHC is not a new phenomenon. It originated in the 1940s and 1950s, with Sydney Kark and his colleagues in South Africa when there was a movement towards community-based health care, and the term “community oriented primary care” emanated. Unfortunately their attempts to establish community health centres that were then prototypes for the PHC approach were curtailed and dismantled by the apartheid regime (Kautzky & Tollman, 2008). It was only in 1978 that the PHC approach achieved global recognition, when the World Health Organisation (WHO) in its Alma-Ata declaration outlined the underlying philosophy of primary health care (Hills & Mullett, 2005). Hills and Mullett (2005) demarcate the principle features of comprehensive PHC based on this declaration as follows

Firstly PHC is accessible and in the process removes preventable barriers to access, such as economic, physical, geographical, cultural, linguistic and social barriers. Secondly it is participatory, in that it is contingent upon community participation, planning, operating evaluation and control. As such it promotes empowerment of communities in their responsibility for the health of their members. Thirdly PHC is comprehensive, culminating in care that is integrated, multidisciplinary and intersectoral, incorporating all aspects of the state resources that impact upon health care, such as housing, agriculture, employment and education. Fourthly it is holistic in the sense that the individual cannot be viewed in isolation from the environment, and cognisance is taken of other factors affecting overall health, such as the political, social and physical environments. As PHC embraces a holistic view of health care it incorporates health promotion aspects as well as preventative, curative and rehabilitative care based on what communities themselves define as being critical to

the health of their members. Finally, PHC is equitable, it aims to counteract an unequal and unjust provision of health resources and address existing power imbalances inherent in the distribution thereof.

Post-1994, the new South African government rapidly utilised the PHC approach as the pinnacle for their health strategy. The White Paper on Transformation advocated by Parliament in 1997 and the National Health Care Act of 2004 cemented the resolve that the national health system would adopt a PHC approach delivered via the district health system. Such legislation was not only a means of counteracting the inequities of health service provision of the past but was also seen as an attempt to align South Africa's health system with the philosophy and underlying principles of the WHO's Alma Ata Declaration of 1978 (Mkhize & Kometsi 2008). Furthermore, it was envisaged that users would be able to access all their health care requirements under the umbrella of an integrated health care system at critical points, namely in communities where people live (Mkhize & Kometsi, 2008). There was a concomitant shift in focus from a previous health care system that was mainly curative and hospital based to one that emphasised health promotion and prevention (Mkhize & Kometsi, 2008). Mental health services, including services for substance abuse, were to be integrated into PHC to ensure that users would receive both medical and mental health care in one visit, which should simultaneously lessen the stigma of mental illness (Mkhize & Kometsi, 2008).

In line with this shift in the discourse of care advocated by PHC, in 1998 community service became mandatory for newly qualified medical practitioners. By 2003 there were a further nine categories of health care providers required by legislation to perform community service: dentists, pharmacists, radiographers, occupational therapists, physiotherapists, speech therapists, physiotherapists, environmental health practitioners and clinical psychologists (Pillay & Harvey, 2006). Pillay and Harvey (2006) rationalise the theoretical basis for this promulgation to include a form of 'compensation', whereby graduates repay the state for its outlay for the training of health professionals. Further community service was also seen as a measure to counteract the "brain drain" in the country that has culminated in a severe skills shortage, particularly in the area of health care. Unique to the South African context, community service legislation was seen as addressing the imbalances in the provision

of health resources such as that between urban and rural areas and particularly for historically disadvantaged groups (Pillay & Harvey, 2006). Implementing community service for clinical psychologists within the PHC system would provide critical mental health care in the communities of the majority of the people who were disadvantaged in terms of their past access to such a service under apartheid (Pillay & Harvey, 2006).

In their study on the experiences of the first community service clinical psychologists Pillay and Harvey (2006) found that while 90% of the respondents regarded the community service as a valuable experience in terms of boosting confidence levels and having contributed to the opportunity to make a difference in communities, there were many difficulties accompanying this practical experience. For example, half the respondents were unclear of their function and over 40% received no orientation. This Pillay and Harvey (2006) attribute to ignorance on behalf of institutions pertaining to the psychologist's role, and they believe that this has contributed to others confusing the roles of psychologists with the roles of social workers and psychiatrists. Pillay and Harvey (2006) maintain that there is still a long way to go in terms of educating health practitioners in understanding the core competencies of clinical psychologists. However, in this context of ignorance pertaining to the role of psychology many of the community service psychologists were nonetheless expected to start a new clinical psychology service from scratch, which Pillay and Harvey (2006) believe can be overwhelming for any new graduate.

With regards to the training of clinical psychologists, Pillay and Harvey (2006) found that only a third of the community service psychologists were involved in training of community members and more than half of them had no previous experience in community preventive work. In light of the degree of psychosocial problems within the South African context and a proposed shift towards health promotion, Pillay and Harvey (2006) believe that urgent curriculum reform is imperative as a means of making community psychology theory and practice applicable in a more meaningful way. Furthermore, the vast majority of the psychologists surveyed in the study were not proficient in indigenous languages, and over 90% of them were white and spoke English or Afrikaans as their first language (Pillay & Kramers, 2003) (as cited in

Pillay & Harvey, 2006). Considering the demographics of the country the majority of the psychologists are not linguistically equipped to assist the majority of the population as English and Afrikaans are the home languages of only 21.5% of the population (Statistics South Africa, 2004) (as cited in Pillay & Harvey, 2006).

In terms of equipment, two-thirds of the psychologists had not been supplied with basic psychological tests nor had they any play therapy equipment. This is an area for particular concern, considering that 20.8% of the South African population is under the age of 10 years (Statistics South Africa, 2004) (as cited in Pillay & Harvey, 2006), and the prevalence of childhood mental disorders is approximately 15% (Pillay & Lockhat, 2001) (as cited in Pillay & Harvey, 2006). Furthermore, only one in ten respondents in this study had their own computers and more than a third had no lockable filing storage space to ensure confidentiality of patient's particulars. The latter, Pillay and Harvey (2006) believe, could constitute a contravention of the Health Professional Council of South Africa (HPCSA) ethical regulations.

Although Pillay and Harvey's study raises real concerns regarding the difficulties experienced by community service clinical psychologists it has been argued that community service for clinical psychologists was a means of offering the discipline a reprieve for its shady past (Pillay & Harvey, 2006): in particular, its deafening silence during apartheid and, by implication, its condoning of the status quo; its individualistic nature, ignoring the socio-political aspects impacting on well-being; the inappropriate transposition of Western worldviews to the South African context; as well as the division of psychology along racial lines, culminating in the majority of psychologists being mostly white, urban-based and middle-class, likewise catering for the psychological needs of middle-class whites—so hampering the discipline's ability to meet the mental health needs of the majority of the population (Rock & Hamber, 1994).

### **1.1 Motivation for and Aims of the Study**

It is against this backdrop that the motivation for this paper emanated. In 2006 the University of Stellenbosch received a request from three community psychologists

employed by the Department of Health in the Boland/Overberg region to investigate their current mode of delivery of psychological services. Of the three psychologists, one was employed as the senior community psychologist for the region while the other two were in their community service year. In essence, the reason articulated underlying the request for the investigation was: “It’s not working for us”, which alluded to the delivery of psychological services within the PHC framework.

Subsequently, the author and two other students (who were psychology honour’s students at the time) arranged a 'focus-group interview' with the three community psychologists, primarily for exploratory purposes. The focus-group interview conducted was an hour and forty-five minutes in length and generated a considerable amount of data pertaining to the difficulties that the community psychologist’s were experiencing in their daily activities. It must be noted at this juncture that throughout the interview the author was struck by the pervasive sense of despondency and helplessness experienced by the community psychologists in the face of insurmountable obstacles encountered in their day-to-day functioning and lived experiences.

The interview was recorded and subsequently transcribed. On initial analysis of the raw data it was believed that while there was data which elucidated, quite poignantly, the difficulties the community psychologists were experiencing at a practical level, the overall quality of the data was not believed to be sufficient to lend itself to further investigation. It was however also felt that this initial focus-group interview fulfilled a cathartic function for the psychologists concerned, which in itself was believed to be instrumental in affecting the quality of the data. Unfortunately, plans to conduct a future qualitative pilot study with the community psychologists were thwarted by the time constraints of the academic honours programme, and further aggravated by the delay in receiving permission from the Department of Health to conduct the research. As a result, the opportunity did not present itself to engage in an iterative process with the participants. Furthermore, by 2007 two of the three community psychologists had left the country to take up posts overseas.

The raw data generated from the initial focus-group interview was however instrumental in terms of alerting the author to possible tensions between theory,

policy and practice that could be playing out at a practical level. More specifically, there is a possible dissonance between what has been promulgated at the macro level, such as the integration of psychological services within PHC, and at grassroots level, where the community psychologists are located, namely in the PHC context. As a consequence, the author believed that further investigation was warranted, and in this regard it was decided to conduct a literature review specifically focusing on the integration of psychological services within the PHC context.

The aims of the literature review will therefore be to map this process at a theoretical level. As there appears to be a scarcity of research both internationally and nationally on the integration of psychological services within PHC it is also hoped that the content of this paper will contribute to the meagre existing body of knowledge on the subject matter, as well as pointing the way forward for future research, depending on the conclusions reached. While this is not a qualitative study, the raw data from the initial focus-group interview will be used strategically at certain points purely for illustrative purposes. As such, the raw data will be juxtaposed against the theoretical review to both elucidate and/or refute the major findings pertaining to the topic.

To commence the author will look at the discipline of psychology in South Africa, focusing on the long-debated issue of relevance, and then the proposed resolution by theoreticians and academics, namely community psychology. Thereafter the resolution implemented, namely the integration of psychological services within the PHC system, will be examined, followed by a determination of the impact of such transformation on both the current identities and training of psychologists in South Africa.

## **1.2 Methodology**

Literature relevant to the topic under review was sourced from national and international databases, focusing on databases that are well known and respected for their peer-reviewed journal articles. International databases sourced were Academic Search Premier, Blackwell Synergy, Journal Storage (JSTOR), PsychINFO, Proquest Social Science Journals, Science Direct, Springerlink and Pubmed. Local databases sourced included Sabinet, SA ePublications and South African Studies. Reference

books from the University of Stellenbosch were also consulted as well as books and sources from the author's own collection. Non-academic websites were searched for additional sources of information. The search was not limited to the field of psychology, but included other domains such as philosophy, medicine, nursing and sociology.

## **2. Mainstream Psychology and the Issue of Relevance**

Since the 1980s, and more acutely with the transition to a new government in South Africa in 1994, psychology as a discipline has become the object of intense scrutiny, with its credentials being referred to as questionable (Macleod, 2004). A crisis became evident in the discipline of psychology, in particular, and its relevance within the South African context was questioned. Macleod (2004) alludes to the "relevance debate" in which the relevance of psychological assumptions and application in the context of apartheid South Africa was challenged, specifically its neglect of the symbiotic relationship between the individual and the socio-political context in which they are located.

A recent report by the United Nations Development Programme (South Africa Human Development Report 2003) (as cited in Macleod, 2004) has highlighted the pathogenic societal conditions, which are viewed as challenges to sustainable development in South Africa. These challenges include abject poverty, accessibility in relation to basic services such as water and electricity, sanitation and health, as well as extreme disparities in income and wealth. In addition, unemployment, land restitution, insufficient housing, environmental degradation, inadequate education, black economic empowerment, the prevalence of HIV/AIDS, training as well as extension support, were also identified as key challenges to sustainable development and consequently could be used as a barometer of central social issues within the South African context. As a result of these findings, the report recommends public sector transformation, a shift in decision-making from the experts to the hands of communities and a people-centred collaborative approach under the umbrella of an ecological framework.

Macleod (2004) alludes to psychology currently being in no position to address these challenges to the country and that while the report indicates that poverty is the main challenge, psychology continues to be a discipline targeted primarily at the country's middle-classes. Considering the findings of the report, she maintains that the content of psychology research output exists almost in a vacuum, with issues such as race and gender as well as poverty in short supply, and while the report advocates resolutions that fall within the ambit of community psychology, she found that even knowledge production in community psychology was also marginal in comparison to the output of the discipline as a whole.

