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AN EXPLORATORY STUDY: THE FAMILY'S EXPERIENCE OF THE INITIAL INTERVIEW AT THE CHILD GUIDANCE CLINIC

by

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A minor dissertation submitted in partial fulfilment

of the requirement for the award of the

Degree of Master of Clinical Psychology

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University of Cape Town

2005

Compulsory Declaration

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work or works of other people has been attributed, and has been cited and referenced.

Signature: Signed by candidate Date: 14-10-2005

ABSTRACT

This project was an evaluation of the initial interview as experienced by a sample of six families who utilised the services of the CGC in 2003. Families were given a semi-structured interview schedule which focussed on a number of common experiences of the assessment interview. A thematic analysis was employed to understand this qualitative enquiry into the family's perception of a service sometimes criticised as traditional, elitist and contradictory to the proposal that a broader, more community based intervention be proffered. The results showed that families generally linked the outcome of the intervention to the positive or negative experience of the first session. An important indicator in determining the success of the therapeutic intervention was the effective alliance the therapist built up with the family. All but one family, who referred children for scholastic difficulties, were satisfied with the interventions two years later. The greatest objection to the supervision team behind the one-way mirror stemmed from most of the adolescent participants. Another positive finding was that disclosure was considered as helpful in forging closeness within the family. Families shifted in interviews to talk about the intervention and the study concluded that the small sample has conveyed the need and validity for the therapeutic interventions offered by the CGC. Within the backdrop of post-apartheid South Africa there is the sense that demand for the type of service offered by the CGC is desperate. The continued value of such a service can only be properly addressed if more detailed studies are initiated in the future.

University of Cape Town

TABLE OF CONTENTS

ABSTRACT.....I

ACKNOWLEDGEMENTS.....IV

CHAPTER ONE: INTRODUCTION..... 1

CHAPTER TWO: LITERATURE REVIEW.....6
2.1. Introduction.....6
2.2.1. Changing policies and attitudes at the Child Guidance Clinic.....6
2.2.2. Assessment Interviews at the Child Guidance Clinic.....8
2.3. Assessment Interviews.....9
2.3.1. The Family.....9
2.3.2. The emergence of family therapy.....10
2.3.3. The Purpose of the Initial Interview.....11
2.3.4. When a family intake is not advised.....12
2.3.5. The Pre-Interview Stage.....13
2.3.5.1. Referral Sources or Agents.....13
2.3.5.2. Initial contact with the family.....13
2.3.6. The Interview.....14
2.3.6.1. The Therapy Room.....14
2.3.6.2. First Stage of the Interview.....14
2.3.6.3. Second Stage of the Interview.....15
2.3.6.4. Third Stage of the Interview.....17
2.3.6.5. The end of the Interview.....18
2.3.7. The one-way mirror, videotaped interviews and the supervision team.....19
2.3.7.1. Background.....19
2.3.7.2. Supervision using the one-way mirror and the video camera.....21
2.4. Features that may impact on the initial session.....23
2.4.1. The notion of family secrets.....23
2.4.2. Perceptions of the therapists.....24
2.4.3. The family's expectation therapy.....26
2.5. Family therapy within the South African context.....27

CHAPTER THREE: METHODOLOGY.....35
3.1. Background.....35
3.2.Evaluation of semi-structured interviewing.....35
3.3.Research Design.....37
3.4.Sample.....38
3.5.Data Collection.....40
3.6.Data Analysis.....40
3.7.Ethical considerations.....42
3.8.Reliability and Validity.....43

CHAPTER FOUR: FINDINGS.....45
4.1. Introduction.....45
4.2. Main findings from the interviews.....45
4.2.1. Referral to the CGC.....45

University of Cape Town

4.2.2. Feelings about being present for the first session....46
4.2.3. The family's experience of the waiting room....46
4.2.4. Feelings about talking to each other during and after the first session....48
4.2.5. Perceptions of the one-way mirror and the supervision team....51
4.2.6. Perceptions of the knock on the door and the video camera....53
4.2.7. Views about the effectiveness of the CGC....53
4.2.8. Highlights and concerns....55
4.2.9. Perceptions of the therapist....57

CHAPTER FIVE: DISCUSSION OF FINDINGS....60
5.1.Introduction....60
5.2.1. Referral to the CGC....60
5.2.2. Feelings about being present for the first session....62
5.2.3. The family's experience of the waiting room....63
5.2.4. Feelings about talking to each other during and after the first session....65
5.2.5. Perceptions of the one-way mirror and the supervision team....66
5.2.6. Perceptions of the knock on the door and the video camera....68
5.2.7. Views about the effectiveness of the CGC....69
5.2.8. Highlights and concerns....70
5.2.9. Perceptions of the therapist....72

CHAPTER SIX: CONCLUSIONS....75
6.1. Limitations of the study....75
6.1.1. Sample....75
6.1.2. The Interview Process....77
6.1.3. Literature in the field....78
6.2. Outcomes of the research....79
6.2.1 Outcomes relating to initial interviews in the South African context....79
6.2.2. Outcomes of the interview process....79

RECOMMENDATIONS....85

REFERENCES....87

APPENDIX A....96

APPENDIX B....98

APPENDIX C....99

University of Cape Town

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University of Cape Town

CHAPTER ONE: INTRODUCTION

The intention of this thesis is to provide insight into the subjective perceptions of a selected sample of clients who utilised the services of the University of Cape Town Child Guidance Clinic (CGC) in 2003. These clients are families who attended the initial assessment sessions as part of the treatment or intervention plan.

The CGC at the University of Cape Town is the central training institution for the eight students selected annually to become clinical psychologists. As part of the practical training, student psychologists are required to work with families that are referred to the clinic via various referral sources. The most likely scenario is the family who presents at the clinic because a child in the family is experiencing emotional and or scholastic difficulties.

The approach is often determined by the nature of the problem. However the one consistent feature, which is largely structured according to the ethos of the training institution, is the method of intake. Even though the child may initially be recognized as the identified patient, the entire family or household is requested to be present at the initial interview. Many clinicians maintain that this is where intervention, assessment or therapy begins. Firstly, the trainee therapist telephones the family. The family or all members of the household are asked to come in for an initial interview. On arrival the family often wait in the waiting room, which is comfortable with some reading material available for adults and children as well as drawing material for younger children. Sometimes there are forms to be filled in.

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The therapist meets the family in the waiting room and accompanies the family to the designated room for the session. The therapist has the initial responsibility of framing the session for the clients. She/he will outline the ethos of working or therapy at the CGC, explaining the purpose of the one-way mirror and the supervision team behind the mirror, the camera and the video camera. The therapist briefly explains the length of the session, the intention in meeting the entire family, the fee structure and the issue of confidentiality for the family.

The next stage is known as the social or joining stage. The therapist aims to establish rapport with the family by showing an equal interest in every member. This is accomplished by eliciting details like ages, occupations and interests of each member. During this stage the therapist is expected to make a number of preliminary observations about the family based on their seating positions in relation to each other, behaviour, emotional responses and attitude towards being at the interview.

The third stage entails the exploration of the presenting problem. The therapist investigates this by taking a family history and a history of the identified patient, where appropriate. This means collecting information about developmental histories of children, or adults if it is required and includes educational, medical and psychiatric problems and illnesses, the development of the family and the extended family, occupational history, support structures, stressors and strengths of the family. Such information is usefully garnered by engaging with the family through the drawing of a genogram.

University of Cape Town

During the final stage of the interview the therapist aims to provide directives for the family as well as closure. There is guidance in terms of a plan for the identified patient or whomever the therapist believes is the identified patient. The course of action and the number of sessions recommended is usually negotiated.

The Child Guidance Clinic adopts a particular style of family therapy in order to facilitate effective supervision of students. This entails the session often being observed by the rest of students and one or more lecturers from behind a one-way mirror. The purpose of the "Greek Chorus"(Papp, 1980) is to advise the neophyte therapist when necessary, to be a supportive messenger and at times to act as a buffer with families expressing high degrees of conflict or emotion. In addition the session is videotaped and becomes a source of reference for the student's supervisor and the student. Even before the session begins the therapist negotiates the entire procedure with the family.

These strategies have been adopted by combining the principles of Minuchin (1974), Ackerman (1958) and Haley (1977), who are pioneers in the field of family therapy. Joining, circulatory feedback, economical interventions in the form of goal setting and contracting for a number of sessions and reframing are strategies employed using simple language with the family. The experience of talking together as a family is often perceived as strange because families are unaccustomed to talking openly about their difficulties and perceptions of each other in front of professionals whom they hardly know.

University of Cape Town

An important part of assessing children and families who present at the CGC is to understand the social, economic, political and cultural contexts from which they emerge. Bronfenbrenner, an ecological systems theorist (Berk, 2000; Dawes and Donald, 2000) put forward a bioecological model, which proposes that the child develops "within a complex system of relationships affected, by multiple levels of the surrounding environment, from immediate settings to broad cultural values, laws, and customs" (2000, p. 27). Within the South African context individuals and families have been deeply affected by the consequences of apartheid. At various strata families have been impoverished: materially, emotionally, physically. It is therefore important to become cognisant of the backdrop against which South African families present at the CGC.

A key question is the relevance of this style of therapy within the South African context. Historical imbalances have created situations where poverty has prevented individuals, groups and communities from making links between reality states and psychological distress simply because survival rather than the developing of the psyche is critical (Snoyman, 1989). Especially for such families where oppression has gagged any opinion, it may be unheard of to offer any critique or compliment within the confines of a building or institution that once represented not only oppression but elitism as well. Nell and Seedat (1989) question the value of traditional family therapy as practiced by the dominant classes in South African psychological institutions. Practical issues that have become a consequence of our political and socio-economic history and now intersect with the services offered by psychological institutions must be considered.

University of Cape Town

For families struggling in the here and now there may be pressure to accept the ethos of the CGC. However, often little else is available and families become quite solution focussed as they search for answers to their dilemmas.

The thoughts, experiences, benefits, opinions that clients take away as a result of their first encounter with professionals at the CGC should be evaluated against the background of the dynamics that shape the lives of South Africans. The result of such an evaluation could prove useful in establishing the value of these initial interventions at the CGC. While this study is a focus on the initial interview, it is not the only study conducted about the CGC. The CGC service is currently being evaluated across a number of its services, including outcomes of community projects and psychotherapy interventions (Deglon, 2004; Tilley 2004; Jardine, 2005).

The goal of this dissertation therefore is to provide a qualitative account of six families experience of their initial interview of the CGC. This analysis, based on the outcome of semi-structured interviews will explore the challenges and benefits of family interviews against the race and class background of post-apartheid South Africa.

University of Cape Town

CHAPTER TWO: LITERATURE REVIEW

2.1. Introduction

This chapter will cover the following areas: I will first briefly describe a period of shifting policies at the Child Guidance Clinic, which coincided with and was influenced by the turbulent years of transformation around the country (Melville, 2000). I will provide a brief overview of the method of assessment and intake interviews that is taught and practised at the Child Guidance Clinic.

Secondly, I will elaborate on literature relating to assessment and intake interviews within the context of family therapy as practised at international psychiatric or psychological and training institutions, which have influenced policy at the CGC of the University of Cape Town.

Thirdly, I will present an overview of the thinking of academics, theorists and mental health practitioners who are role players in family therapy, social work and psychology in South Africa. There are many social, economic and political issues that influence the subjective perceptions of practitioners and relevance of psychological assistance in mental health settings. The observation of the respondents in my study will provide in part a response to some of the questions and concerns around psychological intervention offered at the CGC with regard to initial interviews.

University of Cape Town

2.2.1. Changing policies and attitudes at the Child Guidance Clinic

The Child Guidance Clinic was established in 1935 and from its inception adopted practices and policies in keeping with international trends in psychology (Melville,

2000). It is located within a previously, white middle-class vicinity and like other institutions during the apartheid era served mostly the population that lived in the surrounding area. Gibson (2002) notes that this trend continued into the 1980s, until concerned staff and students at the CGC adopted a more progressive resistance to apartheid, offering support to some people of different racial and class groups, some of whom were victims of urban unrest, violence, detention, and torture (Melville, 2000).

As the staff at the clinic shifted to meet the challenges of changing client profiles one of the tasks was to review the "Maudsley", a psychiatric history-taking format. This instrument, which originated from the Maudsley Hospital in London, was used initially to ensure a standardised quality of information gathering. The Maudsley was used to obtain a history of the individual and his/her family. The original format began with an interview of one or both parents, followed by a separate examination of the child. Siblings were not seen. The use of the Maudsley involved an implicit assumption and acknowledgement that pathology usually existed within the individual who came from a nuclear family (Melville, 2000). However, at the CGC, individuals who were seen often had complicated family circumstances and did not come from a nuclear family context.

In 1982 the staff at the clinic revised and reworked the Maudsley and made:

> "provision for the index patient to be seen together to with his/her significant family members during the initial history-taking consultation. This practice allows the clinician to observe the interactions that occur amongst members within the family context, and it lays the foundation for family should this be later indicated in the light of the clinical findings. The revised Maudsley also

University of Cape Town

makes provision for information concerning the religious and political affiliation of clientele" (Melville, 2000, p 7).

The difference is that the earlier Maudsley document contextualised the individual in the family while the revised format was extended to take the history of the whole family, not just the parent and the child. The Maudsley instrument was abandoned altogether as a format for the initial interview in 2000.

2.2.2. Assessment interviews at the CGC

The CGC accepts telephonic and personal referrals from adult individuals and parents or guardians. The secretaries process the telephonic referrals, writing down identifying information like names, ages, contact details and very concisely the reason for referral. The CGC does not accept referrals from other agencies like schools because there have been cases where children were referred for intervention without consulting parents.