According to Ahmed and Pillay (2004), poverty in South Africa is the most significant social problem. A study by Bradshaw and Steyn (2002) (as cited in Ahmed & Pillay, 2004) indicates that 40% of the South African population live in poverty. While poverty impacts on all aspects of the individual's mental health it is also correlated with violence. In this regard Unnithan and Whitt (1992) (as cited in Ahmed & Pillay, 2004) found that homicide rates decrease when the gross domestic product (GDP) increases. Ahmed and Pillay (2004) maintain that poverty is also linked to the HIV/AIDS pandemic in South Africa, where 26.4% of adults are HIV positive, and, when taking into account the number of the economically active affected population as well as discrimination experienced by this population, the impact on affected families is tremendous. Furthermore, it is envisaged that within a few years there will be over a million AIDS orphans in the country (Actuarial Society of South Africa, 2004) (as cited in Ahmed & Pillay, 2004). Of particular importance is that the prevalence of HIV/AIDS has a more detrimental effect in poor communities (Ahmed & Pillay, 2004). Similar to Macleod (2004), Ahmed and Pillay (2004) argue that psychology has paid very little attention to the issue of poverty, most evidenced by its minimal representation within the South African literature. Likewise, Petersen (2000) alludes to the material basis of problems encountered at a primary care level with patient's concerns regarding such matters that fall outside the traditional concerns of psychology.

Among other criticisms levelled at the discipline of psychology were its adherence to a noncritical, conservative ideology, consequently perpetuating the *status quo* of apartheid (Dawes, 1986) (as cited in Macleod, 2004). In this regard some authors

have alluded to the ideological complicity of psychology with the racist discourses and conditions that were characteristic of the apartheid government (Duncan, Stevens & Bowman, 2004). Not only was South African psychology chastised for its failure to address the psychological impact of apartheid by acts of omission but it was also implicated in human rights violations in the service of the apartheid state (Magwaza, 2001) (as cited in Duncan, Stevens & Bowman, 2004). Psychology's buy-in with the prevailing ideologies of that period has until today still thwarted its ability to free itself from its past collusion with racism and its respective manifestations (Duncan, Stevens & Bowman, 2004).

It is argued that racism still forms part of the landscape of South African psychology. In this respect Duncan, Stevens and Bowman (2004) allude to continued forms of marginalisation replicating racism under a new dispensation. In particular, the skewed racial distribution of knowledge production in the form of black authorship has come under the spotlight, although this has increased significantly since 1994. However, this under-representation has been attributed to various factors, but primarily to the minority representation of blacks in academia (Duncan, Seedat & Bowman, 2004). When black academics do find themselves at historically privileged white universities they often find themselves in the position of being perceived as affirmative action appointees, and hence unworthy, further marginalising them in terms of publication opportunities (Duncan, Seedat & Bowman, 2004). Furthermore, with the availability of more funding for research the onus is on black academics compromised by historical disparities in educational opportunities to be able to perform on the same playing field as white academics, while no attempts are made to either redress and/or acknowledge these historical disadvantages (Duncan, Seedat & Bowman, 2004). This has been referred to in some quarters as "symbolic racism", specifically a neglect of attempts to acknowledge the affects of the legacy of apartheid (Duncan, Seedat & Bowman, 2004).

Duncan, Seedat and Bowman (2004) maintain that racism in South African psychology continues to be perpetuated by the training of psychologists particularly with regards to the continued use of European and American ideologies that do not adequately address the psychosocial demands of the majority of the population. While some institutions have implemented more contextually appropriate models for

training, this has had varying degrees of success (Duncan, Seedat & Bowman, 2004). In a similar vein attempts at addressing the shortage of mental health professionals by the introduction of a four-year exit counselling degree, while initial implementation appears laudable, the reality is that it may in effect perpetuate racialised professional divisions (Duncan, Seedat & Bowman, 2004). Concomitant with this new professional category, there was an extension in the professional training of psychologists by an extra year at a doctoral level. Duncan, Seedat and Bowman (2004) raise the issue that such an extension in training excludes many black candidates due to the unaffordability of training. This culminates in a racialised division between professionals who are predominantly white and fourth-year graduates who are mostly black

On a theoretical level, other authors (Ahmed & Pillay, 2004; Rock & Hamber, 1994; Seedat, MacKenzie & Stevens, 2004) have questioned South African psychology's "alien" and non-African nature, as well as its uncritical relationship with Euro-American philosophical traditions. Much and Harre (1994) (as cited in Mkhize, 2004) maintain that a culture's psychological discourse mirrors the dominant local metaphysical ontologies, and from which emanates theories of the person, the social context and the natural order. In this sense traditional Western approaches to psychology are based on certain philosophical assumptions about the person and the world while claiming to be free of roots independent from specific philosophical and value frameworks. According to Mkhize (2004) it is illogical to explain the psychological needs and experiences of people in developing countries in terms of conceptual categories and philosophical systems adopted from the West.

Mkhize (2004) believes that modern psychology is primarily a Western product and it attempts to emulate the natural sciences advocated as being objective and value-free, with its findings purported to have universal application. As a consequence, based on Western conceptual categories, psychologists have tried to understand individuals from developing societies. Attempts have also been made to replicate Western studies in developing societies based upon these frameworks (Mkhize, 2004).

Mkhize (2004) further alludes to the fact that traditional Western psychology is premised on an independent view of the self and that a transfer of knowledge, values

and worldviews from developed to developing societies is akin to cultural colonisation. Consequently, it is argued, the danger of importing Western systems of understanding is that research and theorising are irrelevant to the needs of local populations in developing countries, such as eliminating poverty and illiteracy.

Traditional psychology has focused on the individual as the unit of analysis, with psychopathology situated within the individual, coupled with psychological individual strategies for change, such as psychotherapy (Nelson & Prilleltensky, 2005). This Western view places the individual at the fore. However, in comparison with conceptions of self in indigenous societies the self is more context-based in the sense that the self is defined in terms of the person's relationship with others, namely one's community and family (Mkhize, 2004). From a cultural psychology perspective participation in the symbolic system of a culture culminates in the social construction of meanings, worldviews and values, and as a result psychology cannot claim to be value-free (Mkhize, 2004). Rather, it must be realised that a complete understanding of individuals in developing societies should begin with a critical awareness of their assumptions and their foundations for meaning-making (Mkhize, 2004).

Some scholars have carried the argument further by maintaining that, due to the Eurocentric nature of psychology, Africans need their own unique psychology, namely a psychology that takes cognisance of African cosmology and worldview (De la Rey & Ipser, 2004). According to Mkhize (2004) such a move does not imply that a unique African framework would be a panacea, but its purpose should rather be to elucidate how psychology should be attempting to engage in dialogue around the theoretical frameworks that are informing the lived experiences of the people concerned.

Other authors have alluded to clinical and counselling psychology in South Africa as a-historical and contextually disconnected from the "spirit of Africa" (Seedat, MacKenzie & Stevens, 2004). In the international arena, the question of relevance has also been raised, in particular a concern with the degree to which the Eurocentric tradition of psychology as a positivistic endeavour could be regarded as universal and hence relevant in the lives of people in disparate social contexts (De la Rey & Ipser, 2004). However, within the South African context, the crisis of relevance has taken

on a unique dimension because of the socio-economic inequities entrenched by the policies of the apartheid regime, psychology was perceived to be the exclusive reserve of middle-class white men (De la Rey & Ipser, 2004). Consequently there was a crisis regarding the appropriateness and applicability of psychological theorising and practice as related to the socio-political context in South Africa (De la Rey & Ipser, 2004).

Concern has also been expressed about the individualist nature of the psychology paradigm and its humanistic theories that locate problems within the individual, while neglecting the degree to which the social context impacts upon the manifestation of mental health problems (Rock & Hamber, 1994). As a consequence, psychopathology is synonymous with disease and individual weaknesses rather than with inherent pathogenic factors found within the socio-political system. Whittaker (1993) (as cited in Rock & Hamber, 1994) maintains that this framework is unsuited to the comprehension of what it means to be human in the world.

Similarly, Nelson and Prilleltensky (2005) maintain that when problems are framed in terms of individualistic conceptions of human nature a new dimension takes effect, particularly that of blaming the victim, which is common in social sciences. This point of departure posits that individuals are solely responsible for the causes of and the solutions to their own problems (Nelson & Prilleltensky, 2005).

In the South African context the individualistic nature of the traditional psychology paradigm, with its location of psychopathology within the individual, and its failure to link the social context with problems in mental health, is inherently problematic. Accordingly, Rock and Hamber (1994) argue that this stems from an inappropriate transposition of American and Eurocentric ontologies into a diverse and unique South African context. In this regard they maintain that it is an ahistorical and acontextual psychology that fails to posit a social link, and which adds weight to the debate around the relevance of psychology.

On a practical level, the disciplines of clinical and counselling psychology have been criticised for their inaccessibility, elitist orientation, their area of focus—namely

pathology—as well as their primary means of intervention—primarily individual one-on-one psychotherapy (Seedat, Mackenzie & Stevens, 2004). Much has been written on the shortfall of psychological services and on the racial disparities evident within existing services (Rock & Hamber, 1994). Rock and Hamber (1994) maintain that, historically, health services have been fragmented as well as poorly planned and duplicated, which has been exacerbated by a lack of intersectoral collaboration. In addition, currently psychological services are predominantly curative and urban based, with scant attention paid to psycho-education training and prevention.

Access to psychological services by the majority of the population is severely curtailed by unaffordability: the vast majority of black patients are not even subscribers to medical aid schemes, coupled with the fact that most psychologists work in private practice on a fee-for-service basis (Rock & Hamber, 1994). This in effect excludes 80% of the population from accessibility to such services (Pillay & Petersen, 1996). In 2002, according to Statistics South Africa (as cited in Ahmed & Pillay, 2004) the majority of the South African population was black, comprising 90% in total, and only 16.2% of the population of over 40 million had health insurance. Of the 90% black population, the IsiZulu and IsiXhosa speakers compositely comprised 40.8%. When this is considered in the light of the study of Pillay and Petersen (1996), who found that 92.4% of clinical and counselling psychologists in South Africa were white and 91.2% of them spoke Afrikaans or English, the distribution of and access to mental health care in South Africa for the majority of the population is, to say the least, skewly distributed. Considering that the majority of clients accessing psychological services in this study were urban and white (75%), and that 46.3% of the country's population live in rural areas (Statistics South Africa, 2002) (as cited in Ahmed & Pillay, 2004), it is argued that the human rights implications of the disparities in service provision is disturbing (Ahmed & Pillay, 2004). With regards to state funds available to develop mental health services, Rock and Hamber (1994) maintain that these funds are rarely allocated to psychological services.

In response to the crisis in psychology, calls were made for a more socially relevant psychology (Ahmed & Pretorius-Heuchert, 2001; Pillay, 2003; Rock & Hamber, 1994)—specifically a psychology that involves a shift of focus from individual

sessions in a consulting room, to a focus on the community as a whole. A theoretical resolution, namely that of community psychology, was proposed by progressive psychologists who attempted to transform and reconstruct clinical counselling and social psychology (Seedat, Mackenzie & Stevens, 2004). In this regard Pretorius-Heuchert and Ahmed (2001) maintain that it is the discipline of community psychology that will be the answer to South Africa's social ills, because it "aims at mass intervention, trains and uses large numbers of people for interventions, and purports to prevent psychological problems before they arise" (2001:28). They further support the adoption of community psychology for the South African context, and tabulate the historical context and motivations for the need for the development of community psychology:

Too many people with psychological problems and a limited number of people who could help: financial and physical resources are inadequate to provide help: traditional mental health services provide inefficient, ineffective and inappropriate services: traditional mental services function on a waiting basis, rather than a seeking and preventing basis: societal factors, such as apartheid, poverty and oppression caused psychological problems and stressors: there is a need for intervention in the larger system: prevention rather than remediation is becoming a priority and the struggle against apartheid and oppression demands psychologists to apply their knowledge and skills towards liberation (2001:23–24).

## **2.1 The Resolution: Community Psychology**

Community psychology as a discipline owes its roots to both the U.S. Civil Rights movement and the Swampscott Conference held in Massachusetts in 1965. The Swampscott Conference was to be instrumental in shaping community psychology and providing the community psychologist with a mandate extending beyond the individual to systems in which the individual was simultaneously nestled, such as the family, organisation, institution, community and nation (Ngonyama ka Sigogo, Hooper, Long, Brinton Lykes, Wilson & Zietkiewicz, 2004).

In the 1980s community psychology in South Africa took on a more radical form. Community psychology was seen as a medium for an obliteration of apartheid structures as well as a means of bridging the gap between the traditional psychologist in a consulting room and the disenfranchised masses (Ngonyama ka Sigogo et al.,

2004). Its local proponents drew on liberatory discourse informed by liberation struggles in North Africa and Latin America as well as on Freire's theory of conscientisation (Ngonyama ka Sigogo et al., 2004). These points of departure encouraged a transformation of society, including addressing inequities in the distribution of resources and the liberation of the oppressed from the injustices of colonialism (Ngonyama ka Sigogo et al., 2004). The community psychologist was believed to be a voice for the voiceless despite the fact that the majority were mostly white, which did not mirror the demographics of the population (Ngonyama ka Sigogo et al., 2004).