Usually supervisors or lecturers assess the suitability of the case before referring it on to the student psychologist, who then calls the family in for an appointment. The most important message is that the entire family is expected to be present at the initial interview. On arrival the family is given forms to fill in along with information sheets about the procedure the clinic adopts and the fees charged, which are based on a sliding scale according to the income of the family. This is done in the waiting room where there are books, paper and crayons available for children and magazines for parents. The student psychologist collects and accompanies the family to the designated therapy room.

University of Cape Town

Chairs are usually organised in a horseshoe shape with a little table and chair for younger children. The psychologist begins by introducing himself or herself and framing the session for the family. This entails an explanation for the use of the video camera, the one-way mirror, and the purpose of the supervision team behind the one-way mirror. Confidentiality is emphasised and the fee structure is discussed and possibly negotiated, depending on the family's financial circumstances.

The social stage involves the therapist becoming acquainted with the entire family. Identifying details are requested and families are questioned about the route of referral to the CGC. The therapist does not assume that the entire family wants to be at the session so time is spent asking each member how they feel about being present at the CGC. In the same spirit each member is asked what he or each believes the problem is. The major part of the session is spent trying to understand the reason for referral and then eliciting data, which supports the referral. Detailed histories of families are determined, often by using a genogram. If necessary certain members are seen on their own while other family members wait in the waiting room. The therapist aims to derive information from each member of the family at every stage In the final part of the initial interview brief feedback is proffered to the family and subsequent appointments are set up, depending on the course of action to be pursued.

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2.3. Assessment Interviews

2.3.1. The Family

The Penguin Dictionary of Psychology (1995) attempts to be inclusive in its definition of the family: in its strictest definition it refers to the nuclear family, broadly it refers to the extended family members. The definition also includes a group of members

with close ties. The strictest definition corresponds with the Maudsley: the family is a nuclear unit consisting of parents and children of their own. The broader definition includes the term extended family as well as any group of people who have a connection, even though it may not be biological.

Barker (1998, p 14) stipulates that there are many more types of families the therapist should consider: such as childless couples, one-parent families, adopted families, reconstituted families, communal families, homosexual families as well as ethnically different families. He however points out that it is equally important to hold the concept of the "healthy family" as a norm against which one can assess families who present for treatment. His view is that healthy families meet the needs of all its members, emotionally and psychologically, and encourage autonomy at appropriate stages (ibid, p 13).

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2.3.2. The emergence of Family Therapy

Allmond et al (1979) note that traditional psychoanalysts were opposed to working with families because family members thwarted the transference between therapist and patient. Even though Freud preferred working with individuals, in the case of Little Hans he worked with the father instead of the child (Allmond et al, 1979; Bloch and LaPerriere, 1973). Family therapy began to take on significance especially in the 1950's. Group psychology, new psychiatric approaches and a growing understanding of the patient as part of a social system influenced psychological thinking. Bloch and LaPerriere (1973) believe these shifts championed the case for family therapy by postulating that "change which is significant to the psychotherapeutic endeavour, takes place in the family system" (p. 1).

2.3.3. The Purpose of the Initial Interview

No matter what the outcome and who the identified patient may be, within the field of family therapy, there are some clinicians who advocate the essential benefits of meeting the whole family or household at an initial meeting (Franklin and Prosky, 1973; Rutter, Taylor and Hersov, 1994; Barker, 1998; Minuchin, Colapinto and Minuchin, 1998; Sattler, 1998, Kumar, 2000). The term "initial interview" is a reference to the family attending therapy for the first time together for an assessment of the referral problem. Wilkinson (1987) defines the term assessment as "the process of understanding problems in order to make an intervention which is designed to help solve them" (p. 369). Wilkinson points out that assessment is not the same as a diagnosis, which has "medical connotations" and refers "more to the final, decision making aspects of the assessment" (p. 369).

Haley (1977) is of the view that to begin an assessment with one person is to begin with a "handicap" (p. 10), as each individual will most likely present his/her own version of the problem. . By requesting the entire family's presence the organisation or therapist essentially communicates to the family the priority placed on the importance and value of the family as a whole (Minuchin et al, 1998).

Franklin and Prosky (1973) assert that the initial interview is most effectively used to diagnose the problem. Barker (1998) and Rutter et al (1994) maintain that it is useful for a number of reasons: individual problems are best understood within the context of family dynamics, the behaviour of one member may affect that of one another and families themselves are hardy enough to assist in providing solutions. Moreover, Sattler notes, the therapist is able to elicit "the extent to which the family is using

University of Cape Town

functional or dysfunctional strategies to cope with the child's problems" (1998, p. 150).

Haley (1977) suggests that issues of power become more evident when the family is present initially. The therapist is able to make better sense of the hierarchy in the family or the lack of organisation within the family. Kaplan and Sadock point out that "family therapy aims to bring to light the often hidden patterns that maintain the group's balance and to help the group understand the purposes of the pattern" (1998, p. 904). According to Carr (1999) the therapist may use interviews with the family to test the validity of his/her preliminary conjecture about the problem. This involves taking a complete history and understanding the family's physical and social circumstances. Kumar (2000) also notes that assessment is a two-way process between the therapist and family, or as Minuchin (1977, p. 206) explains "a social gathering" that builds rapport. Wilkinson (1987) asserted that it is "a problem-solving process" (1987, p. 368) that enables the family to be understood both subjectively and objectively. This creates an atmosphere of openness and inclusion with the family (Sattler, 1998).

2.3.4. When a family intake is not advised

It is important to note that therapy is most effective when the entire family is willing to be a part of the therapeutic process. Families that resist coming in together should be viewed as an important prognostic indicator for the therapist (Franklin and Prosky, 1973). There are a number of reasons why the initial family session might be contra-indicated. Kumar (2000) points out that when sexual abuse is the problem and the perpetrator is a member of the family, a family session could exacerbate the situation

University of Cape Town

for the victim. The threat of domestic violence is also a potential indicator in abandoning the family meeting. Barker (1998) accentuates a number of factors for consideration. If families present too late for successful or meaningful intervention, then it is best not to meet. Intervention can lead to dangerous consequences like attempted suicide or even greater distress for the family.

2.3.5. The Pre-Interview Stage

2.3.5.1. Referral Sources or Agents

Referrals may come from a number of sources and organisations. It may come from a parent, especially when changes in the family have affected the child. Schools regularly refer children when there is an indication of academic and emotional difficulty. If there is a crisis, referral may come from a children's or welfare organisation (Kumar, 2000). Douglas (1992) stipulates that if the referral is from an organisation then it is vital to gain the parents' perspective, in their own words. Some families are referred by an agency like a school, who may have secret agendas, perhaps to expel the child. Families might also have agendas, such seeking support in the event of a court case for their child. The therapist has to verify all details regarding the presenting problem with the referring agency. There are occasions when parents who are embroiled in a custody battle aim to discredit the other party. In this case referral to a mediation expert is the suggested route.

University of Cape Town

2.3.5.2. Initial contact with the family

Many clinicians articulate the idea that assessment begins with the initial telephonic contact with one member of the family. Clinicians caution therapists to avoid long conversations, especially since this first contact lays the foundation for building trust

(Karpel and Strauss, 1983). Allmond et al (1979) argue that a caller may use the initial contact to further his own agenda. Andolfi (1979) enumerates the various possibilities for this. The caller may feel entitled to be the family's spokesperson, and in doing so assume a privileged relationship with the therapist, especially if her/his version is heard first. This may lead to the assumption that the therapist can be manipulated to meet the callers' demands. Some callers use the opportunity to locate the blame for the problem on a child or another member. Yet others communicate their sense of despair or embarrassment. Any such attempt should alert the therapist that while this is but one version of the problem it could be used to formulate a hypothesis about the family problem.

Whether the therapist makes use of a secretary or makes contact herself/himself, it is important to ensure that important details are conveyed to the family. These include the date and time of the meeting, the venue, who should come along, the procedure on arrival, the length of the first session, the purpose of the first session and details around costs or billing (Barker, 1998).

University of Cape Town

2.3.6. The Interview

2.3.6.1. The Therapy Room

Very little literature is available on the waiting room, where families often fill in forms and wait for the therapist to collect them. Brief references are made to the place being comfortably child centred with books, paper and crayons available for use.

Slightly more information is available on the therapy room, with an emphasis placed on the manner in which the therapist places the chairs. Karpel and Strauss (1983)

suggest that chairs be placed in the form of a horseshoe. Family members may sit anywhere they choose. The places they occupy in relation to each other are of importance to the therapist in understanding alliances and splits within the family (Haley, 1977; Minuchin, 1977; Karpel and Strauss, 1983).

2.3.6.2. First stage of the interview

There are many names for describing the process at the beginning stage of the first interview. It can be called "joining" (Minuchin, 1974), "social stage" (Allmond et al, 1979) "building working alliances" (Karpel and Strauss, 1983) or "establishing rapport" (Barker, 1998). However, even prior to this the therapist frames for the family the procedure and agenda of the session (Haley, 1977; Minuchin, 1977; Andolfi, 1979). The therapist begins by explaining the use of the one-way mirror, the use of the supervision team, the camera, the possibility of interruption and the fee structure.

2.3.6.3. Second Stage of the Interview

The joining or social stage encompasses many techniques and approaches. The exchange of names, enquiries about each member and other pleasantries set the stage for trust and collaboration (Andolfi, 1979; Douglas, 1992). The therapist has to be quite judicious in selecting to whom questions should be addressed initially, avoiding especially the identified patient, or the parent who may come across as the dominant figure in the family. By establishing an atmosphere of neutrality the therapist conveys the hidden message that everyone is equally important and will be treated fairly. Karpel and Strauss maintain "the therapist's earliest goal is to relax the family as

University of Cape Town

much as possible, and to start to establish therapeutic alliances with each family member" (1983, p. 117).

Haley (1977) advises the therapist to be aware of the embarrassing position the family is placed in. It is understandable that families will be defensive, expecting perhaps to be blamed for the problem. Therefore the mood of the family should be carefully noted. It is vital to see how they respond to the therapist and each other. All these signals are useful information in assisting the therapist in formulating hypotheses about the problem and the way in which the family engages with each other (Franklin and Prosky, 1973; Haley, 1977; Andolfi, 1979). Again, any conclusion should remain tentative and should not be shared with the family before rapport and trust is established. One must not forget that a hypothesis may be incorrect, especially when one is faced with a family who is of a different cultural milieu (Zeitlin and Refaat, 2000).

Barker (1998) stresses the value of establishing rapport with family in the early stages. He feels the family should not be challenged until rapport is established. Only then will the family be secure enough to allow the therapist to propose radical suggestions to them. Barker's (1998) experience is that many families have long-standing difficulties with authority figures and may perceive the therapist as a powerful figure. To challenge a family early on in the session may create conflict or cause withdrawal.

The therapist has to impart genuine warmth and interest in the family. This is communicated by allowing the family freedom to express themselves in their own

University of Cape Town

words, but also for the therapist to use the language of the family. Warmth is also communicated through non-verbal communication such as body language, tone of voice and a sensitive approach that reflects an understanding of the context of the situation (Barker, 1998).

2.3.6.4. Third Stage of the Interview

Once preliminary contact has been made and the foundation laid for rapport, the therapist will move onto the crux of the interview. This is referred to as the presenting problem. Asking each member how he or she perceives the problem has numerous advantages. The whole family is included in the discussion, making each one feel valued. This of course provides the therapist with a broader perspective of the problem within the family (Karpel and Strauss, 1983).

In trying to figure out the factors causing and maintaining the problem, the therapist aims to elicit historical, developmental and current information from the family (Rutter et al, 1994; Kumar, 2000). In addition, the therapist makes observations about the structure, the communication patterns and the feelings of the family (Minuchin, 1974; Kumar, 2000). Minuchin (1974) advises that one will make very little progress if one does not understand the family within the all the contexts it operates: be it social, political, economic or cultural.

University of Cape Town

Therapists can gather information through circular questioning (responding to an answer by asking more questions and asking other members for their opinion by questioning them as well) (Barker, 1998). Through this process the therapist also feeds back to the family his neutral and non-judgemental observations and comments.

Another method of extracting information is to ask specific probing questions about the family's daily activities, which allows the therapist a deeper understanding of the routine and organisation of the family (Karpel and Strauss, 1983).

Some theorists advocate the use of a genogram or family map in gathering data, which is non-threatening and appealing to the family (Rutter et al, 1994; Barker, 1998; Carr, 1999; Kumar, 2000). This can be done by involving the whole family and can cover a range of pertinent issues and concerns. A genogram "gives a concise, graphic summary of a family's current composition" (Barker, 1998, p. 83). The genogram also functions as a constructive tool in building a three-generational picture of the family. Carr (1999) recommends the use of a lifeline for little children who may express their feelings by drawing happy, sad, angry or worried faces of family members alongside the key events in the child's life.

2.3.6.5. The end of the interview

The manner in which the therapist draws the interview to a close is crucial. The focus is first on summarising the core aspects of the interview (Sattler, 1998), and then on "defining areas of difficulty and on goals for change" (Rutter et al., 1994, p. 72). The way forward for the therapist and the family is of course dependent on the presenting problem but there are a number of standard guidelines to follow at the end of the session.

Barker's (1998) approach is to allow the family a brief interval before the close of session. This break gives him time to work on a formulation before providing feedback to the family. He suggests initial interviews be closed with reassurance to

University of Cape Town

the family that they are doing the best they can by offering what he calls "positive connotation" (1998, p. 93). Clinicians accentuate that families should be given directives about the treatment plan the therapist has formulated (Haley, 1977; Almond et al, 1979; Douglas, 1992; Barker, 1998; Carr, 1999; Kumar, 2000).

The treatment plan will vary, depending on the nature of the problem: it may be that couple therapy, play therapy, individual therapy, any type of assessment or family therapy is advised. The therapist will advise on the number of sessions that will form part of the treatment plan. If medical intervention is required she/he will make the necessary recommendations. Administrative details like the next appointment and the fee structure will form part of the closure.

2.3.7. The One-Way Mirror, Videotaped Interviews and the Supervision Team

2.3.7.1. Background

The idea of family therapy emerged in the 1950s. Christian Midelfort (1957) and Nathan Ackerman (1958) were among the first to point out the significance of the family in therapy. Ackerman argued that family work would deepen the study of mental illness. Several clinicians emerged as pioneers in the 1950s and formed a group to study schizophrenics and their families. These began with Bateson in 1952, Haley, Weakland and Fry in 1953 and Jackson in 1954. Jackson founded the Mental Research Institute (MRI) in 1959 and was joined by Satir soon after. She influenced many therapists with her interest in the psychodynamic functioning in families (Barker, 1998). Whitaker began practising in Atlanta in 1946 but developed his own style from the mid-1950s. Borzormenyi-Nagy formed a psychiatric institute in Philadelphia in 1957. Bowen and Laing were pioneers in the 1960s. Many of the

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original studies began with trying to understand the schizophrenic patient within the context of the family (Barker, 1998).

During the 1960s Haley developed a directive style of therapy where the therapist instigates change within the family by encouraging them to perform an activity. Another key figure to emerge in the 1960's was Salvador Minuchin, an Argentinean psychiatrist. He developed the Structural system of family therapy after realising that his approach in working with slum families was limited.

> "Structural therapists are interested in how families are organised in sections, or subsystems, and in the boundaries between these parts; also in the boundaries between the family unit being studied and the wider community. Therapists using this model see family problems as related to their structure" (Barker, 1998, p. 5).

It was Minuchin who proposed the use of the one-way mirror or screen. Initially therapists simply reported the session to their supervisors (Barker, 1998). Families are complex and it is of immense benefit if the trainee therapist is watched. The use of a one-way mirror to do this is helpful and non-invasive at best, but intrusive and uncomfortable at worst. It was another clinician, Montalvo, in 1973, who advocated direct supervision as a method of training therapists (Selvini and Palazzoli, 1991). Andolfi (1979) pioneered the use of audio-visual equipment to enhance the training of therapists. As a teaching tool it can be utilised to allow the trainee to view the family system objectively while at the same time being engaged with the family in a mutual task.

University of Cape Town

2.3.7.2. Supervision using the one-way mirror and the videotape

> " Family therapists have opened up the process, both by the common practice of having observers watch and listen through one-way observation screens, and by the use of videotapes which enable therapy to be reviewed, if necessary, repeatedly" (Barker, 1998, p. 6).

Papp (1980) has explored the benefits of the consultation team, which she refers to as the "Greek Chorus, providing a running commentary on the interaction between the family and the therapist" (p. 49). The consultation team can support the family by offering compliments. In places such as the Ackerman Institute for Family Therapy experienced practitioners work as a team and often the therapist is one of the experienced members of the team.

> There are occasions when the team will reflect the confusion and split in the family by being divided in their understanding of the problem. After a discussion they will reflect this to the family. Sometimes, without awareness the therapist engages with family in forming a therapeutic triangle, where she/he becomes enmeshed in the family system. This triangulation is clearer to the team and when brought to the awareness of the therapist allows for shifts to take place within the therapeutic endeavour. Thus the team is able to offer the therapist objectivity from behind the one-way mirror.

Barker (1998) notes that it is on rare occasions that families object to being watched. He suggests that families who defend against being watched can be reassured that a team, rather than one individual therapist, is taking care of them. He adds that when the therapist is a student, live supervision is critical, and it is unethical to conduct the session without the presence of a supervision team. If the family still opposes the presence of the team, then alternate arrangements for their treatment must be made.

University of Cape Town

Barker's conclusion is that it is individuals with paranoid personalities or paranoid psychoses that most object to being watched.

A study conducted by Persaud (1987) investigates the effects of the one-way mirror on family therapy. While the team behind the one-way mirror is viewing the family, the family see images of themselves in the mirror. He cites numerous studies (Wicklund and Duval, 1971; Sheier et al, 1974; Carver, 1975; Diener and Wallbom, 1976;Gibbons, 1978; Bearman et al, 1979) that have shown that mirrors in rooms influence behaviours, possibly as a result of individuals becoming more self-aware. Persaud (1987) describes a study by Archer et al (1979) where two groups were asked to disclose information to an individual and a tape recorder, while in a room with a one-way mirror. One group was asked to disclose intimate matters while the other group was asked to disclose more superficial matters. The former group rated their experiences as more negative whereas the ones who disclosed less private information were more positive. The study concludes that the presence of mirrors reinforces negative perceptions. The may suggest that when individuals regard private information as secrets they may be reluctant to talk and may withdraw by being quiet or not complying by refusing to answer questions.

Persaud (1987) believes that similar situations need investigation. However, he recommends that families be seated so that they do not face the one-way mirrors. He acknowledges that families may feel awkward initially, but this may soon wear off. He is of the opinion that therapists often position themselves so that they do not have to look at the mirror but families are expected to simply comply and comfortably reveal their most personal issues.

University of Cape Town

Knott and Espie (1997) also conducted a survey of families' perceptions of the one-way mirror. Forty-three families responded to a questionnaire. The findings of this particular study concluded that families who read the information leaflet about the one way-mirror prior to the session forgot about the mirror soon after the session began. This survey also deduced that families would welcome the opportunity to meet the members behind the mirror to demystify the process.

Videotape recordings of the family session have a two-fold purpose. The first purpose is for the therapist to learn more about the family in hindsight. The second benefit is for the supervision, so that therapists can analyse their way of working (Barker, 1998). However, the therapist should be equally aware that the family may express discomfort about being videotaped and this should be negotiated sensitively (Barker 1998).

2.4. Features that may impact on the initial session

2.4.1. The notion of family secrets

An issue that often goes hand in hand with the consequences of being watched by a team behind a one-way mirror is the issue of sharing secrets within the context of family therapy. Karpel (1980) describes three types of secrets within the family: individual secrets that are known by one person only; internal family secrets where at least two people know a secret which they do not share and shared family secrets which is known to the whole family but not shared with others outside the family in a bid to perhaps protect one member.

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Family members, very often children feel that to reveal a secret is to betray family members or show disloyalty. On the other hand, holding a secret may make the "secret holder" (1980. p. 297) feel powerful, especially when it can be used as a threat or a bargaining tool. Secrets within a family can strengthen alliances or boundaries, which may have positive or negative connotations for the family. It may be that alliances can protect members, but it may have the effect of dividing the family members (Kramer and Reitz, 1980, Selvini, 1997).

It is important to ascertain who is involved in keeping the secret and to what extent it causes suffering for the identified patient and distress in the family. It is not the secret that is important but how it will be revealed and the effect it may have on the family. This decision to encourage disclosure must be cautiously considered by the therapist: would members of the family be able to move on, would it change the system to benefit the identified patient and/or the rest of the family (Selvini, 1997).

At the same time the therapist is faced with the dilemma of whether she/he should disclose information about herself/himself to facilitate the therapeutic alliances. Roberts (2005) cautions the therapist against revealing information that might be less helpful. Sometimes disclosure may create pressure on the clients to feel responsible for the therapist and the client might also feel that he/she is not completely attended to (Pocock, 1997).

2.4.2. Perceptions of the therapist

Selvini and Palazzoli (1991) highlight the various areas where the objectivity of the therapist may be compromised, including where there are cultural differences and

University of Cape Town

when the therapist is unable to communicate with someone from a lower socio-economic class. Age differences between the therapist and the families may lead to a therapeutic impasse; the therapist's style of working may not match the family's temperament and the therapeutic process may be hindered by certain traumatic experiences of the therapist, which may be similar to the family's experiences.

Bennun (1989) notes that the individual clients' perceptions of the therapist influences outcomes. He was interested in whether the views of family members affect outcomes and if some member's perceptions are of greater consequence than others. Though this study was conducted with only 35 families, with complex variables affecting the outcome, one small but significant finding was revealed. If fathers rated the therapist as more active and competent then, the outcome for therapy was more positive. Bennun (1989) warns however against making assumptions that mothers are less likely to influence the outcome of therapy. The attitude of the therapist to the father and the role of the father within the context of his family are important variables to bear in mind.

An earlier study by Merrington and Corden (1981) (which is discussed in the next section) notes that some families have an expectation that the therapist should disclose personal information about herself/ himself. The advantages of disclosure may only be determined by the merits of the case and whether it will positively affect the outcome.

Figley and Nelson (1989) note that many trainee therapists are expected to see families within a month of beginning their training, often having received no formal

University of Cape Town

training. A comprehensive study was conducted, asking participants to rate generic skills and personal traits they thought family therapists should possess. While it is difficult to measure traits, the following skills that could be taught were regarded as important: interviewing skills, establishing rapport, reinforcing positive behaviour, separating process from content and identifying manageable goals (p. 362). Figley and Nelson (1989) cite various skills therapists should possess but highlighted those noted by Falicov (1981, cited in Figley and Nelson) as observational, conceptual and therapeutic.

Pocock's (1997) contention is that often families feel misunderstood by the therapist. In support of his argument he draws on contemporary psychoanalytic and postmodern approaches to family therapy, reiterating that, "a listening therapist helps to create a space for thinking in the family" (p. 287). Pocock (1997) argues that it is conversation between the family and the therapist that facilitates meaning and understanding (p. 287).

2.4.3. The family's expectations of therapy

Merrington and Corden (1981) summarise what they considered to be the main tenets of family therapy. The first is that though the identified patient is referred for treatment the family as a system is considered as the patient. Another principle is that the therapist manages the session, providing guidance and support for the family. Lastly the objective is to facilitate change in the family.

A qualitative study of eight families' perception of family therapy (Merrington and Corden, 1981) identifies some useful overall findings that are directly relevant to this research. One key result is that families were taken aback at the expected

University of Cape Town

involvement of the whole family. A second challenge was the notion that the therapist should be more of an expert and offer advice. A positive outcome, despite the small sample, was that six families of the eight families constructed the intervention as helpful.

2.5. Family Therapy within the South African Context

In Europe and America family therapy institutions, assessment interviews are standard features of the treatment or intervention strategy. In South Africa very few such institutions exist. Psychological institutions in South Africa have been products of the apartheid system and have been used to maintain the status quo (Suffla et al, 2001). Through the transition towards democracy and a non-oppressive society the discipline of psychology has attempted to move away from its reputation of being white dominated. This has meant re-positioning its role in a society where psychological services are needed by all but are still largely denied to the majority.

There are constant calls for a relevant South African psychology to emerge. Models which offer individual, family or couple therapy primarily are still regarded as elitist as it is an expensive treatment, which very few can afford. In some institutions traditional models, which may not be regarded as racist, are still employed but there is pressure to deliver quickly to more people. Against this background I examine the complex state of South African society as a consequence of discrimination and the status of family therapy.

Sachs (cited in Campbell, 1990) points out that the state was shrewd in disregarding family life at every level. Laws that enforced the forcible removals and migrant labour

University of Cape Town

destabilized black families. Biersteker and Robinson (2000) note that apartheid policies have devastated the lives of many children and their families. 60% of South African children are poor. In addition, poverty is evident especially when people are black and unemployed, homes are female headed, the level of education is lower than matric and there is an increase in the number of young children (Office of the Deputy President, 1998 as cited in Biersteker and Robinson 2000).

During the 1980's family therapy has been practised at various institutions across the country. In 1989 the Mamelodi Counselling centre was set up in Mamelodi, Pretoria. Here the vast majority who attended therapy were adults. Very few families were available for therapy in the first year (Lifshitz et al, 1992). At the same time the centre for family therapy had been established as part of the department of Psychiatry at Groote Schuur Hospital (Phillips, 1992). European and American models often influenced the modality of family therapy. As the number of low socio economic status black families increased the traditional model was challenged about its relevancy within the context of poor communities where so few people had access to psychological help (Mackintosh, 1992). A study by Magwaza (1992) establishes that intervention must be multi-systemic to understand the challenges and pitfalls facing migrant families. Magwaza (1992) notes that change at family or individual level is insignificant unless oppressive laws were abolished. This highlights what Bronfenbrenner underscores: that the macrosystem inadvertently affects the microsystem and change will not occur if systems do not change.

University of Cape Town

Gibson (2002) also documents the consequences of political conflict on people's lives. Though trauma in this context has been documented, the emotional consequences have been

> "harder to measure and code. They exist in people's ideas about themselves, their country and their future. Fundamentally they also exist in the quality of relationships people develop with one another – the degree to which these can be open, respectful and compassionate or are damaged by hatred and suspicion" (2002, p. 10).

Ahmed and Pillay (2004) note that while the level of mental health problems have escalated psychology, as a discipline, has been notably ineffective in developing mental health interventions. They reiterate that the factors that have entrenched the black majority in a state of impoverishment and powerlessness have not changed. Poverty spawns violence. Access to mental health care is still not possible for the majority who continue to live in townships, far away from the anyway limited government resource services where assistance is only available to the acutely distressed for a brief period of time. Even though mental health problems are on the increase, globally, the disparities in terms of access to mental health care for rich and poor remain huge. Inaccessibility to mental health care is further intrinsically linked to the notion that mental ill health is constructed as that which arises from within the individual instead understanding the role of the environment and greater social and political context.