With the theoretical resolution to the relevance debate implemented, the requisite roles of psychologists were expanded and the dominant community psychology models as a vehicle that radicalised conceptualisations of mental health were embraced. In this regard the community psychology models such as the mental health model, the organisational model, the ecological model and the social action model were accorded more utility in the search for a more relevant praxis (Ngonyama ka Sigogo et al., 2004).

According to Ahmed and Pretorius-Heuchert (2001) the Mental Health Model endeavours to treat and prevent mental illness within a specific catchment area while the psychologist's role is that of an expert in an advisory capacity. The main point of departure of this approach is that earlier and larger-scale intervention is more financially feasible in efforts to reduce the incidence of mental health problems (Ahmed & Pretorius-Heuchert, 2001). This model utilises various levels for intervention, such as primary, secondary and tertiary prevention. Primary prevention targets the reduction of the incidence of the number of new cases presenting while secondary prevention aims to reduce the intensity and degree of symptoms. Tertiary prevention alleviates the impact of a disorder on the individual's life circumstances while putting mechanisms in place to prevent a relapse to the acute phase of the disorder (Ahmed & Pretorius-Heuchert, 2001). This model has been criticised for reducing the complexity of human behaviour to pathology, and viewing the individual in isolation from the pathogenic qualities of their respective environments.

The Organisational and Ecological Models draw on systems and group process theory, with the community seen as the “unit of analysis” (Ngonyama ka Sigogo et al., 2004). The Organisational Model focuses on group processes and change as the points for intervention. Based on management models, criticisms have been levelled at individuals utilising this model for their tendency to “manage” people and the process (Ngonyama ka Sigogo et al., 2004). These management models underlying organisational theory imply that the community is not capable of managing its own affairs, which can culminate in resistance by the community and limiting the role that the community can play as a collaborative partner (Ngonyama ka Sigogo et al., 2004). The Ecological Model places the accent on macro-level variables and systems analyses, and seeks to move away from victim blaming, towards ecological explanations for psychosocial problems (Seedat, Mackenzie & Stevens, 2004). The environment is portrayed as a variety of niches in which the individual is simultaneously embedded from the interpersonal domain through the wider society (Ngonyama ka Sigogo et al., 2004). Ngonyama ka Sigogo et al. (2004) maintain that it is often both difficult and impractical to be able to intervene at multiple levels simultaneously given the complexity and dynamic nature of social problems and contexts.

According to Ngonyama ka Sigogo et al. (2004) the three models outlined above are more ameliorative practices than transformative. As a consequence, some community psychologists sought an alternative model such as the Social Action Model. This model challenges mainstream psychological thought in that the individual is entirely responsible for his or her own fate. The dominant psychological discourse would imply that circumstances such as poverty can be attributed to personal failings rather than to structural inequities inherent in the social order (Ahmed & Pretorius-Heuchert, 2001). Therefore, the Social Action Model challenges the individual’s complicity in their social circumstances, maintaining that structural inequality culminates in a broad range of psychological and social problems (Ahmed & Pretorius-Heuchert, 2001). This approach questions existing systems and strives to establish alternatives to the existing socio-economic systems that continue to marginalise certain groups (Ngonyama ka Sigogo et al., 2004). At the heart of this model is the empowerment metaphor, which serves to fuel the transformation of social conditions via individual and social action (Ahmed & Pretorius-Heuchert, 2001). This approach not only served

to inform the struggle against apartheid in South Africa but also currently informs existing challenges in South African community psychology today (Ngonyama ka Sigogo et al., 2004). Commensurate with the transformation of the national health system post-1994, the current location for the majority of community service clinical psychologists is within the PHC setting.

## **2.2 The Resolution Implemented and Problems with Implementation**

### **2.2.1 A Global Perspective**

The original Alma Ata Declaration (WHO & UNICEF, 1978) (as cited in Schaay & Sanders, 2008), upon which comprehensive PHC in South Africa is based, defines PHC 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 full participation and at a cost that the community and country can afford to maintain...It forms an integral part of the country's health system of which it is the central function and main focus, and of the social and economic development of the community. It is the first level of contact of individuals, the family and community...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. 4).

The PHC approach as defined above is also referred to as second generation reforms, shifting the focus from first generation health systems that were predominantly hospital based and inaccessible to the rural poor. (Mkhize & Kometsi, 2008) The PHC health system makes allowance for the provision of basic health services at the level of care where people are located, namely in communities where people live (Mkhize & Kometsi, 2008). By its nature the PHC approach implies community participation in health promotion and empowerment. As social and material conditions are considered essential components that impact on health and overall well-being on initial implementation worldwide a matter of priority was the provision of safe water, sufficient nutrition and food supply (Mkhize & Kometsi, 2008).

While the principles of PHC as elaborated on by the Alma Ata include comprehensive care, intersectoral collaboration and action, active community participation and

empowerment, appropriate care and use of technology and equity, the emphasis of this approach is a strategy for organising health care systems and society with the aim of promoting health (Schaay & Sanders, 2008). Comprehensive PHC and its concomitant shift of focus from the individual attempts to target the “upstream” social determinants of health using the family and the community as the criteria to assess risk, to plan interventions, and to prioritise (Schaay & Sanders, 2008).

It is worth noting that although the promotion of mental health is indicated as an essential element of PHC, it had no mention in the body of the Alma Ata declaration. This, according to Sartorius (2008), gave those responsible for mental health programmes a discrete disadvantage in terms of procuring funding. It was the government of Panama that objected to the exclusion of mental health in the declaration. As adjusting the text of the declaration would have entailed another session of the Alma Ata conference it was decided to include mental health in the report of the conference and to leave the declaration intact (Sartorius, 2008).

Sartorius (2008) maintains that while in the Alma Ata report it was possible to include “positive” mental health, both the promotion and treatment of mental health was not recognised as a valuable cause because mental disorders were not deemed to be a major public health concern. This is despite the fact that a mental disorder does satisfy the criteria for a major public health problem. In this regard Sartorius (2008) defines a major public health problem thus:

The criteria for the designation of a disease as a major public health problem are high prevalence, severe consequences if left untreated and the tendency to remain stable if left untreated and the tendency to remain stable or grow in the future unless prevented or reduced by health care interventions (p. 75).

According to Sartorius (2008) the concept of the promotion of mental health as outlined in the Alma Ata report is vague and subject to diverse interpretations. In this regard, at its most basic it could be construed as the reduction of the incidence of mental illness within a community. He elaborates when he maintains that a more comprehensive and appropriate interpretation would be both the treatment and prevention of mental illness coupled with the fortification of the resilient capacities of

individuals and communities. He believes that this is more in line with the attainment of “positive” mental health, as outlined in by the Alma Ata conference.

While most countries incorporated mental health as an integral part of their PHC implementation, many did not (Sartorius, 2008). It was primarily Thailand that was instrumental in defining more broadly than other countries an interpretation of mental health as an integral component of PHC (Sartorius, 2008). Concomitant was a concerted effort to pay close attention to the psychosocial aspects of health care, which, in Thailand’s case, became an exception to the rule (Sartorius, 2008). This was in sharp contrast to other nations who by paying attention to a discrete number of mental disorders, encapsulated for them the concept of primary mental health care (Sartorius, 2008).

Over time, the priority of mental health in developing countries has remained relatively low (Sartorius, 2008). This has also been documented by other authors in Africa. Kigozi (2003), in his review of the provision of mental health services and development of psychiatry in Africa over the past two decades, maintains that while most countries in Africa have embraced the integration of mental health into general health this is not mirrored by the situation on the ground. According to him mental health services continue to be a low priority and resource allocation is minimal. He cites the following reasons, which he argues are the main constraints to the development of mental health services in sub-Saharan Africa: a decentralisation policy that remains highly specialised; lack of awareness and studies available in respect of the incidence of the problem; insufficient human and financial resources; the “brain drain” of trained professionals to greener pastures, predominantly in Europe; the absence of and/or dated mental health policies; and widespread violence and civil unrest in the region (Kigozi, 2003). He further states that the arrival of HIV/AIDS has created havoc, adding to the vicious cycle of poverty and disease (Kigozi, 2003).

Likewise, in South Africa, as early as 1993 Hayes (as cited in Rock & Hamber, 1994) predicted that psychological services were not going to be a priority of the new democratic government, not because they were not concerned with mental health issues but because the other social pressures on them would be huge. Seedat, Kruger

and Bode (2003) maintain that despite the preponderance of mental illness in low to middle income countries, there are few countries that exhibit the will to make mental health services an integral component of PHC. The reasons put forward for this state of affairs are:

Ignorance about psychology's function within medical health care, psychology's poor status in low income countries, the dichotomisation of biomedical and psycho-social intervention modalities, and the inordinate influence of the medical hegemony...are among the factors that account for the absence and/or peripheralisation of mental health services, including clinical psychology in PHC (p. 44).

Ignorance in respect of both psychology's function and role within a biomedical framework has also been previously alluded to by Pillay and Harvey (2006).

*"...The lack of knowledge was not from everyone, it wasn't just the management it was also at the clinics. We arrived there (at the clinics) with the idea of when we did our internship we would also work in a clinic where there was a dedicated psychiatric nurse who screened all patients. So everything would be still very much contained. When we get there (to the clinics) there's no one that takes responsibility for psychiatry, no one knows anything or people claim they don't know anything about psychiatry, they don't know what a psychologist does"*

(Source: Focus group interview 06.10.2006).

*"...The kind of practice that we do isn't very well understood...the fifty minute sessions are a new concept to them.... We need a room that stays closed. We need an environment which is friendly and helpful towards people and which is welcoming and respects privacy. And a lot of that goes against the grain of what the clinic is about"*

(Source: Focus group interview 06.10.2006).

While in many countries the incorporation of mental health was originally restricted to its respective provision in historically colonial-built mental institutions, as a consequence it proved difficult to implement changes in terms of service delivery (Sartorius, 2008). Unfortunately the implementation of mental health care within

PHC was sporadic and primarily restricted to the domains of medical schools and their respective catchment areas for training (Sartorius, 2008).

Over time, the focus of mental health in PHC was placed on the recognition and treatment of mental illnesses specifically at the primary level of contact. This culminated in common mental disorders being identified such as anxiety and depression, and general practitioners targeted these disorders for treatment (Sartorius, 2008). This was followed by the training of other PHC personnel such as nursing staff in their recognition and treatment of such common disorders under the auspices of a mental health specialist. However, the idea of training all health care personnel was soon replaced with training personnel who explicitly expressed an interest. Similarly, the content of the training became restricted with emphasis placed primarily on disorders requiring referral and on the recognition of mental disorders presenting at PHC level with a high frequency, namely anxiety and depression. According to Sartorius (2008), while these attempts of a restricted focus of treatment appear laudable, in essence they are harmful. Rather, the mental health effort at a PHC level should also include attempts to deal with the psychosocial components of health, as well as both the prevention and promotion of mental health. In this manner mental health as an integral part of PHC can contribute more significantly to health care than constraining itself within a narrow vision as outlined above. This restricted focus for intervention neglects the promotion of mental health.

*“...And when you want to deviate and do other things for instance maybe do workshops and running of support groups, they (management) are supportive but they want you to keep in mind that you must always do individual therapy almost all of the time”*

(Source: Focus group interview 06.10.2006).

Another factor that has been instrumental in affording mental health a back seat within PHC is Selective Primary Health Care (SPHC)—also referred to as third generation reforms. No sooner was the Alma Ata declaration endorsed with its slogan of “Health for all by 2000” than criticisms were levelled at it for being too broad and idealistic (Cueto, 2004). It was at a conference sponsored by the

Rockefeller Foundation in 1979 in Bellagio that the concept of (SPHC) was introduced (Cueto, 2004). The foundation for this conference (Health and Population in Development) was based on a paper co-authored by Walsh and Warren, entitled “Selective Primary Health Care, an Interim Strategy for Disease Control in Developing Countries” (Cueto, 2004). As the title suggests, it was an “interim” strategy in the light of the perceived unrealistic goals of the Alma Ata declaration and advocated both strategic goals and cost-effective planning via what basic health services could be implemented (Cueto, 2004). Overall, the purpose of SPHC comprised an array of low-cost technical interventions to eradicate the primary disease problems of developing countries (Cueto, 2004). These interventions were referred to as GOBI, entailing growth monitoring, oral rehydration techniques, breast-feeding and immunisation (Cueto, 2004).

Very soon, international agencies, donors and scholars were quick to jump on the bandwagon as both funding and resultant proof of efficacy of these programmes could be rapidly produced (Cueto, 2004).

This approach to PHC was seen by some as contrary to the vision of comprehensive PHC as adopted by the Alma Ata declaration and in particular oral rehydration was seen as a band-aid measure as it failed to address the underlying socio-economic conditions that perpetuated its usage. SPHC was accused of diverting the focus away from the social causes of disease, as well as from basic health and socioeconomic development (Cueto, 2004). This approach was criticised further for being vertical in nature (Cueto, 2004).

Critics, particularly from Latin American countries, postulated that “primary” was akin to “primitive” health care and a mechanism for social control of the poorest of the poor, and an insult. However, with recession and economic debt characteristic of developing countries in the 1980s, the SPHC approach gathered momentum. By 1997 supporters of the original holistic PHC approach believed that PHC remained very much an ideal (Cueto, 2004). Although initially the SPHC approach was purely an interim measure bridging the transition to comprehensive PHC, it culminated in an approach that became institutionalised as a unique approach to service delivery (Schaay & Sanders, 2008). In conclusion, Cueto (2004) believes that a holistic

approach to the implementation of PHC must be adhered to, namely one that simultaneously embraces idealism, technical expertise and finance.

Similarly, in South Africa, the add-on of psychiatric care into PHC is commensurate with third-generation reforms, with the emphasis on both cost-effectiveness and tangible measurable outcomes (Mkhize & Kometsi, 2008). This is coupled with a focus on serious mental disorders to the exclusion of common mental disorders, which do not lend themselves so easily to tangible indicators for measurement and consensus (Mkhize & Kometsi, 2008). Other authors (Petersen, 2000; Sartorius 2008) believe that this approach is harmful as mental health does not just imply the absence of a psychiatric disorder but also entails other realms of the individual's existence, such as the cultural, spiritual, physical and social. In this manner a comprehensive and universal provision of health care in line with the Alma Ata vision is provided—one that takes cognisance of the social imperatives impacting on general well-being. Mkhize and Kometsi (2008) take the argument further when they maintain that SPHC is in effect a return to the medical model and contrary to the vision of integrated services within PHC as well as in opposition to the Alma Ata declaration. As a result, development in terms of a broader sense is ignored.

*“But the province has a list of crucial things that...each department...needs to focus on, and mental health is nowhere to be found. Also our department has its own operational plan and psychology per se has no mention in that whole plan, and it's a thirty–forty page document”*

(Source: Focus group interview 06.10.2006).

*“And if your programme is not part of the eight priorities of health, basically there is not a lot of money spent on your programme. So you just have to go and do your thing, because its not a priority now”*

(Source: Focus group interview 06.10.2006).

Newell (1988) (as cited in Mkhize & Kometsi, 2008) captures the implications of Selective Primary Health Care when he states:

Selective Primary Health Care is a threat and must be considered as a counter-revolution. It is a form of health feudalism that is destructive rather than an alternative. Attractive to professionals, financing agencies and governments that are seeking results in the short term, but it is a pure illusion (p. 106).

In conclusion, Mkhize and Kometsi (2008) argue that PHC personnel should be trained in the identification of common mental health problems proven to be presenting at a community level, such as school-related problems, post-traumatic stress disorder (PTSD), mental retardation and depression.

## **2.2.2 “Health”, “Mental Health” and “Mental Health Promotion”**

### **2.2.2.1 Health**

It is only recently that the WHO has begun to pay attention to the critical role of mental health in overall health, as well as providing clarity on often vaguely perceived definitions and concepts of its original declaration. As early as 1948 the WHO (WHO, 1948) defined health as:

“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (p. 100).

This definition has remained remarkably unamended since 1948 despite numerous objections (Jadad & O’Grady, 2008). Some authors have taken issue with the idealised concept of complete well-being because it appears to be synonymous with health. This creates problems in that health is identified with a state of subjective well-being (McDonald, 2005). Furthermore, the condition of completeness as related to all the components of well-being appears to be the definition's most inherent flaw (McDonald, 2005). In this respect it is vague as to how one can achieve completeness in each of the domains of the physical, the mental and the social. It does not point to how one can measure completeness either as a measure of individual potential or as an intersubjective measure (McDonald, 2005). As an example, McDonald (2005) alludes to using only elite athletes as a hypothetical example of individuals with complete physical well-being. To elucidate, she maintains that if we use an intersubjective measure using “physical” well-being as an example then, in terms of

using this standard, most people are doomed to failure. Likewise, if we use the maximum unique fitness potential of each individual as a criterion to measure complete physical well-being then determining the upper limits of each individual's capacity becomes another problem. Accordingly, if an individual can improve his or her physical well-being then, in terms of the WHO definition, they do not have complete well-being and therefore are not entirely healthy (McDonald, 2005). This lends credence to the belief that the concepts of complete and well-being have not been operationalised, adding further to the confusion.

Similarly, issues abound pertaining to the application of well-being criteria across all the components of health. In this regard producing well-being in one component does not guarantee simultaneous well-being in the other. McDonald (2005) uses the example that while one can be rich and affluent, which is usually correlated with physical well-being, it is still possible to be affluent and/or mentally and physically unwell. As a consequence the WHO definition of health becomes problematic by maximising several variables simultaneously (McDonald, 2005).

While the definition of health does acknowledge social determinants of health, the inclusion of social and mental well-being under the umbrella of health impedes endeavours to establish a specific hierarchy of health needs, and, simultaneously, it broadens the magnitude of possible health needs to the realm of unsustainability (McDonald, 2005). McDonald (2005) argues that it is unclear as to how the WHO wishes us to interpret the concept of mental well-being, which can be construed in three ways. While it can be taken for granted that it does entail the absence of severe disturbances of cognitive functioning, it may also refer to aspects related to neurology, psychology and even the subjective state of happiness (McDonald, 2005). McDonald (2005) argues that if mental well-being refers to those aspects usually dealt with by neurology it will be extremely limited considering the discipline is far from understanding the full complexities and workings of the human brain. Furthermore, psychological theorising on what constitutes mental health ultimately collapses into theories incorporating subjective aspects of well-being, which complicates matters more (McDonald, 2005).

Finally, mental well-being could be construed as subjective well-being, taking us into the realm of “happiness”, which some authors believe to be bordering on the absurd (Mc Donald, 2005; Saracci, 1997). The definition of health was conceptualised in the aftermath of World War 11 when peace and health were perceived to be intertwinable (Saracci, 1997). Saracci (1997) concurs when he maintains that a state of complete physical, mental and social well-being is more akin to the condition of happiness than to that of health. Failing to distinguish the condition of health from happiness is inherently problematic in that individuals may be inclined to construe any emotional problem as a health problem, and the boundless nature of happiness will likewise impose unlimited demands on health services (Saracci, 1997). Furthermore, juxtapositioning health and happiness as a universal positive right could culminate in prescriptive views of happiness usually established only in totalitarian societies (Saracci, 1997). It would appear that the inclusion of all terrains of existence affecting well-being leaves the WHO definition of health ultimately unintelligible (McDonald, 2005). Other authors such as Jadad and O’Grady (2008) believe that all attempts to define health are futile, remarking that health, similar to beauty, is in the eye of the beholder, and that no definition can adequately capture its complexity.

#### **2.2.2.2 Mental Health and Mental Health Promotion**

The domains of mental and public health have had historically weak collaborations, which has been argued to be the result of the stigma attached to mental illness and the vagueness pertaining to the concepts of mental health and mental illness (Herrman, Saxena, Moodie & Walker, 2005). Despite the WHO's 1948 definition of health, alluding to the elements of physical, mental and social well-being, mental well-being has been historically forgotten and misunderstood (Carter, 2005). However, in light of the previous argument pertaining to the much-contested definition of health this is understandable. As a consequence, over the past few years the WHO has been concerned with addressing the factors that have impeded access to mental health care as well as re-assigning themselves to campaigning vehemently for the full integration of mental health care into public health worldwide (Carter, 2005).

Recently the WHO (2001a) proposed the following definition of mental health:

“a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (p. 1).

While defining mental health is, by its nature, inherently problematic, it is believed that this definition has the ability to be understood across cultures, without restriction of its interpretation (Hermann et al., 2005). This definition is construed in a positive sense, with mental health being seen as the foundation for overall well-being, and implies that mental health is more than the absence of a mental disorder (Hermann et al., 2005). However, Hermann et al. (2005) maintain that mental health is still perceived as a luxury, but the WHO is still more than ever committed to the prioritisation of the improvement of mental health specifically in low- and middle-income countries. The reasoning behind this renewed interest is that mental health is increasingly seen as a critical foundation to both physical health and quality of life, and integral to the improvement of overall well-being (Herrman et al., 2005). Furthermore, studies have shown that by 2020 depression will be the second largest cause of the burden of disease worldwide (Murray & Lopez, 1996) (as cited in Herrman et al., 2005). More significant is that the burden of mental health in developing and developed countries is well beyond the treatment capacities of those countries and by solely focusing on the treatment of mental disorders the associated social and economic costs will not be reduced (WHO, 2001b).

Studies have indicated that mental illness is more prevalent among individuals who are socially disadvantaged (Desjarlais et al., 1995) (as cited in Herrman et al., 2005). In this respect the risks of mental illness are correlated with poverty as well as low levels of education. This association appears to be universal (Hermann et al., 2005). Despite this, mental health is still seen to reside outside of the public health tradition and there has not been a keen endeavour to exploit opportunities for mental health promotion within communities (Herrman et al., 2005). Most governments have also neglected mental illness and mental health, and the WHO has shown the large disparity between the burden of mental illnesses in countries worldwide and the available resources to treat them (Hermann et al., 2005). Most countries, in attempts to reduce the social and economic costs of mental illness, focus primarily on the treatment of individuals with mental illness (Hermann et al., 2005).

According to Hermann et al. (2005) one of the main reasons behind this neglect is that the stigma of mental illness has caused those to use the term mental health as a euphemism for the treatment of people with mental illness. This, coupled with the view that the promotion of mental health is far removed from more relevant issues and that a focus on mental health could cause a shift in the re-allocation of resources from individuals who were living with mental illness, has compounded matters further (Herrman et al., 2005).

Consequently, the WHO has recommitted itself to the promotion of mental health as an integral component of public health because mental health and mental illness are themselves determined by the interaction between social, psychological and biological factors that can converge and impact negatively on behaviour and overall well-being (Herrman et al., 2005). In this regard Herrman et al. (2005) maintain that the promotion of mental health demarcates the three main themes around which the personal, social and environmental factors determinants of mental health and mental illness are clustered and the fostering of which are the objectives of mental health promotion. The three main themes are the following (1-3):

1. The development and maintenance of healthy communities:

This includes the provision of a safe environment; good housing; positive educational experiences; employment; good working conditions; and a supportive political infrastructure. These aspects are believed to minimise conflict and violence; allow self-determination and control of one's life; provide community validation, social support, positive role models, and the basic needs of food, warmth and shelter.

2. Each person's ability to deal with the social world through skills like participating, tolerating diversity and mutual responsibility:

This aspect pertains to the positive experiences associated with early bonding, attachment, relationships, communication and feelings of acceptance.

3. Each person's ability to deal with thoughts and feelings, the management of life and emotional resilience:

This is associated with self-esteem, the ability to manage conflict as well as the ability to learn.

It is believed that these components that aid in the promotion of mental health will also have a significant outcome, namely the prevention of mental disorders (Herrman et al., 2005).

### **2.2.3 The Biomedical Approach : A Cartesian Dualism**

The concepts of health and mental health, and the promotion thereof as stipulated by the WHO (as discussed above) and the laudable and sometimes referred to as "lofty" ideals upon which they are based are relevant for the purposes of this study, which is primarily concerned with the integration of psychological services into PHC.

The Primary Health Care model refers to front-line health care that is accessible in the case of any health problem. PHC sites in South Africa include district hospitals, primary health clinics, general medical practitioners, traditional healers and adolescent health services (Pillay & Lockhat, 2001). The concept of PHC was advocated and adopted in South Africa because of its non-specialist approach, particularly in low-income countries, with the intention of making quality health care accessible to all members of the population (Pillay & Lockhat, 2001).

The PHC model is a hierarchy of three levels of care, namely primary, secondary and tertiary level care (Pillay & Lockhat, 2001). Primary health care as referred to above targets predominantly physical problems and also children at risk, while the secondary level of care focuses on cases that cannot be handled at the PHC level (Pillay & Lockhat, 2001). These sites include general hospitals, welfare services, child guidance clinics and private practice (Pillay & Lockhat, 2001). Tertiary level care is associated with care provided at academic hospitals by super-specialist staff and referral is usually from secondary level. At the tertiary level follow-up is routed back to the secondary or the PHC level (Pillay & Lockhat, 2001).

Pillay and Lockhat (2001) maintain that the main advantages of the PHC model is its grassroots accessibility, its holistic approach to health care, as well as its relative lack of stigma in terms of individuals procuring mental health care within a general facility. These authors also mention the disadvantages of this model, namely the low detection rate of psychological problems and the burden of physical complaints on PHC personnel, compromising the position of mental health care within this framework (Pillay & Lockhat, 2001). More disconcertingly is the probability of mental health care being subsumed by the powerful medical model within which PHC is located, hampering efforts in the provision of truly holistic care (Pillay & Lockhat, 2001).