University of Cape Town

Ahmed and Pillay (2004) further note that training for clinical psychologists is still very Euro-centred and does not prepare future psychologists to work in communities where physical and emotional deprivation are correlated. Furthermore, psychologists

are mainly English or Afrikaans speaking while the majority of South Africans speaks Xhosa and Zulu. Thus there are hardly enough psychologists available for the black majority and access to psychological services are mainly available for those who can afford it.

It is apparent that the complexity of social and interpersonal relationships is influenced on many levels. Bronfenbrenner's bioecological theory of child development has intrinsic value in understanding the complex nature of South African society. The theory is dynamic and takes note of external events that constantly influence the child's development and relationships.

There are four levels which impact on the child's internal and external environment. The first is what Bronfenbrenner terms the microsystem, which is the relations between the growing child and those that form part of the child's immediate environment. While the interaction between parent and child is mutually interactive the child's personality has a bearing on the outcome of the relationships.

The second level is called the mesosystem and refers to the connections between the child's immediate settings such as the home, school, neighbourhood and child-care facilities. The development of the child will be fostered by the parent's involvement in these structures.

The exosystem is the third level and refers to any social settings that have an indirect influence on the child's development like the parent's place of employment, the health and welfare services. This level includes the parent's social networks and

University of Cape Town

family support systems. Where support is less or absent and unemployment is high there is an increased rate of conflict and child abuse.

The fourth level is the macrosystem, which consists of the laws, customs, values and resources of any given society that have an impact on the child's life. Laws that emanate from wealthier, industrialised nations have better and more protective laws for children.

The chronosystem is not a level but refers to the manner in which a child's environment changes dynamically both from influences outside the child as well as the shifts that occur within the child (Berk, 2000; Dawes and Donald, 2000).

Bronfenbrenner's theory is of particular relevance within the context of a country that has undergone a traumatic transformation. Children and their families have suffered. Divisive laws, little or no income, poor housing and education, communities ripped apart by abuses of all kinds are poor prognostic indicators for the stability of the child within his family.

In support of the bioecological theory, Bernstein (1990) also advocates an analysis of the various systems that impact on the family. Buhrman (1990) contends:

> "any viable psychotherapeutic approach for the people of South Africa must have great depth and width. It must encompass the individual, the family, bodily factors, socio-economic conditions, cultural norms and values and for the black people, the role of the clan, living dead and also the distant, numinous ancestors who are not clan-linked"(p. 204).

University of Cape Town

Dawes and Donald agree that intervention in whatever form must be guided by "ecological sensitivity" (2000, p. 19). The relevance of Bronfenbrenner's theory is perceptible in any given impoverished South African family. There is almost no support or resources available at the microsystem (the family structure), the mesosystem (family or child-care support systems), the exosystem (health system) or even the macrosystem (the financial resources) (Dawes and Donald, 2000). Rojano's (2004) ground breaking Community Family Therapy (CFT) where poor families are encouraged to be agents of change can be adopted as a model for intervention in many communities within the South African context. Rojano's CFT is a

> "multi-pronged approach that includes interventions in three different areas of the family and community ecosystem… The intervention …also proposes to design a lifelong action plan that includes elements of personal growth, economic development, and leadership training" (2004, p. 60).

Rojano (2004) also notes that therapists have to address the issue of poverty on a daily basis. He cites Minuchin (1974) who postulated that survival is essential to the poor family. Rojano isolates various factors and signs that are frequently encountered in low income families. These are individual signs (personal problems), systemic signs (family matters), internal factors (household issues) and external factors (community problems). However Rojano concedes that CFT can only be effective if there is ongoing support from various organisations and institutions.

More than ten years after democracy has been officially introduced, the status quo of the poor is prolonged, as is the status of psychology as an elite discipline. Currently it is struggling to make shifts in terms of membership and its position as a professional body. However it has not yet addressed the issue of how best to intervene in

University of Cape Town

communities. Theorists and clinicians practising within the South African milieu have themselves been overwhelmed by the pressure of working with large numbers of impoverished children and their families. The lack of resources and poor infrastructure remains frustrating at all levels. The majority of South Africans are destitute and access to support structures like the Child Guidance Clinic is still prevented by geographical distances and financial difficulties. With such overpowering needs the issues of how to best intervene have taken precedence. The focus is therefore to intervene in as effective a manner as possible so that interventions take place on multiple levels thus having positive outcomes for families and communities alike (Mackintosh, 1990; Le Roux, 1990; Dawes and Donald, 2000; Louw, Donald and Dawes, 2000; Ahmed and Pillay, 2004). Thus the literature at this stage about assessment interviews in isolation in South Africa remains sparse

While family therapy continues, the situation in many low socio-economic status communities has created a sense of urgency around intervention for communities. Psychologists have begun addressing the role of psychology within the context of the South African situation (De la Rey and Ipser, 2004). This state of limbo for family therapy practitioners has resulted in barren annals of assessment interviews in South African family therapy.

This scarcity of South African literature has forced most therapists who practice family therapy or regularly conduct assessment interviews to draw support from literature emanating from America and European countries. That South African families are assessed using overseas models makes the need for such an evaluation

University of Cape Town

even more pertinent in determining the worth of such a method in the face of the challenges the disadvantaged South African family faces.

In the light of this need, the CGC is at present conducting a number of research programmes in an attempt to evaluate its services to the public. Deglon (2004) conducted telephonic interviews with 24 clients who utilised the services of the CGC in 2003. She found that the majority of clients were pleased with the service they received at the CGC. Those who reported satisfaction with the services rated the therapeutic alliance to be an important indicator of the successful outcome of the intervention. This study is an attempt to furnish a more in depth account of the clients' perception of the service offered by the CGC. In doing so, this research will continue to evaluate the service provided by the CGC and endeavours to interrogate the appropriate of the assessment interview format in a South African context.

University of Cape Town

CHAPTER THREE: METHODOLOGY

3.1. Introduction

In this chapter I will attempt to describe and elucidate the rationale for employing semi-structured interviews as a useful instrument for gaining insight into the subjective perceptions of the participants. After expanding on my method of data collection I will discuss all the factors that may affect the outcome of the research such as ethical considerations and reliability and validity.

3.2. Evaluation of semi-structured interviewing

In support of the use of this method of collating data Kvale is accurate in describing interviews as "inter views" because it is "an inter change of views between two persons conversing about a theme of mutual interest (1996, p. 2). Therapy, be it between a therapist and a single client or a family can be aptly viewed as a relationship where intersubjective dynamics are played out. Such a relationship can be best be evaluated by opening up an honest dialogue, exploring feelings and validating opinions. The interviewer needs to be reflexive about differences in language, culture, class, educational background, race and values. Reflexivity around the issue of language is vital when planning the research question: working out whether language will be employed to construct meaning or whether it is simply a tool for understanding meaning (Kvale, 1996; Willig, 2001).

University of Cape Town

Willig (2001) maintains that researchers use semi-structured interviewing frequently because the analysis of data is compatible with a variety of theories. It can be relatively uncomplicated to plan and execute, if the research question is clear-cut. If it

is complex then the process can become complicated. Although the researcher directs the research question, the style is non-directive allowing the respondents "to speak freely and openly, and to maximize their own understanding of what is being communicated in the interview" (Willig, 2001, p. 22). Described by Flick (1998) as a method that is partly open and partly guided, it encourages the interviewer to be less rigid and more sensitive in her expectations of the participants' responses. Kvale concurs: " Interviews are sensitive to the qualitative differences and nuances of meaning, which may not be quantifiable and commensurable across contexts and modalities" (1996, p. 44).

Therefore the success of the interview is dependent on the rapport that is established between the interviewer and the interviewee. It is the responsibility of the interviewer to further ensure that the space created for communication encourages the interviewee to share information linked to the topic, and not to convert the interview into a therapeutic session where the interviewee discusses his/her difficulties and the interviewer responds as a therapist might, instead of conducting the interview according to particular guidelines.

Silverman (1993) makes clear the distinction between an etic analysis where an external, perhaps objective perspective is employed and an emic analysis that focuses on the internal perspective of the subjects. The latter enables the researcher to flexibly explore the subject matter " through the eyes" of the participant, attending carefully to the construction of meaning and action within social contexts (Silverman, 1993; Kvale, 1996; Willig, 2001).

University of Cape Town

Semi-structured interviews have numerous additional benefits: they obviate difficulties in getting information from people who may be illiterate, like grandparents or those who are not yet completely literate like young children. Once families acquiesce to participation in the research, race and home environment (if it is conducted at their homes) of the interviewees will be known and enhance the study in terms of racial, cultural and socio-economic influences. Probing would be implemented when inappropriate or non-committal responses are supplied (Babbie and Mouton, 2001).

3.3. Research Design

The first step in planning a research design is to thematize one's research question. In my case it was to explore the way in which the participants perceived their initial encounter at the Child Guidance Clinic. Research about the CGC has focussed largely on its historical development, shifts in policy and perceptions of role players (Hay, 1990; Smit, 1997; Melville, 2000, Elkon, 2001). Only the most recent study (Deglon, 2004) documented the perceptions of 24 clients who utilised the services of the CGC.

When a family presents at the clinic many experiences are novel, but none more so than the first. The family are expected to talk about their problems with each other and to the therapist with the knowledge that eight or more people are witness to their dilemma via a one-way mirror. In addition this group of witnesses discuss their case, they are videoed and possibly interrupted by a knock on the door. These experiences laid the foundation for the formulation of my questions (Appendix B). These questions would form the impetus to gain some insight into the experiences families had in their initial contact with the CGC. My exploratory study was shaped by the

University of Cape Town

benefits of hermeneutical enquiry: to hold a meaningful conversation about a particular experience and then to further interpret the meaning that can be derived from that conversation.

3.4. Sample

In selecting a sample, it is crucial to consider the variables that will inform the outcome of the study. In any given year approximately 55 to 65 families and individuals will present at the clinic but the sample had to be selected from those families who presented during what is known as "live supervision". Historically this has taken place on a Thursday afternoon, which until 2004 has been taught and supervised by an experienced family therapist. However not all families selected to form part of the sample were prepared to be interviewed. Moreover, certain families were not exposed to the "team" behind the one-way mirror. The families chosen for the interview were all seen at the CGC for the first time during the Thursday afternoon slot. At the time of the interviews one family revealed that though they were seen for the first time on a Thursday afternoon, there was no one present behind the one-way mirror. They were included in the sample.

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Six families were interviewed in their homes for about 20-40 minutes each. Initially eight selected families were sent a letter (Appendix A) explaining the purpose of the research, requesting their participation and outlining the procedure that would be followed. Most of the families claimed they had not received the letter or they were not available. The approach was then altered as more families had to be approached than was initially planned for. Only when families agreed to participate, were they given the letter. A number of issues were reiterated: like confidentiality, the guarantee

of privacy by changing identifying information and the offer of follow-up debriefing sessions should families' feel the trauma for which they initially sought help with, was revisited. Questions pertaining to the research and the letter were encouraged before the interview began.

The following table summarises information about the family and the therapist who worked with them. All names have been changed to protect and respect the identities of the families.

Names* and ages** of family members	Reasons for referral	Type of Family	Gender and age** of therapist
Iris (12) and Mavis (40) North	Scholastic and emotional	Single parent, separated, only child	Male (32)
Denise (10), Trevor (14), Cheslyn (41) and Vera Williams (38)	Scholastic	Married, two children	Female (23)
Miranda (12), Hamish (16) and Angela (38) Ingram	Emotional	Single parent, divorced, two children	Female (29)
Sarah (12), Vernon (7) and Patty (35) Smith	Emotional	Single parent, divorced, two children	Male (32)
Shaun (10), Charne (17) and Mandy Visagie (43)	Scholastic	Single parent, three children (eldest not at session)	Male (32)
Yolanda (7), Dylan (7 months), Tarryn (28) and Joe (27) Brenton	Scholastic	Married, two children	Female (29)

*All names have been changed to protect the identities of participants.

University of Cape Town

**** Ages indicated were in 2003 when families utilised the services of the CGC**

3.5. Data Collection

The interview schedule contained standardised questions aiming to elicit specific information about the initial session of the clinic. As detailed earlier, interview questions were based on the expected common experiences of all participants which included their opinions about the one-way mirror, the video taping, the usefulness of feedback from the supervising team, the purpose of the interruptions, whether they found the first session useful and whether they would return to the CGC if the need arose. Families were interviewed in their preferred language. Participants were probed when they seemed uncertain, could not clearly remember or if I felt I was not explicit enough. All interviews were taped to ensure accurate collection of data and then were transcribed and thematically analysed.

3.6. Data Analysis

The analysis of the semi-structured interview is dependent on what the research question is and how the researcher intends answering it. When the intention is to explore the perceptions of participants' two types of analyses have relevance. The first is the interpretation of meaning, which emanates from the researcher's perspective. The researcher interprets beyond the text for that which is not explicit but is conveyed on a deeper level (Kvale, 1996).

The second type of analysis is thematic or content analysis. O'Leary submits

> " to move from raw data to meaningful understanding is a process reliant on the generation/exploration of relevant themes. While many of these themes are likely to be discovered through inductive analysis, themes can also be identified through engagement with the literature, prior experiences of the

University of Cape Town

> researcher, and the nature of the research question. Themes can also emerge from insights garnered through the process of data collection" (2004, p. 196).

O'Leary (2004) suggests that themes emerge through analysis at various levels, by first engaging with the text. The researcher should be able to identify themes by recognising patterns and repetitions that occur in words, concepts, linguistic techniques and body language.