In this regard DeGruy (1997) refers to the suboptimal recognition and management of mental disorders and mental health within the PHC setting. The biomedical approach in which it is contextualised is inherently problematic in that the clinical reality of primary care within a Cartesian dualism perpetuates the division between the psyche and the soma and pays consistent inattention to this relationship (DeGruy, 1997). The origins of the biomedical approach can be traced to Vesalius, a 16<sup>th</sup>-century Flemish anatomist, to the mind-body dualism of Rene Descartes, and to the philosophical assumptions of rationalisation in the West during the Period of Enlightenment. This was followed by the scientific progress in the sphere of Germ Theory by Robert Koch and Louis Pasteur in the 19<sup>th</sup> century.

As early as 1977, Engel (1977) criticised the overly reductionist and exclusionist nature of the biomedical model when he wrote:

The dominant model of disease today is biomedical, with molecular biology its basic scientific discipline. It assumes disease to be fully accounted for by deviations from the norm of measurable biological (somatic) variables. It leaves no room within its framework for the social, psychological, and behavioural dimensions of illness. The biomedical model not only requires that disease be dealt with as an entity independent of social behaviour, it also demands that behavioural aberrations be explained on the basis of disordered somatic (biochemical or neurophysiological) processes. Thus the biomedical model embraces reductionism, the philosophical view that complex phenomena are ultimately derived from a single primary principle, and mind-body dualism, the doctrine that separates the mental from the somatic (p. 130).

Engel (1977) was of the opinion that there is an interaction between health and the conditions of life. In this respect the social system in which people are situated and the living, working and cultural conditions thereof are in their own right health variables. These variables in turn interact with the physiology of the body and have a bearing on the time of the manifestation, the degree of severity and the duration of diseases (Engel, 1977). He also points out the fallacious nature of the biomedical approach that ignores the psychosocial aspects of health. He was instrumental in introducing a major theory in medicine, namely the BioPsychoSocial Model of Health and Illness, which incorporates the biological, psychological and sociological interdependent systems of the individual, recognising that all these factors influence the course, recovery and recuperation from disease.

The biomedical model has dominated health care for over a century and rests on three main assumptions: all illnesses have a single underlying cause; disease is always the singular cause; and the removal or attenuation of the pathology/disease signals a return to health and equilibrium (Wade & Halligan, 2004). This model also purports that diseases give rise to symptoms and although there are other aspects that may influence the outcome of the disease they are not connected to its manifestations (Wade & Halligan, 2004). Health is construed as the absence of disease while mental phenomena like emotional disturbances are unrelated to and distinct from bodily functioning disturbances (Wade & Halligan, 2004). The patient is viewed as a victim of circumstances and in the treatment process is a passive recipient, although cooperation is expected (Wade & Halligan, 2004).

Many other authors have criticised the overarching biomedical model of illness characteristic of the PHC context, which runs contrary to the albeit insufficient definition of health by the WHO (de Gruy, 1997; Gilbert, 1999; Nell 1994; Petersen, 1999; Petersen, 2000; Ransom, 1997; Reeler, 1993; Swartz & MacGregor, 2002; Thom, 2004; Uys & Schene, 1997; van Wyk & Naidoo, 2006; Verwey & Crystal, 1988; Weihs, 1997; Wickramesekera, Davies & Davies, 1996; Winefield & Chur-Hansen, 2004).

#### 2.2.4 The Matrix of Detection

It has been stated that as many as 75% of the total number of patients accessing primary care is attributed to psychosocial problems masquerading as physical complaints (Roberts, 1994). Other authors have however put this figure at approximately 50% (DeGruy, 1997; Wickramasekera, Davies and Davies 1996). Somatisation disorder has been identified as the fourth most prevalent diagnosis in primary care (DeGruy, Columbia & Dickenson, 1987). Furthermore it has also been reported that patients with a mental diagnosis show higher utilisation rates of medical resources (DeGruy, 1997). Locally, it is maintained that 25% of all patients consulting a general practitioner do so because of psychological distress rather than biological causes (van Wyk, 2002). Thom (2004) has indicated that the detection rate of new mental illnesses in PHC services in Gauteng is less than 1%, implying that the screening for and the identification of mental disorders within PHC facilities is inadequate.

In Australia a great impediment to the provision of psychological intervention in cases of anxiety and depression has been the paucity of government health sector employees with specialist skills in the detection thereof (Winefield & Chur-Hansen, 2004). In this respect it is maintained that many general practitioners do not feel confident in their abilities to detect and manage mental health problems (Winefield & Chur-Hansen, 2004).

While the results of studies may differ in terms of detection rates, mental distress and disorders are usually embedded in a matrix of medical illness and explained or unexplained physical symptoms (DeGruy, 1997). Some authors propose that clinicians in primary care encounter mental symptoms as part of a broader problem, maintaining that the more pronounced the physical symptoms are the greater is the likelihood that the patient has a mental diagnosis (Kroenke, Spitzer, Williams, Linzer, Hahn, DeGruy & Brody, 1994). Furthermore, the converse also holds true: the more psychological distress the patient experiences the more likelihood there is of the existence of increased physical symptomology (DeGruy, 1997). Consequently, the physical and psychological symptoms are inevitably inextricable and it follows that systems of care that consign the patient in a dichotomous category result in an

incomplete clinical reality, which subsequently undermines a comprehensive delivery of care, culminating in a patient who is not completely understood (DeGruy, 1997). This raises the issue of accountability that DeGruy (1997) alludes to when he maintains that the primary care clinician has a moral responsibility to the patient—to the “whole” patient. He elaborates further, maintaining that it is impossible to divorce mental health care from primary medical care and that all such attempts are “doomed to failure”.

DeGruy (1997) tabulates the factors that collude and inhibit the provision of mental health care in the primary care context and which adversely affect detection rates. Besides the somatic presentation of mental distress, there is also the patient’s resistance in terms of the stigma attached to a mental diagnosis (DeGruy, 1997). Insufficient knowledge and skills on the part of the clinician is another factor, and (more significantly) the pace of primary care (DeGruy, 1997). In this respect it is usually customary for a clinician to see approximately four or five patients an hour, which leaves no time to carry out a detailed psychological assessment—never mind the management of mental distress. Furthermore, the somatic and biological orientation of medical education culminates in psychosocial components as being unscientific or, at a minimum, being of secondary importance. As a result personnel in primary care have lost the ability to understand the human condition and the ability to give meaning to symptoms (DeGruy, 1997).

### **3. South Africa, and a Biomedical Discourse for Care**

It has been predicted that if psychological services are incorporated within the heavily medicalised health care system characteristic of South Africa and other developing countries then the outcome will result in continued somatisation and its associated costs, as well as continued client distress (Nell, 1994). According to Nell (1994) the disempowerment that the “little professions” such as psychology and social work experience under medical supremacy hampers their abilities to develop their professional skills, and better serve the mental health needs of South Africans. This also appears to concur with the factors alluded to earlier by DeGruy (1997), which inhibit the provision of mental health care within PHC.

*“Medically I think mental health generally is laid in the background within the Department of Health. By the fact it’s in the Health Department, its medical, so we work on a medical model. That’s possibly what the problem is, that psychology is placed in health where psychology actually should straddle both health and social services and also social development, and possibly other areas as well, such as education. But because of that split we have to work on a medical model because we are in the Department of Health, and that kind of leads to a lot of problems, in that we are expected to work in a medical way. Therefore provide primary services at a primary health care facility. The understanding that our type of intervention is based on a perhaps more philosophical different kind of therapeutic, non-medical therapeutic model, that is beside the point...but our bosses are nurses and doctors and they expect things to be done in a particular way. And they understand often, well not always, how therapy works. But really there’s no space for it. We’re coming with a round system and they’ve got a square hole and so we shave off the sides and we slip into the hole”*

(Source: Focus group interview 06.10.2006).

Furthermore, as indicated by DeGruy (1997), the overarching biomedical discourse impacts expectations for praxis in terms of a curative approach and a patient turnover commensurate with a medical framework for delivery.

*“They (management) actually want us to go to the clinics and be there and deal with the cases and its almost like there is a magical thinking about what a psychologist does. Because even the doctors and the psychiatrists, they expect us just to go in there and fix it, fix it, fix it! Here is 10 (cases) of sexual abuse. Fix it! I don’t think I’ve been effective in one single case this year when it comes to severe trauma. I sometimes call it my cure. I’m able to cure people for some magical reason, but not because of what I provide them therapeutically, they (the patients) heal”*

(Source: Focus group interview 06.10.2006).

*“And...if you say, I can only see five or six patients a day, people (personnel) are like, what are you going do for the rest of the day? We (personnel) see sixty patients a day and you only want to come and see five to six patients a day”*

(Source: Focus group interview 06.10.2006).

Within the medical setting the disempowerment of the little professions takes on other forms, such as the creation of false client expectations (Nell, 1994). In this regard Nell (1994) alludes to patient's expecting a "quick fix", such as a pill or an injection from the psychologist.

*"And the clients perception is that we're medical doctors and are able to cure diseases"*

(Source: Focus group interview 06.10.2006).

*"Sometimes you speak to a person for twenty minutes and they say but can I have my sleeping tablets now"*

(Source: Focus group interview 06.10.2006).

As a means of illustrating that the Department of Health is not serious when it alludes to psychology's supposed parity in terms of its status with medicine, Nell (1994) maintains that psychologists are still represented by psychiatrists at management level. The misrepresentation of psychology at management level hampers what was earlier alluded to by Nell (1994) in terms of the development of the professional skills of psychologists.

*"So the people above you, the high management, are all in different fields, and everyone has the idea of what they saw of psychology on TV. We're (the psychologists) going to see everyone, we're going to do individual therapy. So that was the expectation. I think a lot of the time that was the difficulty because there was only a few of us and you can't, you can only do so much individual therapy"*

(Source: Focus group interview 06.10.2006).

Van Wyk (2002), in her study on a counselling internship in a PHC setting in Jamestown appears to corroborate the negative consequences of psychological services integrated into a heavily medicalised context. The location of the internship within a medical paradigm such as the PHC clinic, by association, affected the nature of the therapeutic relationship in that clients were passive recipients of services subject to the expert status of the intern (van Wyk, 2002). In effect, this has

perpetuated a victim mentality. Although the researcher resisted this hopelessness and lack of personal agency on behalf of the clients there was still the expectation of a magical cure or the “quick fix” mentality, as alluded to earlier by Nell (van Wyk 2002). Likewise, Rappaport (2000) is of the opinion that dominant discourses characteristic of a specific context strongly influence the expectations of patients for treatment. Van Wyk’s (2002) study again raises the issue alluded to by Nell (1994) whether engulfment by a biomedical hegemony will limit the role that psychology can play in mental health (van Wyk, 2002). It also appears to substantiate the criticisms levelled by Pillay and Lockhat (2001) on the disadvantages of the integration of mental health into PHC.

In terms of stigma associated with mental illness van Wyk (2002) maintains that a historical absence of psychologists and other mental health professionals in disadvantage communities have culminated in people being of the opinion that psychologists were there to help “mad” people limiting potential client’s willingness to utilise the services.

*“And people are still like, if you need to see a psychologist you are crazy. So that’s what scares a lot of people who come to see us and that’s also the perception that a lot of nurses still have. They don’t really know what you do. It’s still... I think they don’t understand what we do behind closed doors and they’re not going to ask as well. So if nurses have that perception it also flows over or carries over to the client as well”*

(Source: Focus group interview 06.10.2006).

A study by Hugo, Boshoff, Traut, Zungu-Dirwayi and Stein (2003) has also shown that with respect to community attitudes towards, and knowledge of, mental illness in South Africa that stigma and misinformation still exist, affecting treatment modality and help-seeking behaviours. Van Wyk (2002) is of the opinion that the education of South African society is the key solution to both the subordinate relationship of mental health to physical health in the national health system as well as the problem of stigmatisation.

Another relevant finding by van Wyk (2002) was the prevalence of psychological distress as a direct consequence of socio-political conditions, namely poverty and unemployment, and the importance of community psychological services, on not treating the psychological manifestations of such distress but a focus on addressing these issues “upstream”. This again casts doubt on whether the location of mental health services at a PHC level is suitable. Psychiatric disorders presenting as a manifestation of social problems has also been alluded to earlier by DeGruy (1997).

*“I think a lot of the times people bring social problems that present as certain disorders. So if we can help them with the social problems we could almost cure the psychiatric disorder as well”*

(Source: Focus group interview 06.10.2006).

Van Wyk and Naidoo (2006) maintain that it is important to establish positions for psychologists at other sites in the community such as schools and community centres as a means of broadening the provision of mental health care in communities.