O'Leary's statement about the researcher's immersion into the analysis of the material is particularly significant for me as both a researcher directing this study and as a student who trained at the Child Guidance Clinic. My personal experience as a student therapist and as an observer and member of the supervision team behind the one-way mirror has helped to determine the basis for my study. The familiarity of my work spawned a plethora of thoughts around assessment interviews that I hoped would be supported by themes that emerged during the interviews. However the motivation for my investigation also emerged from my curiosity as to whether the participants found the process meaningful and useful. Louw (2000) is incisive and practical in addressing the issue of programme evaluation:

> "One of the tasks in an evaluation is to make theses assumptions about linkages clear and explicit so that reflection on their validity becomes possible. By making the assumptions explicit, we are in a better position to discuss whether they are reasonable in terms of what the available research literature tells us about these kinds of strategies, or the findings from case studies, or from the insights and perceptions of people involved in similar programmes" (pp. 62-3).

The themes, which I discuss in the next chapter, will be briefly mentioned here. The first theme is the process of referral to the CGC. Following this I discuss how family

University of Cape Town

members feel about having the entire family present at the initial session. Then briefly I explore how families experienced the waiting room. Families were then expected to make explicit their opinions about what it was like to talk to each other during the first session and afterwards. The perceptions of the families about the one-way mirror, the supervision team, the knock on the door and the video camera were dealt with in detail. The family's view of the extent of the effectiveness of the CGC, as well as highlights and concerns about the service was examined. Other issues that emerged were around referral to other organisations/ professionals, the availability of resources and issues around termination of therapy. The interpretation of and analysis of these themes will be discussed in the next chapter.

3.7. Ethical considerations

The process of interviewing must be considered as a moral exercise by exercising integrity through sensitivity, respect, honesty and transparency about the process of the research and its objectives (Kvale, 1996). The American Psychological Association also emphasizes the ethical duty of psychologists to respect the worth and dignity of every individual. Willig (2001, p. 18) highlights a number of basic considerations for the researcher to implement, which I used as a basis for the execution of my study and which I will elaborate on:

- Informed consent: I explained to participants the aim of my study and the procedure I would implement. Before beginning with the interview I presented the letter to them and asked them if they had any objections before continuing.
- No deception: It was necessary to assure the prospective participants that they would not be asked to discuss the reasons for presentations, but rather

University of Cape Town

the interview would focus on programme evaluation. I encouraged participants to contact me if they were interested in reading my research dissertation.

- Right to withdraw: In some cases teenagers were reluctant to participate as were some parents who, despite my reassurances to the contrary, felt they would be subjecting their young children unnecessarily to further trauma. These families were not interviewed
- Debriefing: all participants were enlightened as to the nature and aim of the study. Free debriefing sessions were offered in the event that a member or members of the family were distressed by the interview
- Confidentiality: all names and identifying data were altered to protect and respect the privacy of the families. For the same reason the names of the therapists who treated the families were also changed and the specific reason for the family's presentation at the clinic would not be introduced

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3.8. Reliability and Validity

Reliability is determined when findings in a study is consistent and can be generalised in terms of the wider population. Kvale (1996) points out that reliability may be affected by inaccuracies in transcribing interviews as well as the subjectivity of the interviewer. Willig (2001) acknowledges that interpretive analysis can be complicated. She adds that no method is without flaws but the researcher needs to remain reflexive about the possible shortcomings. However, the chief criticism against this form of qualitative research is that often enough samples are too small to be generalizable (Kvale, 1996; Willig, 2001). Though this is true, working with small

samples allows for fresh insights, which emerge during the interviews, to be spawned by interpreting the experiences of the respondents.

Validity is determined when what was intended to be measured, is measured. Kvale (1996, p. 237) points out that in an interview situation validity has to measured along the way: through thematizing, designing, interviewing, transcribing, analysing, validating and reporting. This meticulous approach is what Kvale defines as the "quality of craftsmanship" (1996, p. 240).

Despite this, semi-structured interviewing as an open-ended method of research is still regarded by some researchers as invalid. Willig contends that its location within the real world setting, rather than a contrived one, implies a "higher ecological validity" (2001, p.16). And in response to the criticism that interviewing lacks objectivity, Kvale notes that the interview is essentially an "intersubjective interaction"(1996, p. 66). Participants use language as language as a medium through which to present their knowledge of their subjective experiences.

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CHAPTER FOUR: FINDINGS

4.1. Introduction

In this chapter I present the findings of the semi-structured interviews in thematic form. The themes that I cover have been listed in Chapter 3. The emergent themes based on the questions asked, will be discussed first, while fresh insights that emerged as themes during interviews, will be integrated into the latter sections. All themes will be analysed in the next chapter.

Six families were interviewed: five in English and one in Afrikaans. Copies of the interview format can be found in Appendix B and C. With regard to racial categories five families were "coloured" and one family was "white." These are terms that were employed historically to divide people into racial categories. The pilot interview was conducted in December 2004 while the other five were conducted from April to July 2005. In one of the families, the daughter was not present.

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4.2. Main findings from the interviews

4.2.1. The process of referral to the CGC

In two of the families, the mothers are non-academic employees of the University of Cape Town and were advised to seek help from the CGC by their colleagues. Two were referred by organisations: one by the Parent Centre and the other by an employee at a police station. In both cases the mothers confirmed that these organisations often referred people to the CGC. A fifth parent was referred by an acquaintance whose daughter had been treated at the clinic some years back. A school

that regularly refers learners to the CGC encouraged the sixth family to seek assistance. A student psychologist had been conducting a school visit as part of an assessment for another learner when the teacher requested a referral for the child in question. Members from three of the six families had received prior psychological or intervention. The families who referred their children to the CGC did not have available free income.

4.2.2. Feelings about the entire family being present at the first session.

Feelings about the family presenting at the clinic together varied. The Williams family was wary about being told they had to go in as a family: Vera pointed out that she told her husband Cheslyn and son Trevor that it was for " only one session". In two cases the mothers expressed their gratitude at this request as it was what they specifically they sought. They needed closure for themselves and their children after the problems they had experienced as families. One of the children indicated he felt a little worried about going to the clinic.

Another teenager, Iris, was upfront and said: "I didn't feel too comfortable with this decision, I didn't feel like I should express, you know my personal…". Mandy and Charne Visagie were pleased about any decision that would benefit Shaun. Charne pronounced: "dis vir sy beswil" (it's for his good). In the Brenton family, Joe initially felt that referral was mainly for his daughter and said his initial reaction was simply "why"? His wife simply laughed, then said "scary" without elaborating.

4.2.3. The family's experience of the waiting room

University of Cape Town

There was general consensus that the waiting room was pleasant and welcoming. Some families focused only on the setting and atmosphere while others made mention of their feelings while waiting to be seen. The Williams couple knew a staff member of the clinic and commented on the friendliness of the staff. They were able to "unwind" in the waiting room and Cheslyn felt their daughter was occupied there.

Both mother and son in the Visagie family were not very responsive and said the waiting room was fine. Mandy Visagie gave the impression that they were helped soon after their arrival when she said, "Ons het daar gesit, en agterna het ons almal in een kamer ingegaan" (We sat there and afterwards we went into another room). The children (Charne and Shaun) mentioned that there were books and Shaun said he was colouring in.

Sarah Smith also noticed the magazines. She was relieved that the place was "relaxed" and not too "uptight". Her mother, Patty felt it was "very pleasant" and the "whole atmosphere" was "quite open, light" and "it wasn't one of those dreary places". She "felt much more at ease because there was a lot of young people walking in and out of the room". Vernon said he "liked the pictures". Everyone in this family agreed that they did not wait for a long time.

Mavis North reported that she felt "some apprehension" and described her experience as "daunting". She felt "miserable" as she wondered whether she had made the right choice, especially since her first option was to seek counselling through the church, which did not materialise. Iris, her daughter claimed she was nervous because "you never know what questions they going to ask you".

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The Ingram family described their feelings on arrival at the clinic as "nervous" and "anxious" because they did not know what to expect. However Angela Ingram described the waiting room as "child friendly," as she noticed "there was lots of kiddies books, there were pictures on the walls, some were hand-drawn". She had wondered when children had drawn the pictures. Her son felt the place " calmed me down because the atmosphere was so calm and while we were sitting there, the windows wide open and the trees just out, it was very serene."

Yolanda Brenton was shy but remembered she saw "pictures" and said "I drawed a picture for her" (the therapist). Her father, Joe, described the room as "cosy", but felt it was a place for children rather than parents. His wife, Tarryn, thought it was "like being in someone's lounge, comfortable". Joe reasoned that the waiting room was meant to help "take that nervousness away".

4.2.4. Feelings about talking to each other during and after the first session

All families did not place the same value on talking to each during and after the session. Some families were initially vague in response to this question while others were very vocal about their interaction during the session. The Ingram and Smith families were seeking assistance to work through painful concerns when they came to the clinic. The children in these families felt that talking to each other evoked painful memories. In the Ingram and in the Smith family the younger children became noticeably quieter and more soft-spoken with regard to their family problem during the interview.

University of Cape Town

Patty Smith felt the first interview "opened up wounds" and her daughter echoed these sentiments: "sometimes you'd hear things that you didn't know... (The therapist) asked my mom a question and I'd be like, yoh, I didn't know that". Sarah went on to confess that it was "intimidating a little bit, because you were scared you would say something that the other one might not know about you". Patty was reluctant to talk about certain issues that the children were unaware of but acknowledged that opening up was " a process you've got to go through". Vernon, her son, said he was "shy and nervous... and just didn't want to say anything" in front of his family. Though they discussed the first session at home Patty felt they had "opened up wounds they weren't prepared to let go of". Vernon admitted that he "didn't feel like talking" and " I found out a lot of things that I didn't know".

Angela Ingram had been for prior counselling and felt it was "okay" because she was of the view that one must talk about one's feelings: "you need to talk about it, if you angry or if you happy". Her son, Hamish, admitted he was " a bit uncomfortable in the beginning" because it was "opening all the wounds". Miranda also felt "uncomfortable" because I normally don't say all the things; what's inside I don't say, it doesn't come out of my mouth". They acknowledged that though it was uncomfortable in the beginning it felt better as the session proceeded. Both children felt that as a family it was important to work out their problems together.

Vera Williams felt uncomfortable and felt that some "questions were harsh". She wondered why it was necessary for the therapist to ask certain questions and chose not to respond to some. Her son felt it was fine while her husband, Cheslyn, felt it was a useful opportunity to talk and hear problems from one another. The Williams family talk every night so they discussed the problem "here and there", but not "in detail".

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The North family continued to feel anxious and Iris said she was " nervous and fidgety". A big part of her discomfort was that " I don't believe in telling people who I don't know about my personal life". Her mother's discomfort related to her feeling that the therapist was "so young" and mentioned, "Look, he was a young boy to me". Iris said that as she became more comfortable she raised the issue of "race" and wondered what people behind the mirror were thinking. Mavis said she could not remember talking about the issue afterwards and Iris said she went back to school immediately after the session. They did not specifically single out this event because it was something they had been talking about for a while before going to the CGC.

Both mother and daughter of the Visagie family felt it was fine talking about the problem. They initially perceived the room as strange but Mandy Visagie was satisfied with the manner in which the therapist handled everything. She and her daughter Charne discussed the session on the way home. Shaun did not say much. According to his sister: "Hy praat mos nie so baie"(he does not talk much). Mandy's eldest daughter was unable to attend the first session because she was working and she was duly informed about the session that evening.

Tarryn and Joe Brenton acknowledged that they were "nervous" and "sceptical" mainly in the first session. Joe said " when some secrets came out, it was like, I'm not supposed to say this or it's got nothing to do with this lady (the therapist) but afterwards she made it clear to us that, whatever, everything we got inside revolves around the whole family, so whatever we spoke out she actually gave us back and you know at the end of the day everything came out". He voiced his anxiety in the

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statement " cause we were tense, cause she could have seen our faces, this people is like…" then indicated his relief by smiling when he mentioned, "she actually broke the ice". This couple recounted that they discussed every session afterwards to determine whether their daughter would be properly assisted.

4.2.5. The family's feelings about the one-way mirror and the supervision team

This question elicited interesting responses. In a couple of cases families initiated conversations about the one-way mirror before they were asked the question. Families were either intimidated by the one-way mirror or nonchalant about the effect of it.

Iris North commented: "I personally thought it reminded me a bit like a jail cell, I don't know. You know like CSI and when you sit at the table and talk, except there was no table … it was a little more colourful that was the only thing that will stay in mind, the glass and the cameras like a jail cell." Mavis North confirmed it was a daunting experience to talk about issues of race (which was part of her family dynamics) when they had no idea what people were thinking: "And you have no idea what they're thinking, Well, as we got more relaxed we were outspoken about race". Her daughter then digressed to talking about her experience of racism at her school.

Vera Williams felt uncomfortable about the one-way mirror and said she chose not to say how she felt at times. Being watched made her feel as if she "was not going to be yourself." Her husband remarked that they did not get to see the people behind the one-way mirror.

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Mandy Visagie did not mind the one-way mirror. Shaun denied being worried and said: "Ek was nie op my nerves nie." (I was not nervous). Charne was the only one who indicated that she was a bit "nuuskierig om te sien wat aangaan daar agter die one-way mirror " (curious about what went on behind the one-way mirror). At one stage the therapist left the room and consulted the team behind the one-way mirror. Charne commented that it was a bit strange that they were left on their own and she wondered what was going on behind the one-way mirror.

Tarryn Brenton said that at first she was not comfortable about the one-way mirror but actually forgot about it as time went by. Joe added that the therapist "broke the ice" and made them feel comfortable. Their daughter, Yolanda, giggled as she mentioned that she "was looking through it the whole time." The therapist did not leave the room at any time.

The Smith children were initially preoccupied by the one-way mirror even though the therapist had said that on that day no one was behind it. Sarah said: "it was going through my mind, are people watching, cause I couldn't really see the other side and then as the session progressed and things got more easier, I got up and looked through it. Vernon added that he constantly looked at the mirror and "I get like nervous when people are watching".

Angela Ingram disclosed she had never been exposed to a one-way mirror before and considered it " a bit weird". But she laughingly conceded: "it wasn't traumatising or anything". She had wondered about the people behind the one-way mirror who might recognise her if they saw her outside the clinic. Her son, Hamish felt differently: "It

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made me feel almost like I'm a patient, or some type of psychotic person. They must tape you and watch your every move, are you going to look here, are you going to say this". His mother found it amusing and added: "You touch your hair, it's a sign". Miranda also felt it was "weird because other people were hearing what we actually saying".

4.2.6. Perceptions about the knock on the door and the video camera

Very little information was forthcoming from participants. The North, Smith and Williams's families did not experience someone knocking on the door. The Visagie and Ingram families briefly mentioned that the therapist had left the room but did not comment any further. Tarryn Brenton stated that the therapist only left the room during subsequent sessions, but not the first.

The Brenton family indicated that the therapist had made them feel so comfortable that they forgot about the video camera. The Williams family felt just as uncomfortable about the video camera as they did about the one-way mirror. Charne Visagie said that the video camera did not really perturb her and she was able to talk comfortably. The North and Brenton families did not comment on the video camera but focussed on the one-way mirror. The Ingram family saw the use of the video camera as part of the therapist's job.

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4.2.7. The family's' views about the effectiveness of the CGC.

Some participants expressed dissatisfaction or doubt while others indicated that they were helped and would recommend the clinic to other people. Those who felt they

were helped indicated enthusiastically that they would use the clinic again if the need arose.

The Brenton family realised their daughter was not coping at that particular school and had her transferred. They happily reported her academic and social progress, noting that she has made friends at her new school. They felt it was the therapeutic process that encouraged the realisation that their daughter's difficulties could be addressed.

The Visagie family echoed similar comments. Mandy was very pleased with the effort the therapist had made in having Shaun transferred to another school. She said, "hy het die mooite gedoen om na die skool kliniek toe te phone en 'n afspraak toe te maak" (he made the effort of phoning the school clinic and setting up an appointment). She pointed out that were it not for the therapist's intervention he (Shaun) would have continued to struggle academically and they would have simply perceived him as lazy. The family was also pleased that the therapist had visited Shaun at school and spoken to his teacher.

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In the Williams family Cheslyn felt he was able to talk to his daughter. He felt he changed and appreciated his family more than he had before. However his wife felt their daughter was "still the same". She cited as part of her disappointment the fact that she was not referred elsewhere and that she did not understand the (psychometric) report.

Mavis North said, "I actually do not know" and asked her daughter how she felt. Iris felt she was helped to "find a way to solve it, you know find a way to overcome it and I think that helped." Her point that "in a way some things will puzzle me but I mean she (her mother) may have a better understanding that I do and maybe when I'm older, I would have a better understanding" indicated her insight that her situation might be clearer in hindsight. Mavis then acknowledged that she had made academic progress and was mainstreamed again. She added that her daughter had managed to adjust to the many changes she had originally faced.

Angela Ingram described in detail how she was able to talk about many issues and maintained she did not regret going to the clinic. Hamish felt he was assisted during the period he was at the clinic but this did not sustain itself. He expected the therapist to provide advice he could implement. Miranda felt she was not helped and reported that her situation remained unchanged.

The Smith family felt it assisted them in becoming closer as a family. Some "secrets" had been revealed but it made them feel united rather than isolated as individuals. Patty Smith was grateful that the children were able to have a session with their father and he was able to hear them and appreciate their difficulties. He had become more hands on since then and Vernon said he was closer to his father.

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4.2.8. Highlights and Concerns

Participants were asked to highlight the experiences they enjoyed at the clinic and those they did not. Some participants preferred to ask questions about issues that

evoked anxiety about their experiences or ambivalence about the rationale for certain procedures.

The Visagie family was happy about the clinic as it was. Patty Smith said she most appreciated the informal atmosphere which made her "feel at ease" She added that "it was very relaxed" unlike some other places that made her feel "stifled, doesn't make a person open up really." Her children said they noticed all kinds of pictures on the stairs. Vernon especially found the pictures of animals very attractive. Mavis North claimed she did not like anything about the clinic but did not elaborate.

Angela Ingram wanted to know why families had to be told that there were students behind the one-way mirror. I explained to her that the intervention is as transparent as possible and the CGC does not intend to deceive families, especially as the CGC is a training institution and the university ensures that students are professionally supervised. Her son Hamish was keen to know why therapists did not provide advice or answers that he needed. He felt that he spoke too much and the therapist too little.

Tarryn Brenton expressed her gratitude for having the space to speak and being afforded the opportunity to listen to her husband. Joe Brenton felt that everything was "professionally done". He was happy about the treatment his family received, noting that it was handled in a "confidential" and "private" manner. He felt that they were respected as a family as "nobody intervenes or give a look at you" because they experienced problems. The couple felt that as a family they were in a better position to understand their daughter. Joe added, "She gave us ideas and basically with the

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ideas we didn't like take the whole framework, we took bits and pieces, we implemented into our social and daily lives and it actually did help".

Vera Williams was vociferous about proposing recommendations for the clinic. She believed that families should be given ideas for the near future; they should be allowed to come back to the clinic in the following year if they needed to or they should be appropriately referred to another clinic or psychologist.

Patty Smith, too, expressed disappointment around termination and that the therapist would not be at the clinic the following year. She noted that when relationships had just begun developing it seemed "you had to start all again, and you haven't quite finished". She was also concerned that the issue of the cost per session was not raised initially at all and this added to her stresses as a single working parent. In addition, she also felt that as a working parent she struggled to fit the appointment times into her schedule.

4.2.9. Perceptions of the therapist

Although families were not asked about the relationship or perceptions of the therapist every family commented on some aspect of the therapeutic relationship. Families generally rated the therapist as warm and involved. Two mothers were not happy and communicated this both directly and indirectly. But their responses were not confined to the initial session only.

The Visagie family was very happy with the manner in which the therapist assisted them. Mandy said "hy was 'n nice guy" (he was a nice guy) and "hy het goed gewerk"

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(he worked well). She smiled as she spoke about his efforts to help her son and noted that he not only made contact with the school clinic but that he made a school visit as well. Shaun (who did not say much) beamingly added that the therapist played with him.

The Brenton family clearly respected and admired their therapist. Both husband and wife constantly repeated that she made them comfortable and though they were sceptical in the first session she explained everything to them. She was able to allay their anxiety and Tarryn Brenton was especially pleased that she acted as a medium through which she was able to listen to her husband. They recalled her as being "muslim", having forgot her name. Their daughter indicated a positive regard for the therapist by saying she drawn a picture for her.

The Smith family did not comment directly on the therapist but Patty Smith was disappointed that he was moving on and they would be unable to see him. They had not spent many sessions together, but she had communicated with him telephonically. She was appreciative of his work in bringing the children together with their father for a session, and was very happy about the positive outcome thereof.

Though Vera Williams did not say so directly, she seemed unhappy in general. She was upset that she did not understand the report and that the therapist did not refer her to another appropriate centre or similar professional. Her husband did not share her opinion and said he felt comfortable talking and was appreciative of the opportunity to hear how his family felt.

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The Ingram family also did not comment directly but Angela was very pleased about the therapeutic process. She recalled that the therapist had spent a lot of time helping her to understand the origin of her difficulties. Her son recalled that he did a lot of talking and he expected the therapist to give him advice about some of his problems.

Mavis North was very uncomfortable with the therapist. She was vocal in her pronouncement, "Look he was like a boy to me". On more than one occasion she said that he was too young. She did acknowledge later in the interview that he was "a nice guy". Her daughter was more uptight that she told him so much about herself but that he hardly disclosed anything about himself. She added that all he told her was his surname.

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CHAPTER FIVE: DISCUSSION OF FINDINGS

5.1. Introduction

This chapter will examine the findings presented in the previous chapter and convey my understanding of the participants' responses and experiences. In exploring this I attempt to support my discussion by providing both personal insight and research based evidence where applicable. As the sample is small all interpretations are tentative and subject to alternative constructions of meaning. The subsections will be organised according to the themes described in the previous chapter.

The interview was designed to specifically focus on the initial interview. Families were guided by the semi-structured questions to speak about the initial interview. However when questioned about the helpfulness of the CGC the participants shifted their focus away from the initial session to the entire period of interaction with the CGC. Families based their responses on the outcomes of the treatment and to some extent by their relationship with their therapists. This altered the outcome of the research project but at the same time has generated new insights.

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5.2.1. Referral to the CGC

Four of the six families sought assistance from the CGC because their children experienced emotional and scholastic difficulties. These children were assessed using psychometric instruments. In three of the four cases the parents were satisfied with the outcome of the assessment and the recommendations. Melville (2000) indicates that a sizeable number of referrals are related to difficulties at school and assessments of children form a large part of the work at the CGC. Ahmed and Pillay (2004) question

the purpose of assessment training at psychology departments and argue that testing of children is too protracted to fit easily into training processes and is also not free from cultural and class bias. While these criticisms have some validity the reality is that schools and school clinics are overburdened and under-resourced. Sometimes there is one psychologist available for 50 000 learners in disadvantaged areas. When teachers recommend intervention, children from disadvantaged schools are placed on waiting lists and may only be seen a year later. It becomes the prerogative of the concerned parents to seek private and affordable assistance elsewhere. Moreover assessment is useful in assisting appropriate school-based interventions and home-based remedial programming.

The sources of referral for the six families indicate that the CGC has an established informal reputation: it does not advertise its service to the public. Three of the parents were able to access the services of the CGC through acquaintances. Two mothers work at UCT and were well placed to access the services of the CGC. Three families were referred to the CGC via a school, a police station and a parent centre. The implication is that the CGC is well known to the staff at these institutions and referral is made through the staffs that are familiar with the services of the CGC.

Of the six families interviewed four were single parent families headed by women. These women initiated the attempts to obtain psychological intervention. Even in the nuclear families it was the women who initiated assistance. While it is not appropriate to generalise from so small a sample, it does imply that the care giving and caretaking role is still part of the women's domain.

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The CGC always has a long waiting list. This is a good indicator that there is a need for the services offered by the CGC. However access to the CGC is only marginally improved for disadvantaged families, either through their places of employment or the schools their children attend. For those children and families who attend schools where the CGC is not known access is not an option.

5.2.2. Feelings about being present for the first session

Watzlawick et al (1967, cited in Barker, 1998) believes that language, as a tool in therapy must not be underestimated. He suggested that semantic and pragmatic communication helps the therapist to decode the underlying messages conveyed by the family. It is necessary therefore to be cognisant of the tone in which people convey their feelings as well as the diction they employ in conveying messages. In the Brenton family, Joe's response of "why" conveyed surprise. This request to attend the session as a family seemed strange to him. His wife's response of laughter followed by the word "scary" also indicated a sense of unease about being seen as a family. Iris North echoed similar sentiments in her response of "I didn't feel too comfortable". The feelings of fear and discomfort seem to be a spontaneous response to an unlikely request.

The family's surprise at being invited to a family session reinforces the belief that the identified patient is the problem or the one who has the problem (Minuchin, 1977). Only some families realise, as did the Brenton's that the problem is best understood by examining the system from which it emanates.

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In other families persuasion or bargaining had to be used to attend the first session. This was evident when Vera Williams told her husband and her son that they would have to go to the CGC for one session only. This may indicate that assistance is not jointly and openly negotiated but is sought through circuitous means.

When families experienced crises that affected all the members, it appeared as if a family meeting was expected, especially from the adults. Based on the two families who requested "closure" for their children, it seemed as if they had the benefit of prior psychological intervention and realised the importance of such intervention for their children.

5.2.3. The family's experience of the waiting room

The families' experience of the waiting room can be broadly organised into two areas: the physical environment that was a containing space and the internal feelings of the members.

Family members, who were acquainted with some staff at the CGC, felt more comfortable. Perhaps knowing someone at the CGC engendered a sense of familiarity. The environment may have appeared safe and the people easier to trust if an acquaintance of theirs worked in the same space. The physical space induced a sense of relaxation and comfort. Participants spontaneously described the waiting room as "cosy", "like being in someone's lounge". Some families commented on the setting and noticed the tree outside, the light that filtered through and the relaxed atmosphere of the CGC. The implication is that they had perhaps been in other settings, which were not as pleasant or peaceful.

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Those who enjoyed the waiting room perceived it as child-friendly. They noticed the stationery and books available for the young children. It was clear the children felt comfortable because they drew pictures as soon as they arrived. But though one member acknowledged this, his discomfort and perhaps reluctance to be there was explicit in his comment that the place was specifically for children. He attempted to make an unobtrusive reference to his own nervousness by pointing out that setting was meant to obviate nervousness. For the Ingram family the setting was containing enough to calm the family. Angela Ingram recalled that her anxiety was fuelled by not knowing what to expect. She felt the tangible difference the room made to her mood as she vividly recalled trees outside, the wide-open windows and the walls with pictures drawn by children.

Another member felt the setting of the room did not contain her as she wrestled with her thoughts about her decision to seek assistance from the CGC. Her anxiety was combined with her feelings of misery and ambivalence: "it was very daunting, though when you walk in there and you know there's a problem and, ja, you feel miserable… and you think, have you made the right choices".