As a solution to counteract the hypermedicalisation of the health care system and the priority of interventions for physical ailments at the PHC level, Nell (1994) proposes the creation of a department of human services that will include a wide range of nonmedical wellbeing services delivered via Comprehensive Help and Guidance Centres. These centres would be manned by a full compliment of professionals such as psychologists, community psychologists, social workers, vocational specialists, counsellors with specialist skills in mothering and abuse, occupational therapists, and paralegal workers. Services would be targeted at individuals with life problems and psychological distress. They would replace the medical gatekeeping of human services and contribute to the reduction of client loads at clinics, and hence a reduction in the expenses accrued by medical treatment (Nell, 1994).

Petersen (2000) believes that the ideals for comprehensive integrated PHC will remain a pipedream as long as they are located in a biomedically-oriented approach to PHC. While a national health system underpinned by a vision of universal primary health care has been promulgated in South Africa this has been too narrowly interpreted, firstly as an add-on of psychiatric services and secondly in terms of the

identification and follow-up of psychiatric patients at PHC level (Petersen, 1998). This approach to mental health care indicates neither a shift of discourse in care from a treatment and curative stance to the vision of comprehensive care, nor does it serve to provide care to the majority of people presenting at PHC level with non-psychiatric mental distress (Petersen, 1998). Moreover, it is not in line with the vision of mental health proposed by the WHO in that mental health is more than (only) the absence of a psychiatric disorder (Petersen, 1998). Petersen (1998) is of the opinion that the add-on approach will fail to deliver a comprehensive discourse of care as it is based on a psychiatric model which itself is heavily rooted in a biomedical discourse for care. This in effect excludes the focus on both the psychosocial and cultural determinants impacting on mental health. Similar to Nell (1994), Petersen (1998) refers to the manner in which nonmedical service personnel such as psychologists, social workers and psychiatric nurses have automatically assumed a supportive role to psychiatry, which is part and parcel of the biomedical hegemony.

Petersen (2000) maintains that although South Africa has made great strides to transform the biomedical discourse that dominates the relationship between the health care provider and patient, these efforts have been limited and ineffectual. In this regard Petersen's (2000) study on a primary health care site in KwaZulu-Natal revealed that care provided by primary health care nurses was upheld by the context within which it was provided. It was found that although the nurses understood the importance of using a holistic framework in interventions, this did generally not materialise in practice (Petersen, 2000). This was evident in the nurses expressing feelings of inadequacy and frustration when confronted with psychological and psycho-social problems; they felt that they were incompetent in terms of lacking skills and were impeded by time constraints (Petersen, 2000).

Petersen (2000) also found that a biomedical ideology decontextualises and individualises social problems, which serves to perpetuate existing power relations in society at large and which, in a sense, is emulated by the primary health care nurse towards the working classes. In this way the nurse adopts the role as a socialising agent for the broader status quo which is in fact antipathetic to the proposed comprehensive discourse of care which demands an awareness of context and the self-agency of the patient in the treatment process (Petersen, 2000).

Furthermore, it was found that the role of poverty underpinning many patients presentation for physical treatment culminated in many instances of nurses being requested to provide assistance in their personal capacity. The nurses concerned, believing their own material resources were being threatened, reverted to the refuge of the victim-blaming discourse of the biomedical model as a means of protecting their own material resources (Petersen, 2000). Petersen (2000) believes that this substantiates how other services that are outside of the ambit of health care are necessitated and that while comprehensive health care advocates multisectoral collaboration there is very little evidence to support this. As a consequence, health care workers are overburdened and unable to provide comprehensive care, especially as issues such as poverty impinge too acutely on their own personal lives (Petersen, 2000).

Although 500 clinics have been built since 1994 and free health care is now available at primary level the provision of a comprehensive discourse of care has been compromised in the process (Petersen, 2000). Factors such as budget cuts, increasing patient numbers, and lack of emotional support for staff have culminated in a demoralised and overburdened workforce (Petersen, 2000). Petersen (2000) believes that a scaling down of roll-outs in relation to the add-on of psychiatric services needs to be implemented and focus rather be on considering how the PHC context can be transformed to facilitate the vision of comprehensive care.

### **3.1 A Patient-centred Approach**

Petersen (1998) proposes an integrated approach as an enablement to comprehensive integrated primary mental health care in South Africa. This comprehensive discourse of care understands illness as emanating from an interaction of biological, cultural, psychological and social factors (Petersen, 2000). In addition, this discourse demands a consideration of the subjectivity of the illness experience for the patient in line with a patient-centred approach (Petersen, 2000). This is believed will simultaneously shift the power relations inherent in the patient–healer encounter. Via the inclusion of the patient’s explanatory models of illness the patient is viewed as an active partner in the consultation process, which in turn, given the multicultural nature of South Africa,

can make provision for alternate cultural explanations of illness (Petersen, 1998). This approach consequently implies the adaptation of a meaning-centred care (Petersen, 1998).

Verwey and Crystal (1998) concur when they maintain that in South Africa the dominant health care delivery framework is still the biomedical approach and that an overarching theory of health comprising predominantly a patient-centred approach supported by sound contemporary theories of communication is required (Lambert, Street, Cergala, Smith, Kurtz & Schofield, 1997) (as cited in Verwey & Crystal, 1998). The reality is that many consultations take place in a multi-cultural clinical setting and the patient and the mental health provider do not necessarily share the same worldviews, especially with regards to health care (Verwey & Crystal, 1998). Uys (1994) (as cited in Verwey & Crystal, 1998) illustrates this by giving the example that 25% of rural patients in a renal programme absconded in order to consult their traditional healer, and that in some rural areas the tribal system as part of the social hierarchy makes decisions on behalf of the patients. As a consequence, the ability to deliver culturally congruent care is contingent upon a sensitivity to and cognisance of the patient's underlying philosophical assumptions and worldview.

Internationally it has been argued that while PHC is continually undergoing transformation as a means of responding to the continual changes in the demands of health and economic environments there is still very little understanding of the systems of care (Martin & Sturmberg, 2006). In this respect, placing the patient at the centre of care and viewing PHC within a systems framework contributes to the identification of the complexity of the dynamics and interdependencies of care provided in and across various health care systems, and provides the way forward for reforming PHC systems (Martin & Sturmberg, 2006). Governments and universities have been side tracked into myopic concerns such as evidence-based medicine rather than focusing on developing structures that benefit patients and communities (Martin & Sturmberg, 2006). The issue that remains is: how can the goal of patient-centred care be achieved—a care that embraces the multitude of and multifaceted interactions between the individual and their environment in the context of a complex and multilayered PHC system (Martin & Sturmberg, 2006).

### 3.2 Where are we now?

While such theoretical proposals for reforms of PHC systems are visionary, for our purposes the question remains whether the integration of mental health care into the PHC framework has been successful in South Africa.

As recently as 2008 the South African Health Review reported that the integration of mental health care into PHC under the auspices of a biomedical framework was “insufficient” (Mkhize & Kometsi, 2008). Among the reasons cited for this problematic integration were poverty, poor infrastructure, the biomedical orientation of PHC, limited funding and resources, and staff overload coupled with a lack of support (Mkhize & Kometsi, 2008). Furthermore, a shift towards the add-on approach of psychiatric services and Selective Primary Health Care has compromised this integration (Mkhize & Kometsi, 2008).

This report alludes to the biomedical orientation of PHC, which focuses on serious mental disorders requiring psychiatric care and which excludes the common mental disorders such as anxiety and depression, and behavioural problems (Mkhize & Kometsi, 2008). Considering that nurses have been shown to be unable to account for somatic complaints in the absence of physiological causes this appears to corroborate with the pattern of mental health delivery in developing countries whereby it has and still remains entrenched in a biomedical discourse (Petersen & Swartz, 2002) (as cited in Mkhize & Kometsi, 2008).

Other factors cited as contributing to insufficient integration of mental health within the PHC framework are staff overload, compromising time available for mental health issues, coupled with a lack of support and supervision. This concurs with the findings of Saraceno, van Ommermen, Batniji, Cohen, Gureje and O’ Mahoney (as cited in Mkhize & Kometsi, 2008), who allude to the tendency of introducing mental health as an add-on and as a separate unit in the absence of structural support in developing countries. Although the integration of mental health was believed to reduce the stigma associated with mental illness it has been found that non-psychiatric nurses sometimes leave the work of attending to the mentally ill to the psychiatric nurse who

in turn feels stigmatised by other staff members because of the nature of their work (Jones, 1998) (as cited in Mkhize & Kometsi, 2008).

The leadership and organisational style of PHC has also been criticised. It has been found that bureaucratic tendencies of management persist (Petersen, 2000) (as cited in Mkhize & Kometsi, 2008). Furthermore, evaluations of staff are based on biomedical care rather than on the principles of holistic care upon which the principles of PHC are based (Mkhize & Kometsi, 2008).

*“A lot of it (the difficulties) has to do with our boss who has to run quite a few different programmes. So one was occupational therapy, and the other physiotherapy. So a lot of different fields which you have to juggle and keep everybody happy. And the one time I was speaking to them (management) about certain difficulties, what we’d like in the clinics, the reaction was kind of, what made you so special? The physiotherapist also needs this and this and the occupational therapist also needs this and this and this, so what makes you so special? Why should we make a different concession for you and your profession? And that again goes back to the lack of knowledge, the lack of insight into what we are trying to do”*

(Source: Focus group interview 06.10.2006).

Poor infrastructure, limited funding and insufficient supplies and equipment, specifically in rural areas, have also been cited as impediments to the integration of mental health within PHC (Mkhize & Kometsi, 2008). More significantly, privacy and confidentiality are not always available for victims of trauma, sexual and physical abuse and rape (Jones, 1998) (as cited in Mkhize & Kometsi, 2008).

*“They (staff at the clinic) organise rooms for us but a lot of the time people (staff)...when they have an emergency they have to walk inside (the room), or if they want to make tea they have to come in and get tea-stuff. And to try and contain everything in that one room is difficult enough just considering the personal circumstances one (the patient) arrives in. But to be able to have a physical environment that isn’t conducive to that setup, is just, makes it more difficult”*

(Source: Focus group interview 06.10.2006).

*“To hold that space (the therapy space) for a child I find impossible. I don’t like to do play therapy. And so I don’t have very many interventions for children especially like traumatised children. So what else can I do? I can’t hold the space enough to put down a blanket and throw in a few toys, and repeat that on an on-going basis, because it’s about the repetition”*

(Source: Focus group interview 06.10.2006).

Mkhize and Kometsi (2008) point out that integration does not necessarily imply that patients are assured of the best quality in terms of care and that the issue of language entrenches the power differential of those in power. Particularly in the South African context this may marginalise previously disadvantaged groups further considering that proficiency in indigenous languages has not been given priority in the training of psychologists and other health care professionals (Pillay & Kramers, 2003) (as cited in Mkhize & Kometsi, 2008).

In efforts to aid in addressing the insufficient integration of mental health within PHC Mkhize and Kometsi (2008) make the following recommendations:

- Epidemiological research needs to be conducted on the prevalence of serious and common mental disorders to inform the planning and allocation of resources;
- Further research needs to be undertaken into models that address the patient’s explanatory model of illness;
- As a means of reducing the stigma of mental health, research into and the education of communities on mental health should be developed; and
- Monitoring systems pertaining to the integration should be strengthened (p.110).

In terms of training the following proposals are advocated by Mkhize and Kometsi (2008):

- As the training of mental health professionals is incomplete, indigenous conceptions of health and illness need to be included in the training of mental health professionals with ongoing collaboration between the two health care systems in the treatment context;
- Generalist nurses should be trained to identify serious and common mental disorders;

- As a means of relieving the burden on generalist nurses the new category of “counsellor” can go a long way to addressing this; consequently, resources for training and employment opportunities should be made available;
- Training should also be provided to management staff to facilitate a leadership style that is egalitarian; and
- Health providers should be trained holistically, incorporating the psychosocial components of health so that the integration of mental health is seen beyond an add-on (pp. 110–111).

#### **4. Shifting Identities and Anxieties**

*“You are kind of a clinical psychologist which means that you are trained to hone your skills in a specific field, and then you come into a rural setting where you are then expected again to function, not on your masters level as a psychologist, you are expected to function as a kind of a jack of all trades. To do a bit of counselling, to do a bit of social work, to do psycho-education. We need to do a lot of things that do not constitute therapy in the strictest sense of the word. So that also created the feeling that I’m not quite sure what I am doing, I’m not quite sure that what I’m doing is effective enough”*

(Source: Focus group interview 06.10.2006).

Ngonyama ka Sigogo et al. (2004) state that psychologists in South Africa are continuously challenged by the multifaceted and complex identities commensurate with being “South African”. Furthermore, psychological praxis is pushing the envelope and straining to reposition itself in the face of the demands of a changing South Africa. In this regard psychologists are challenged by realities such as the HIV/AIDS pandemic and family violence, and the “rainbow nation” still conceals continuing violence and inequalities (Ngonyama ka Sigogo et al., 2004).