It is interesting how valuable and meaningful the setting was to some families. It highlights the novelty of their experiences but also the importance of the setting in calming families as they prepare for a daunting and unknown experience.

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5.2.4. Feelings about talking to each during and after the session

Satir (1967, cited in Barker 1998) accentuated the significance of communicating feelings. She argued that where the expression of feelings was problematical, therapy must be the platform to improve the communication of feelings. As will be revealed families and individuals come to the CGC with an already established blueprint for managing and expressing their feelings.

Families were candid about the intention to avoid pain by not talking about their feelings. The expression "opening/opened up the wounds," was used more than once. Embedded in these statements I perceived not only a deep sense of sadness but also a forewarning against "opening up the wounds" that were just starting to heal. Others were more vociferous about their discomfort at being confronted with personal issues. Many respondents alluded to the struggle to talk about their feelings: "I just didn't want to say anything", "I normally don't say all the things; what's inside I don't say, it doesn't come out of my mouth" and "when secrets came out, it was like, I'm not supposed to say this".

The idea of change is also a reality that families are reluctant to confront. Patty Smith admitted that she was not "prepared to let go of wounds". Her daughter was also concerned that she might possibly reveal information about herself that others did not know. Even in families members feel they are unable to share everything (Karpel, 1980). Two participants divulged their awkwardness when they inadvertently revealed secrets or information, but only one (Joe Brenton) felt relieved that his revelations were in the best interests of his family (Selvini, 1997).

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Sometimes participants are aware of what they reveal through non-verbal communication (Barker, 1998). Joe Brenton was aware that his facial expression revealed his anxiety and sensed that the therapist was aware of this as well. That she "broke the ice", reveals his impression of the therapist as both active and warm in the therapeutic process (Bennun, 1989).

5.2.5. Perceptions of the one-way mirror and the supervision team

Responses to the one-way mirror and the supervision team raised concerns of surveillance for families. For all the families it was a novel encounter but responses varied from nonchalant to extreme preoccupation about being watched.

What emerged as most interesting in this finding was that most of the adolescents in the study were intrigued and possibly disturbed by the idea of being observed. Even the one adolescent (Sarah, age 12), who had been reassured that no people were behind the one-way mirror on that day, had remained preoccupied about the mirror for most of the session. The analogies that two adolescents (Iris, age 12 and Hamish, age 16) drew to highlight their discomfort were quite striking. Comparing themselves to patients or prisoners accentuates the concept of surveillance as intimidating and distressing and implies a possible violation of privacy (Knott and Espie, 1997).

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An important part of adolescent autonomy is the process separating from one's parents. Asserting his/her right to privacy becomes emblematic of this autonomy. This means not sharing information, keeping secrets and even withholding feelings about issues from his/her family. This autonomy becomes compromised when adolescents

are obliged to share some of the secrets or opinions they have about family issues in settings like the CGC.

However, the extent to which adolescents have absorbed the media culture about the portrayal of people in public institutions like prisons and hospitals must be questioned. It may be that events or scenes from movies or television programmes have influenced the manner in which adolescents, in particular represent reality.

The younger children were equally curious in their responses but less extreme than the adolescents. For Vernon (age 7) the realisation that "other people are watching" evoked the feeling of being spied upon, while for Miranda (age 12), the notion that "other people were actually hearing what we saying" brought home the idea of eavesdropping. The feeling of being watched clearly made the children more self-conscious (Persaud, 1987).

Most of the adults were initially surprised when told about the one-way mirror. Some responses revealed normal anxiety at being surveyed but in these cases, as is supported by the literature, the participants soon forgot about the presence of the mirror (Knott and Espie, 1997). The experience of being observed engenders a sense of awkwardness in some people, affecting perhaps the quality of their responses (Persaud, 1987).

Curiosity about the supervision team may create fantasies or fears about who the people are and what they think. Angela Ingram was anxious that she might be recognised by a member of the supervision team. Her concern was that she would not

University of Cape Town

know who the person was. Cheslyn Williams pointed out that his family did not get to meet the team. This sentiment is one that could be explored and perhaps implemented if families are keen to meet the team (Knott and Espie, 1997).

When the therapist left the room during a session with a family one participant noted it was a bit strange to be left alone, indicating perhaps that the family had been uncomfortable discussing the problem without the therapist to contain them. A final observation is that two participants took the experience of being watched in their stride by laughing and displaying amusement about the one-way mirror.

5.2.6. Perceptions about the knock on the door and the video camera

This question elicited very little response as only one family experienced the therapist leaving the room. It appears as if the sessions were conducted with as few interruptions as possible.

Most families had very little to say about the camera as opposed to their responses about the one-way mirror. One possible reason is that the video camera is small and placed to some degree, out of view, while the one-way mirror is very large, occupying virtually one wall of the room. More than that, the use of the video camera is justified as being a teaching tool, a record of events for the supervision of the therapist. When people are watching from behind the one-way the notion of surveillance implies a partial, critical view of events.

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5.2.7. Views about the effectiveness of the CGC

The intention of the study was to focus on the initial session, but when families were questioned about the CGC's helpfulness, all families assessed helpfulness based on their entire interaction with the CGC.

Two years later all families (bar one) who had their children assessed at the CGC were happy with the progress their children had made. In the two families where intervention was requested for emotional difficulties the overall feeling was one of satisfaction but some members from these families raised concerns about the process and ethos of the CGC.

Significantly, although only two fathers who were interviewed, both reported satisfaction with the outcome of the sessions (Bennun, 1989). Both felt they were better able to understand the situation in their families. Cheslyn Williams, in particular, mentioned that he was able to talk to his daughter more openly and that he appreciated his family more. It seems that the manner in which families communicated and related to each other had undergone shifts.

Two mothers were more disparaging in their comments about the outcomes. Vera Williams was vocal about the situation being unchanged for her daughter. She was unhappy that she had not been referred somewhere else and that she did not understand the report. Mavis North was reluctant to make positive comments, saying, "I actually do not know", but conceded that her daughter had made great strides when she said, "she's done very well this year". While many factors can be considered for clients' dissatisfaction, the relationship between the therapist and the client needs

University of Cape Town

examination to ascertain whether there was a failure to build a working alliance (Karpel and Strauss, 1983) or establish rapport (Barker, 1998).

Three adolescents had differing views about the efficacy of the CGC. Iris North realised that she was "helped" to help herself. On the other hand, Hamish Ingram felt he was not given enough advice to benefit him. His sister, Miranda, believed the situation was unchanged. Perhaps for the Ingram children the closure they had expected did not occur because their father had not come into the CGC for a session with them. In contrast the father of Sarah and Vernon Smith attended a session with them and they reported a much closer relationship two years on.

Research indicates that families differ in their expectation of therapy (Merrington and Corden, 1981; Figley and Nelson, 1989). While some participants like Iris realised that she needed guidance but not advice, others like Hamish felt advice was more constructive.

5.2.8. Highlights and concerns

This section elaborates on how families responded to the question about what they liked and what they did not like about the CGC. Families provided feedback around the treatment they received, the therapeutic process and the ethos of the clinic. Participants questioned the reasons for telling families about the one-way mirror, the policy around the fees charged per session and the lack of referral after what some participants' considered a premature termination.

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Firstly some participants highlighted the setting, which they regarded as containing and uplifting, especially as they were anxious before the first session. Some children noted that the CGC was a child-friendly institution and this too was reassuring. Another positive feature was the treatment by the staff. One member was very impressed by the "confidential" and "private" management of his case. There seemed to be a fear that he would be singled out or labelled because his family was there for psychological assistance. An important benefit was the feeling that space had been afforded to the family to listen to each other and to talk about their problems (Pocock, 1997).

One participant challenged the practice of informing families about the supervision team behind the one-way mirror. My response involved an explanation about the UCT training programme and the policy of being upfront and transparent with the families who utilised the services of the CGC. Her son also questioned the function of psychologists as he expected the therapist to be more active and directive in the session (Merrington and Corden, 1981; Bennun, 1989; Figley and Nelson, 1989).

One of the participants was very unhappy about the outcome. She believed that her daughter should have been referred elsewhere and felt there was no change in her daughter. She felt it would have been more constructive if alternate referral options were provided. This is a useful recommendation and needs to be addressed. However her husband reported that the relationship between him and his daughter had improved and he was able to better communicate with her.

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One participant reported feeling disconcerted that the fees had not been discussed initially. She felt that as a single parent she would have appreciated this information early on so that she could negotiate payment. As every other family reported no problems with regard to this matter it seemed that in her case it might have occurred because she had her sessions after office hours. The same participant raised another relevant concern about termination. She felt that they had to terminate before they needed to and thought it would be problematical to start afresh with someone else after having built alliances with a particular therapist. Once again my response was to explain that the training programme at UCT influenced the system and procedures that operated at the CGC. But the participant's point was relevant and is not an isolated opinion as another participant also felt this way.

5.2.9. Perceptions of the therapist

Even though the focus of the interviews was on the initial session of the CGC, many participants inadvertently made some reference to the therapist or the therapeutic process. This theme emerges as very significant as often the rapport established between the therapist and the client is an indicator of the positive or negative outcome of therapy (Barker, 1998). Deglon (2004) also concluded that most of the clients she interviewed were "positive" about the therapeutic relationship, noting that therapists were regarded as "warm, trusting and caring" (p. 16).

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The Brenton and the Visagie families were extremely pleased with the connection their therapists made with them. They conveyed the therapists as competent and caring professionals. In both families the mothers felt the therapists had enabled them to be more understanding of their children's difficulties (Figley and Nelson, 1989). In

support of the finding by Bennun (1989) the two fathers were very enthusiastic about the outcome of therapy. Though it is a finding that must be cautiously interpreted, it nonetheless is promising.

While some participants were happy that the therapist enabled them to develop insight into their difficulties others felt it would have been more useful if they were advised about the best course of action to follow. Merrington and Corden (1981) and Knott and Espie (1997) concur with this in their findings.

There are some factors that may impinge on the therapeutic alliance, like differences in cultural values, age, race and gender (Selvini and Palazzoli, 1991). In the course of a single interview issues may only come up if the participants volunteers information. One family's recollection of their client was evoked by the fact that she belonged to a different religion. This however did not impact on the alliance between the two parties. In fact her respect for and understanding of the family helped them to move beyond cultural barriers.

In another family the age of the therapist was considered to be an important variable by the mother. Her difficulty in coming to terms with a therapist who was younger than herself might have been precipitated by a number of dynamics. She had indicated that she initially sought Christian counselling but was unsuccessful as the counsellor was pregnant and therefore unavailable. It was hard, she acknowledged, for her to reveal her difficulties to a stranger. Having indicated her preference for Christian based counselling she may not have been comfortable with a young and unmarried male therapist.

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Her daughter acknowledged that though he "was nice" she felt that she revealed too much about herself and demanded that the therapist reveal something about himself. Minuchin (1977) preferred telling anecdotes to facilitate therapy and encourage disclosure but the decision to disclose personal information may lead to building alliances with one member and leaving other members of the family feeling alienated. It is a skill that the neophyte therapist should be cautious about employing. There is the danger that disclosure may overwhelm the family or make them feel unsafe. Many families are unsure of how to respond to the disclosure when they have come for help (Roberts, 2005). In this case the therapist exercised his judgement and compromised by offering the safe disclosure of his surname.

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CHAPTER SIX: CONCLUSION

It is an exciting undertaking having worked at the CGC as a student psychologist to then enter into a conversation with families who have engaged those services. It is a rewarding road to walk with families as they recollect and reminisce their experiences at the CGC. This project has potential implications for families who continue to use the services of the CGC, for professionals who work and train there and for other institutions using similar models of practice. The CGC, though a training institution, values feedback as it strives constantly to improve its services to all the clients who utilise the facilities. However the study in itself has limitations. The first section of this chapter will focus on the limitations of my research project and the next section will draw together the outcomes of my findings.

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6.1. Limitations of the study

6.1.1. Sample

While the choice of a semi-structured interview remains an appropriate one, it was not easy to convince families to agree to the interviews. Although I selected eight families to be potential participants not all of them agreed to be interviewed. Drawing from my original list, I subsequently contacted more families.

Participants furnished a variety of reasons against participation in the research study. In drawing up my original list I had attempted to obtain a sample that was representative of the clientele who visited the CGC (Melville, 2000). However my difficulties in securing interviews meant that I interviewed those who agreed to participation. I attempted to interview a Xhosa speaking family. After managing to

secure an agreement for an interview the man and his son were not at home despite confirmation for the appointment three hours earlier. He did not answer his phone. All these obstacles meant my sample was smaller than was originally planned for.

At least two families believed the interviews would traumatise their children again despite my reassurance that it was around service evaluation and that follow up debriefing sessions would be provided. One couple agreed to the interview but their adolescent son refused to participate. I spent more than a week negotiating his participation with the mother, but he did not change his mind. In a similar case a mother also said she would struggle to get her teenager to agree to the interviews. Another mother claimed it would infringe on her son's bathing time. One other mother was eager to be interviewed but said the CGC had turned her son against psychology, which she did not expect. She described her experiences at the CGC as more positive than his.

There were two families where the couples had divorced and the mothers whom I spoke to felt their ex-husbands would not meet for the sole purpose of the interview. At least three families were not sure, another two people said they would call back and they did not. Two families refused and indicated they were not interested. One woman said she would be available in two months time only.

There were two families who were uncontactable. One had relocated and no forwarding contact number was available. Another woman had difficulty with the times for the interview as her husband worked till late.