Within the context of transformation of post-1994, paradoxically trained in an approach, which was aimed at facilitating individual change, psychologists were now faced with developing a theory of intervention that could facilitate their professional roles within this context of transformation (Seedat, Mackenzie & Stevens, 2004). The onus has been on psychologists to forge new identities and shifts in roles to assimilate

with the new order and to silence the relevance critics. Ironically, Seedat, Mackenzie and Stevens (2004) allude to the community psychologists' endeavour to redefine their roles by extending their services to trauma survivors such as ex-detainees and returning veterans, which is akin to replicating the role of traditional psychologists by adapting a passive waiting and curative role. Even psychologists who pioneered the social action approach were challenged and criticised that the power differential in skills between themselves and members of the community could not be resolved by simply declaring themselves “part of the people” (Seedat, Mackenzie & Stevens, 2004).

It could be argued that the identities of South African psychologists are still in a state of flux. To elucidate this, Ngonyama ka Sigogo et al. (2004) raise the question as to what is the meaning of a community psychologist. They allude to authors such as Lazarus, who describes the South African community psychologists' positions as falling under the dual umbrellas of mental health and social activism. The former group is preoccupied with the provision of services to the previously marginalised and radicals who attempted to develop alternative systems for those oppressed by the previous regime (Ngonyama ka Sigogo et al., 2004). Community psychologists who fall under the umbrella of social activism use as their point of departure Marxist theory and empowerment theories and they champion for social transformation (Ngonyama ka Sigogo et al., 2004).

To complicate matters further, Ngonyama ka Sigogo et al. (2004) maintain that recent debates in psychological associations in South Africa have concluded that only an individual who is registered with a professional organisation as a community psychologist can perform the duties of a community psychologist. Others responses that emerged from this debate were that one cannot be “trained” as a “community psychologist”, therefore one cannot be registered in a community psychology category. In conclusion, Ngonyama ka Sigogo et al. (2004) state that if that is the case then community psychologists can include various role-players such as community activists or organisers, as well as the current unregistered community psychologists. They elaborate on this point when they state that community psychologists are then to be found in NGOs, development organisations, community-based health clinics and community organisations. This then raises the question: Can

anybody be a community psychologist, and what differentiates a community leader/organiser or any other community role-player from a psychologist? It also raises the issue of what does the discipline do with what it currently has, and how can traditional psychology as we know it inform the work of the psychologist in communities. In this respect we must guard against throwing the baby out with the bath water.

Interestingly, Long (2002) alludes to applying psychoanalytic principles to inform a consultation relationship with a group of black Xhosa-speaking PHC workers who were located in an impoverished shack-settlement in Cape Town. A psychoanalytic approach to community work was found to be a valuable tool in aiding community psychologists to reflect on how the socio-political history of South Africa influences intrapsychic processes and interpersonal relationships, which are characteristic and inherent in community dynamics. Furthermore, an understanding of the interplay between the unconscious and the conscious with an integrated political understanding can provide a framework for community work (Long, 2002). This integrated approach also serves to add complexity to existing empowerment theory (Long, 2002).

In a similar vein, van der Walt (2002) refers to the application of psychoanalytic concepts in understanding organisational change, particularly the defensive structures of staff that come into play.

*“A lot of time it's about change. You're coming in as a new person and all of a sudden now you say this is how I'm going to work. I have appointments, patients just don't arrive for me, I don't just see everyone that walks in and says they need to speak to someone. And for that a lot of the sisters in the clinic who were in charge there, they didn't like that, that somebody from outside came in and told them how they should run their clinic. There was also resistance”*

(Source: Focus group interview 06.10.2006).

In the light of the integration of mental health care into PHC, which impacts on the already overburdened PHC personnel, the success of such a policy shift is contingent upon the abilities of psychologists to be able to contain such anxieties and emotions

provoked under such uncertainty (van der Walt, 2002). These examples of the application of psychoanalytic theory in community settings suggest novel approaches whereby traditional epistemologies can be used constructively, ensuring their more appropriate applicability within our unique South African context.

Other authors have commented on the anxieties and difficulties inherent in community work (Gibson, Sandenbergh & Swartz, 2001; Johnson, 2006; Joubert, 2007). During psychology training and community service trainees move beyond the confines of their offices and into their community placements far removed from the protocols covered by conventional psychological practice (Gibson, Sandenbergh & Swartz, 2001). In many instances community stakeholders are initially unenthusiastic in their reception, which compounds trainee's experiences of feeling less than competent and unwelcome (Gibson, Sandenbergh & Swartz, 2001). In most South African disadvantaged communities violence has a consistent presence and adds to the stressors of trainees especially when they are not familiar with both the terrains and conventions of the relevant communities (Gibson, Sandenbergh & Swartz, 2001). Furthermore, abject poverty is a common occurrence and reactions evoked in trainees by such deprivation particularly if they are comparatively privileged include guilt and feelings of impotence, especially when coupled with unrealistic expectations of psychologists by communities in this regard (Gibson, Sandenbergh & Swartz, 2001). As a consequence, psychological interventions may be construed as meaningless in the face of such material depravity. With political pressure to succeed and the taboo-like context of political correctness the result is that trainees and psychologists alike may run the risk of becoming disillusioned with the overwhelming terrain of community work and of articulating such concerns (Gibson, Sandenbergh & Swartz, 2001). This is corroborated by the findings of a study carried out by Joubert (2007) on the perceptions of clinical psychologists to community work: participants felt they were unable to discuss their disillusionment and disappointments with trainers in respect of their community work. Furthermore, this perceived lack of support is instrumental in preventing psychologists from even considering permanent community positions after the completion of their community service (Joubert, 2007).

*“...There are some people who have studied with me and they ask me how my job is going, and I say “terrible - it’s horrible” and I realise that is my standard answer.*

*That's my standard answer that I don't like it at all. Because I am actually quite a positive person you know. Now I have started on anti-depressant medication to be able to deal with it because I don't have a choice to leave this job. I have to finish at the end of the year. There are no therapists available in the area where I live and so I have got to find some way of dealing with it"*

(Source: Focus group interview 06.10.2006).

#### **4.1 Training**

Coupled with the shifting identities of the psychologist the foundation upon which the discipline in South Africa has been practiced since its inception as exemplified by training has also been challenged. Pillay (2003) maintains that trainers are still uncertain on how to prepare future psychologists for working in communities.

Numerous studies have alluded to the training of psychologists in South Africa failing to equip candidates with the skills to function effectively and competently within communities (Ahmed & Pillay 2004; Carolissen, 2006; Freeman, 1991; Gibson, Sandenbergh & Swartz, 2001; Johnson, 2006; Joubert, 2007; Kriegler, 1993; Lesch 1998; Ngonyama ka Sigogo et al., 2004; Pillay, 2003; 2006; Rock & Hamber, 1994;). If psychologists are to effectively collaborate with communities in the face of poverty, disease, and limited educational and health resources then the entire discipline of psychology is in need of a complete structural change (Ngonyama ka Sigogo et al., 2004). The challenging of existing theories in order to meet the requirements of the communities in South Africa is necessary (Ngonyama ka Sigogo et al., 2004). In this respect Ngonyama ka Sigogo et al. (2004) maintain that historically psychological epistemologies and current academic structures such as universities are at odds with the underlying philosophies of community psychology theory and practice. These authors state that within these institutions social scientific knowledge emanates from the Euro-American tradition, which in itself is rooted in hypothetico-deductive reasoning. They further state that both academic institutions as well as the professional credentialising bodies themselves are premised upon hierarchical power structures serving to sustain and perpetuate the role of the expert.

A study conducted by Lesch (1998) on the difficulties experienced by psychology students in a community psychology module indicated that students were so pre-occupied with individualistic approaches to helping and understanding problems that it hampered their abilities to think in terms of community and ecological principles. As recently as 2004 Ahmed and Pillay (2004) found that trainees in clinical psychology produced mostly decontextualised and individualised psychodynamic formulations in their clinical work, and failed to include contextually relevant formulations. This points to the manner in which trainers are instrumental in reproducing dominant Eurocentric discourses despite the commitment of training institutions to the implementation of more relevant training programmes in the South African context. These authors argue that the current clinical psychology training does not prepare students to operate competently in the South African context and specifically within a PHC framework

*“The lack of support was also quite uncontained for me as a therapist...The specific factors within the clinics, the lack of knowledge pertaining to psychiatry and psychology, the interruptions, all of those just culminated in a feeling of “Phew, I can’t take this anymore, its just too much”*

(Source: Focus group interview 06.10.2006).

Pillay (2003), in his study on whether the training of psychologists equipped them to be confident in the practice of psychology, concurs by maintaining that a paradigm shift is necessary in the training of psychologists within the South African context. He believes that the trainee psychologist must be equipped with generic skills to function in communities and that the training in community psychology should be integrated in a holistic manner into all modules. He elaborates further that if the intention is to address the psychological needs of the South African population then the focus needs to shift from one-on-one therapy in a consulting room to mass interventions that are preventative in nature within an eco-systemic framework.

Likewise, in the study of Joubert (2007), participants stated that the training was very insular in that it was primarily focused on the individual, although within the hospital setting one does not have time to conduct psychodynamic therapy with patients.

*“I think it was for me very difficult too, my previous therapeutic frameworks that I wanted to do therapy in. I needed to adapt quite severely to deliver a service in the community. And I do not like to work very directly but that is what you needed to do was to work very directly and very concretely. So I think I personally was probably very eclectic, but I tried to maintain a stance of respect and creating the relationship and the containing environment. Not just one assumption or framework”*  
(Source: Focus group interview 06.10.2006).

This is compounded by the number of patients one is expected to see: whereas one was trained to conduct a 50-minute structured interview when the psychologist arrived at the clinics, in reality there would be up to 15 people expecting to see the psychologist in the space of 3 hours (Joubert, 2007).

*“...I don't think it is just the travelling, it is the amount of clinics you need to visit within a set period of time...you can only visit a clinic once in two weeks and if you can only see say five or six people per day, how big of a chunk of the people that need to be seen are you seeing? How effective are you within the community that you need to service? You may be effective for three patients, but within the larger community the greater scheme of things, you are not delivering such a broad service as they want, as they are expecting”*  
(Source: Focus group interview 06.10.2006).

The teaching of the core clinical competencies as demarcated by the HPCSA has also been challenged, considering that the current context in South Africa demands different competencies (Ahmed & Pillay, 2004). In this respect the type of psychological services required by clients attending PHC facilities differs considerably from that provided in private practice (Ahmed & Pillay, 2004). In a study carried out by Seedat, Kruger and Bode (2003) at a community clinic in Soweto over the period 1987–1997 the average number of counselling sessions per client was less than two. In fact, 82% of the clients only came for one counselling session. Among the reasons cited for the once-off consultations were inappropriate referrals, the social base of problems, an unstructured booking system, as well as the demand for cognitive assessments. However, the long-term therapeutic orientation of the counsellors was also cited as one of the main reasons for the once-off consultations

(Seedat, Kruger & Bode, 2003). According to Ahmed and Pillay (2004) government hospitals and clinics predominantly cater for clients who are in severe psychological stress, demanding symptom alleviation, and hence require more short-term and problem-orientated solutions.

*“The patient’s perceived success of therapy is very different from what you see in a training institution...you would measure your therapeutic effectiveness by how well the person has insight... you don’t need to do all that, your effectiveness relates to the here and now, the tangible, the what can I take home and the quick-fix type of phenomena approach”*

(Source: Focus group interview 06.10.2006).

This would appear to be corroborated by van Wyk (2002) in her study on a counseling internship in a primary health care setting in Jamestown. It was found that, given the many social constraints affecting the duration of therapy, reality therapy and solution-focused therapy was frequently used.

While comprehensive assessments, formulation, and long-term psychotherapeutic management, predominantly psychodynamic therapy, forms up to 40% of the core clinical competencies advocated by the HPCSA in the training programmes for psychologists, the effectiveness of this approach in light of the demands of the South African context is debatable (Ahmed & Pillay, 2004). Furthermore, while psychotherapy should still be regarded as a core competency, as well as assessments that usually require more than one session, their respective relevance should be challenged and engaged with (Ahmed & Pillay, 2004).

*“We learnt to do the very intensive very long assessment beforehand and I think that is one of the reasons why patients don’t want to come back. Because the first session we kind of learnt to spend on getting a comprehensive history, to get a comprehensive understanding of where, why...And I think if there had been a kind of a screening person (at the clinics) who knew how to do most of the background, then we could go straight into therapy or just get to building rapport first. Instead of having to go through all the assessment...you kind of break it down into only the bare essential and at times you find that it is not enough. There is a reason why we have to do the*

*whole long assessment and at times you see that is efficient if you don't...but most of the time it is the here and now stuff (instead of the comprehensive assessment)"*

(Source: Focus group interview 06.10.2006).

While short-term modalities such as solution-focused and cognitive-behavioural therapy do attempt to address these issues they must still be critically reviewed in the light of the current health care contexts and the respective challenges that they pose (Ahmed & Pillay, 2004). As early as 1991, Freeman (1991) alluded to the role of equity in intervention with the tendency of South African psychologists to perceive clients as "failed Euro-American middle-class subjects", and not taking into account that individuals are primarily socially constructed beings. He too concurs when he maintains that the usual therapeutic modalities characteristic of training institutions are too long-term and labour intensive to be regarded as a relevant therapeutic interventions. He advocates training institutions taking up the challenge to develop more effective short-term therapeutic modalities.

Ahmed and Pillay (2004) warn of using individual narrative models as a basis for training whereupon the skills required for community work are automatically perceived as competencies that are "tacked on" to these core skills. Similarly, Gibson, Sandenbergh and Swartz (2001) maintain that there is a tendency in training institutions to add-on community psychology to an already existing full clinical training programme. A recent study by Joubert (2007) revealed that clinical psychologists believed that their training did not incorporate an integrated approach facilitating competencies to serve the needs of South African society (Joubert, 2007).

This add-on approach further contributes to the marginalisation of community psychology within training institutions and in particular influences students' perceptions of community psychology heavily coloured by race, gender and class (Carolissen, 2006). In this manner community psychology is devalued as a legitimate discipline. This appears to be corroborated by Johnson (2006) after carrying out a study of the perceptions of community psychology among Honours/BPsych students in the Western Cape. It was found that the participants perceived community psychology as akin to social work, and hence a lesser form of helping in the mental health hierarchy.

*“It’s a misnomer to actually call us community psychologists because we’re doing the work in a rural community; we are not actually community psychologists. We are clinical psychologists. And that’s what they brought us in for is to do clinical psychology but we should have maybe actually been community psychologists. I think if we have to prioritise the order of needs I would say that community psychologists are maybe more necessary and in demand than clinical psychologists because you have to lay the groundwork, the foundation, before you can provide the service. And we are going in there you know and giving people a lift around in a porsche (clinical psychology)... We need to be trained in terms of what the whole idea is behind the situation (community psychology)”*

(Source: Focus group interview 06.10.2006).

Johnson (2006) also found that participants viewed the discipline of psychology from a Eurocentric framework, with individual psychotherapy as the primary means of intervention. As community psychology was not considered to be an integral component of psychology it was rather seen to be more suited as a stepping stone into the Masters in Clinical Psychology programme (Johnson, 2006). More significantly, students felt that the more ideal candidate for working in a community setting was a middle-class, hard-working black female, and that community psychology was more suited to addressing the needs of only poor black individuals (Johnson, 2006). Alarming, results indicated that students had very little exposure or access to community psychology. In this regard, during the four-year programme 70.7% of students did not do community psychology in their first year, 75.6% of students did not pursue the module at all in their second year, 44% of students did not pursue the module in their third year, and 61% of final year students did not do the community module at all (Johnson, 2006). Consequently, Carolissen (2006) believes that community psychology continues to be understood from a perspective that perpetuates its marginalisation.

*“But then you kind of need to re-invent psychotherapy and in terms of our training, we were trained in classical style, being therapeutic, containing the space. But a lot of community psychology is supposed to be like the person is political, giving them*

*(patients) general information and stuff, but we were not being hired for that...that is not in our job description”*

(Source: Focus group interview 06.10.2006).

These negative perceptions may be instrumental in the production by training institutions of mental health professionals ill-equipped to cope with the demands of South African mental health users. Joubert (2007) maintains that in the clinical training of her participants it was perceived that the community psychology components were only “paying lip service” to the broader context.

Training and qualifications are not always aligned with professional identities. According to Ngonyama ka Sigogo et al. (2004), those sharing this view believe that registering community psychologists into a dichotomous category is paramount to ghettoising community psychology within a subdiscipline of psychology. Rather, they believe the answer lies in students of psychology needing to familiarise themselves with the underlying theory and practice of community psychology and ensure that such a base informs “best practice” within the total realm of psychology. In this way training in the discipline of psychology will ensure that ultimately it maintains a community focus. Furthermore, the point of departure informing community work should not be from an individual-curative perspective but rather engaging with the challenge of subjecting the modus operandi to intense scrutiny and consequently restructuring praxis and assumptions (Ahmed & Pillay, 2004). Joubert (2007) alludes to suggestions made by clinical psychologists for future training that the training does not begin and end in individual therapy rooms but rather the students are provided with something “tangible” to facilitate practice. Van Wyk (2002) found in her study that the greatest challenge to her functioning within a community setting was the inadequate theoretical training at Master’s level, where such training was geared more towards private practice than for community praxis.

*“Because there’s such a great discrepancy between what you prefer, your preferred therapeutic model and your way in working it creates a lot of personal tension. And you feel ineffective, and you don’t feel like a psychologist anymore. I think that to me was a very very strong feeling”*

(Source: Focus group interview 06.10.2006).

The state of flux in both the identities and training of psychologists within the South African context lends credence to the belief that the psychologist trainees are possibly compromised in their preparation for professional practice, namely in the PHC context (Ngonyama ka Sigogo et al., 2004). This raises a critical issue specifically pertaining to the ethical obligations of training institutions in their readiness to prepare trainee psychologists for the unique demands of practice in the South African domain.

## **5. Conclusion**

In the context of transition in South Africa post-1994, a comprehensive discourse of care for delivery of health services to the previously marginalised populations was promulgated, the location for which was the PHC setting. Commensurate with this shift was the integration of psychological services within this framework. This literature review has attempted to delineate this progression, more specifically the theoretical underpinnings of such a resolution, as well as the feasibility thereof. While this was mainly a literature review, juxtaposed against this review was the inclusion of raw data that was obtained from an exploratory focus-group interview conducted with community service clinical psychologists in the field. The purpose of the latter was primarily illustrative, and a means of elucidating the lived experiences of those at grassroots level as a consequence of policies implemented at a macro level.

PHC, as defined by the WHO in the Alma Ata declaration of 1978, was followed by governments in sub-Saharan Africa, restructuring their entire health systems in line with a PHC framework. While initially progress was observed in improving health status, overall “health for all” was not achieved in any of these countries (Chatora & Tumusime, 2004). In South Africa, obstacles hampering the full implementation of PHC policy include the HIV/AIDS pandemic; the lack of strong leadership within the political and public sector, and health leadership; a complex and a protracted health transition; as well as both health worker shortages and inequities in terms of resource distribution. (Kautzky & Tollman, 2008). Despite this, in 2008 there was a vociferous re-commitment to PHC by the government, the success of which is dependent upon recognition of the lessons learned from South Africa’s experience with PHC to date

(Kautzky & Tollman, 2008). Furthermore, this re-commitment will demand a consistent and committed leadership, informed by research and conducted as a means of facilitating an ideal and innovative approach to PHC in this country (Kautzky & Tollman, 2008).

However, in terms of the focus of this study, the integration of psychological services within PHC is of primary importance. The rocky foundations of this integration have been highlighted; they emanate from an ideological discourse that proposed this integration, uninformed by research. Furthermore, concepts in the original 1978 Alma Ata declaration of the WHO were poorly operationalised, which only served to both marginalise mental health care in terms of procuring funding as well as taking a back seat to health. Despite protestations that comprehensive PHC including the integration of mental health services would be compromised by the biomedical approach of PHC for service delivery this framework still guides and informs service delivery. In the African context economic constraints, political instability, the HIV/AIDS pandemic, poverty and more significantly SPHC have served to marginalise mental health care further within a public health framework.

In South Africa the integration of mental health services has been conceptualised as an add-on of psychiatric services, which themselves are rooted in a biomedical discourse for service delivery. Within this framework, among the factors identified that have inhibited the integration of psychological services include the disempowerment of psychology under a medical supremacy compromising the abilities of psychologists to develop their professional competencies; the ignorance of psychology's function and role; the false expectations of patients heavily coloured by the biomedical context; the misrepresentation of psychologists at management level; the stigma associated with mental illness; the focus on the individual while neglecting the pathogenic social conditions such as poverty and unemployment, which runs contrary to a comprehensive discourse for care; overburdened personnel and staff shortages; and the precedence of a SPHC approach. With mental health being construed as a euphemism for the treatment of mental illness psychologists have been constricted in their capacities in promoting healthy communities in line with the recommendations advocated by the WHO. In an ideal world the comprehensive help and guidance centres proposed by Nell (1994) would be a more appropriate medium

for psychological services but the costs of such an infrastructure would be exorbitant and in some instances a duplication of existing services.

While the integration of psychological services within a biomedical framework is inherently problematic, with a re-commitment by government to PHC, the discipline of psychology will have to quickly restructure itself in terms of making its praxis more relevant to the needs of the population within the restrictions imposed by an overarching biomedical mode of service delivery. In this regard psychology needs to be more innovative in terms of its location within communities. Van Wyk and Naidoo (2006) have already alluded to the procurement of other localities in communities for psychological services. Furthermore, the discipline of psychology has been accused of being historically irrelevant because of its Eurocentric underpinnings as well as its collusion with the status quo during apartheid. Under the new dispensation and the context for service delivery, namely PHC, the pressure and impetus to restructure itself is more pronounced—specifically in terms of psychology being able to claim its stake as a discipline of relevance in the new South Africa.

This can only be achieved by a bottom-up approach to training, where community psychology as part of the training programme for new psychologists is not perceived as an add-on, and hence marginalised. It could be argued that this points to the existence of an inherent fear of institutions daring to free themselves of the shackles of Eurocentric epistemologies, having the courage to venture out and create new and even hybrid models for praxis unique to the South African context. This is not to suggest that we throw away the old, but rather that new models for praxis can be informed by traditional approaches such as psychoanalysis, as alluded to earlier by Long (2002). As early as 1992, Vogelman, Perkel and Strebel (1992) maintained that the tendency to separate community and mainstream arms of psychological practice needed to be challenged. These authors stated that it was imperative that the synthesis of both of these modes of practice be addressed in order to make the discipline as a whole relevant to the needs of the majority. This implies that the principles and values of community psychology must permeate all levels of training. Is it really that difficult to imagine that instead of the individual therapy room as previously referred to by Joubert (2007), that training begins and ends in the community?

The literature review has clearly shown that future psychologists are compromised by their training in terms of their abilities to function both within communities and the PHC setting. The future psychologist requires more generic skills, in particular the ability to start psychological services from scratch in areas where there are none. There must also be an emphasis on systemic and ecological frameworks for conceptualising problems and training in the application of traditional knowledge systems to inform interventions within these frameworks. Furthermore, the emphasis of training institutions needs to shift from a pre-occupation with psychopathology and diagnosis to one that inculcates positive mental health and mental health promotion.

In terms of educating the public with regards to psychology's function and role, trainee psychologists must be equipped with these skills. Education, locally, has also been alluded to as a critical issue (Mkhize & Kometsi, 2008; van Wyk, 2002). In this instance a proactive stance needs to be adopted instead of a lack of knowledge and ignorance being construed as an impediment to service delivery. Ignorance about psychology is not just unique to the South African context. Wild (2003) has shown that the work of clinical psychologists is largely misunderstood by health care professionals. His study, carried out in a general hospital in Scotland, revealed that the low referral rates in this setting were attributed to low levels of awareness and understanding of psychological issues. The recommendations of this research were that education of other health care professionals, and improved communication between psychology and other departments within the hospital, was necessary (Wild, 2003). This finding also points to the necessity of psychology being able to position itself at management level in PHC systems rather than it being the passive recipient of policy and directives emanating from the top. As indicated earlier by Mkhize and Kometsi (2008), it is also important that within the PHC systems the integration of mental health services is continuously overseen by monitoring systems. These authors also highlight the importance of continued research within the PHC framework as a medium to inform policy and praxis.

While this literature review has aided in identifying gaps for training and praxis, as a means of facilitating a smoother integration of psychological services within PHC, ultimately it has revealed that it is imperative that a convergence is reached in terms

of policy, theory and practice. As indicated earlier, there has been a paucity of research driving the promulgation of and integration of psychological services. This is believed to largely account for the dissonance experienced by community psychologists at a grassroots level. As a consequence, further research in this area is advocated, hopefully culminating in an equilibrium between policy implemented and its practical manifestations at grassroots. Overall, the literature suggests that a bottom-up approach be followed as a means of informing policy at a macro level.

## **6. Limitations of the Study**

While a scarcity of literature both locally and internationally on the topic under review was a limitation, this literature review in its own capacity adds to this body of knowledge and hence serves as a medium to rectify this state of affairs. Furthermore, while the raw data from the focus-group interview was utilised purely for illustrative purposes, this data was based on a very small sample and as such cannot be generalised to the population of community service clinical psychologists as a whole.

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