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The responses I received led to some speculation about the regard clients held for the CGC. Those who refused immediately seemed to have indicated no interest in continued contact with the CGC. Some of those who refused may have felt they were not assisted and it was unnecessary to have renewed contact with the CGC under any circumstances. One could assume too that the initial interview was very uncomfortable for families who were unaccustomed to speaking about problems to each other. This interview would simply have been a replay of their discomfort, which they wanted to put behind them. Perhaps, as Deglon (2004) points out, the implication of having mental health problems is still shameful for many and it is understandable that they may refuse further association with the CGC. It may be therefore that the responses in the sample that were interviewed are more positive than those with whom interviews were not held. This underlines the importance of doing a broader evaluation in which more families are interviewed. However Deglon's (2004) study found that overall satisfaction with the CGC service outweighed criticisms and doubts.

6.1.2. The interview process

The central theme of the research project was the initial interview. However participants articulated opinions about the entire therapeutic process when questioned about the helpfulness of the CGC. Generally families who appeared more positive about the process of the first session were happier about the outcome of the therapeutic process. The families who found the first session rather disconcerting were dissatisfied about the outcome.

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The inclusion of dynamics beyond the process of the first session means that additional variables were considered in the study. The implication is that families might measure the successful outcome of the therapeutic intervention on the basis of a positive experience of the initial interview and vice-versa. Imbued in the families understanding of a positive or negative experience of therapy is the families' perception of the therapist. The interlinking of first perceptions of overall outcomes, therapist and first interviews makes separating the components difficult to do.

Deglon (2004) is accurate in pointing out the difficulty in assessing outcomes as many factors may have influenced the participants' perceptions. Her study was conducted a few months after clients had been to the CGC and their recall may not have been very accurate. This problem has been similarly experienced in my study. Participants were not able to remember everything about the interviews after a period of two years. Though the prompts were helpful aspects recalled were selective. I opted to interview 2003 families as fellow student psychologists treated the 2004 families. I had watched families behind the one-way mirror and interviewing those families would have affected my objectivity in the research process, as assumptions about them would have already been formulated.

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6.1.3. Literature in the field

Another key aspect of this project was to make links between what is practised and modelled at the CGC and initial interviews at South African mental health settings. While there is sufficient literature in the field of initial interviews outside South Africa, it is sparse in this country. Psychology as a discipline is undergoing transformation and is establishing its role in mental health settings. This lack of

literature compromised my study in using relevant literature as a backdrop to my work.

6.2. Outcomes of the research

This thesis was driven by enquiry into the family's understanding of experience their of the initial interview at the CGC. A selected sample was interviewed using semi-structured questions to elicit perceptions of a novel experience in a strange setting within the context of much surveillance as well as the exploration of family dynamics in a frank and open conversation. There was an expectation that families may have difficulties with some of the features of the first session and that they may voice opposition to these features.

6.2.1. Outcomes relating to initial interviews in the South African context

Mental health institutions throughout South Africa regularly see families, yet hardly any information or literature about initial interviews that include the family has been documented. Conducting initial assessments are routinely taught at universities as part of the clinical masters programme. There have been calls to make psychology more relevant to communities that do not have access to psychological services. It has been acknowledged that the services offered by institutions like the CGC are accessible to relatively few people.

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6.2.2. Outcomes of the interview process

Most participants engaged easily during the interview process. A few participants were reserved and did not elaborate on their responses. Though they were prompted, their continued reticence in response to some questions have a number of causes:

satisfaction about the service, their difficulty recalling what had happened or their dissatisfaction about the outcome, which they may not have felt comfortable discussing.

Despite this experience with a few participants, generally families were not resistant and responded spontaneously to questions. Participants eagerly communicated their feelings and it was gratifying that families paid attention to details like the setting and the treatment they received.

There seemed to be an overall sense that the setting was comfortable, child-friendly and containing. Participants noted that it assisted in relieving the anxiety they felt on arrival and more so when the staff was receptive and they were treated respectfully. For one participant her anxiety could not be contained.

Having to confront the notion of talking to each other began when families were asked to come into the first session. The participants' responses to this and to talking to each about the presenting problem reflect to a large extent their experiences of communication within the family setting. It is significant that all those who found it difficult to discuss their concerns were the same participants who were dissatisfied with the outcome. These participants also expressed displeasure about the therapist or the therapeutic process. Therefore it is difficult to ascertain if their experience of the first session was coloured by negative experiences, or whether negative outcomes was influenced by a flawed beginning.

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A positive observation was the response of participants' to the disclosure of family secrets. While participants felt quite exposed initially when they perceived that they revealed too much, towards the end there was great relief at having released information that somehow freed families and brought them closer. Quite a few participants realised that their feelings that they had not expressed were not unique in their families.

In response to features like the one-way mirror and the supervision team behind it the most striking responses came from adolescents who felt the idea of surveillance quite severely. Some adolescents portrayed the supervision team as powerful figures of authority. This may reflect their struggle to come to terms with various authority figures in conjunction with their own growing sense of autonomy. Younger children were intrigued by the mirror, which merely reflected their images. Adults found that they forgot about the mirror as the session proceeded with the exception of one who felt it prevented her from being transparent. Some families feel more at ease when they are introduced to the supervision team behind the one-way mirror. This issue needs addressing.

The participants', whose children were cognitively assessed, judged the efficacy of the CGC in terms of progress the children had made to date. There was one participant who was not happy with the report. Other parents acknowledged the shifts the children had made emotionally. Two participants felt nothing had changed, while another two valued the opportunity to gain closure for their families and move forward. Two years later it seems that five of the six families had indeed moved on after their presenting problems were addressed.

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The perception of the therapist was a theme that emerged during the interviews. Drawing from the participants' responses one can conclude that all the therapists were professional and committed to the therapeutic process. The differing expectations of the therapeutic relationships may arise from families' cultural and social understanding of the role of therapists and style of therapy. Zeitlin and Refaat (2000) acknowledge that a wide range of family and environmental factors may affect the family's understanding of the therapeutic study. They advise open communication where all members should be allowed to speak to each other, without taking anything for granted about the family. Adolescents, too, have particular expectations of the therapist and may expect the relationship to be an equitable one. The participant who was unhappy about the entire process did not comment favourably on the therapeutic relationship.

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Other pertinent themes that arose were concerns about terminating therapy too soon, proper procedures for future referral and to a lesser degree issues around racial, religious and class differences. Premature termination is a relevant grievance in any setting. It is an issue that families and student psychologists face annually when families are seen towards the end of the year. However, that said, termination is painful in any therapeutic relationship as the therapist and clients become attached to each other. Termination is a part of any relationship and must be discussed within the therapeutic milieu. Perhaps tied to the termination of the relationship is the subject of referring families to other professional and appropriate agencies. There are some families who may request further assistance but in South Africa there are few referral resources. This raises the ethical dilemma about whether it is in some cases harmful to

begin a therapeutic process that cannot be completed. It could be argued that some intervention is better that none at all. This dilemma can fruitfully be explored in future research.

While I had an expectation that issues around race, class and religion would emerge I discovered that it was not a prevalent concern for the participants. In a single interview it is unlikely that the issue of race would feature unless the researcher raises it or the information is volunteered. In one family racial issues emerged but it was clear that it was a dynamic within the family system. The adolescent felt comfortable raising it in the session. One participant felt very uneasy about the therapist who was younger than her and this seemed to influence her reluctance to acknowledge the shifts her daughter made until she was reminded. Statistical information about the ages of therapist and adults revealed that in most of the cases (bar one) the therapist was younger than the adults in the family.

During the interview process I discovered that three of the six families had had previous psychological intervention. The three families found it easier to ask questions about concerns they had or issues they did not understand. Two families who did not receive previous intervention were very happy with the manner in which the CGC was run and did not have any suggestions for improvements.

It has been very useful extracting positive and constructive feedback from participants. It has been my observation that families who had had the benefit of prior psychological intervention were more frank about any experiences they felt uncomfortable about.

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This study has made apparent that the inroads made into therapy with the family in the first session are by and large helpful and meaningful. Though psychological intervention in communities is important I believe that intervention made into the primary unit of socialisation, the family is important in any therapeutic endeavour. This process of encouraging families to communicate in a non-judgemental space serves as an effective model for emotional communication within the family to hear each other.

Though one might be wary of differences around culture this small sample has revealed that "culture is not a vague or exotic label attached to faraway persons and places but a personal orientation to each decision, behaviour and action in our lives" (Pederson, cited in Lifsfhitz et al, 1992).

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RECOMMENDATIONS

The usefulness of this study will be more resonant if subsequent evaluation programmes are conducted. This study has revealed positive findings in terms of the way the initial assessment at the CGC. The following are recommended:

The CGC should draw up a database of psychologists and social workers who are keen to take on referrals from the CGC either at termination or during the course of therapy if the need for longer-term work is indicated. At the same time a referral list of mental health centres available in surrounding suburbs should be drawn up so that some referrals can be outsourced to community centres. This can free up the backlog as the CGC has a long waiting period.

To prepare families for the structure and procedures of the CGC, information leaflets should be prepared and placed in the waiting room for families to read. This may reduce the initial distress that some families experience. The leaflet should contain information about the academic context within which the CGC operates and then the rationale for all the features mentioned and for the presence of the entire family at the first session.

New experiences such as the exposure to the one-way mirror, addressing issues as a family for the first time (for some families) seem to be raised in the initial session only. It may be useful to raise these issues in subsequent sessions or even in the termination sessions. Families can be encouraged to talk through all their unspoken

University of Cape Town

feelings they may not have mentioned earlier on. An opportunity to meet the team behind the mirror should be permitted if the family members request it.

If the situation warrants it or there is an underlying sense that it poses a barrier in the therapeutic relationship then the issues of race, class and religion should be raised. This can be an awkward talking point for therapist and families alike but it may be an empowering exercise for the family to know that issues are not avoided simply because they are not raised.

Families should be encouraged to provide feedback (though voluntarily) about all aspects of the services of the CGC. Once again, feedback forms can be made available in the waiting room and families can be asked prior to termination if they are interested in providing feedback.

The issue of termination remains sensitive and must be carefully handled. The period of the therapeutic intervention must be negotiated with all members of the family so that members are aware of the point of termination.

University of Cape Town

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APPENDIX A: LETTER TO PARTICIPANTS

UNIVERSITY OF CAPE TOWN

Child Guidance Clinic

University of Cape Town: Chapel Road
Rosebank 7700: Cape: South Africa
Telephone: (021) 650-3900
Fax: (021) 689-1006

Dear _________________

RE: RESEARCH IN FAMILY THERAPY AT THE CHILD GUIDANCE CLINIC

I am a student and researcher employed by the National Research Foundation to investigate the possible benefits offered by the Child Guidance Clinic for family therapy. As part of my research I am interested in interviewing families who presented at the clinic in 2003 either in their homes (if it is preferable) or at the Child Guidance Clinic. This means meeting the family for approximately an hour at a suitably agreed time to answer a specified number of questions which will be recorded to ensure accurate collection of information.

The focus of my interest is to determine how you may have experienced the first session at the clinic so that services to the public may be improved and/or strengthened depending on the outcome of the research.

University of Cape Town

Please note that the choice to participate in the research is ultimately yours and will in no way prejudice you from receiving further intervention from the clinic in future if you so desire.

If you choose to participate in the interview all identifying information will be changed to protect the privacy of all members of your family. If you are concerned about having to address any issues which are still painful, free follow-up debriefing sessions will be offered.

Following the receipt of this letter you will receive a telephone call to ascertain your interest in the participation of the research.

Your time and effort is greatly appreciated.

Yours truly

____________________	____________________
Allengary Naicker	Anastasia Maw
Researcher	Director: Child Guidance Clinic

University of Cape Town

APPENDIX B: ENGLISH INTERVIEW SCHEDULE

Stage 1: Pre- Interview

1. What brought you to the clinic initially?

1.1. How did you hear about the clinic?

1.2. What explanation were you given over the telephone?

2.1. Who explained to you that everybody must come in?

2.2. Was everyone told in advance?

2.2. Was everyone on board? How did everyone react?

Stage 2: At the CGC

3.1. How did it feel initially in the waiting room?

3.2. What did you like/dislike?

3.3. How did you feel about discussing the problem in front of everybody?

3.4. Did this change in the course of the interviews?

3.5. Was there any discussion about the interview in the family?

Stage 3: Reflecting on process

4.1. Were you helped?

4.2. Was it important that everyone was there?

Stage 4: Features of the first session

5.1. How did you feel about the one-way mirror and the video camera?

5.2. Were you interrupted at any stage by someone knocking on the door? How did you feel about that

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APPENDIX C: AFRIKAANS INTERVIEW SCHEDULE

Trek 1: Voor die onderhoud

1. Hoekom het julle na die kliniek toe gekom?

1.1. Hoe het julle van die kliniek gehoor?

1. 2. Watte sort verduideliking het julle gekry oor die telefoon?

2.1. Wie het aan jou verduidelik dat die hele familie/gesin moet in kom?

2.2. Was julle voor die tyd ingelig om in te kom?

2.3. Was almal bereid om in te kom? Hoe het almal reakteer?

Trek 2: By die kliniek

3.1. Hoe het julle gevoel toe julle ingekom en in die wagkamer gesit?

3.2. Waavan het julle gehou/ nie gehou nie?

3.3. Hoe het julle gevoel toe julle oor die probleem praat voor almal?

3.4. Het die gevoelens verander terwyl die onderhoud aangegaan het?

3.5. Het die hele familie die onderhoud later bespreek?

Trek 3: Oorweging van die proses

4.1. Was julle gehelp?

4.2. Was dit belangrik dat almal daar was?

Trek 4: Kenmerke van die eerste onderhoud

5.1. Hoe het julle gevoel oor die een-rigting spiel en die videokamera?

5.2. Op enige stadium, was julle gesteur by 'n klop aan die deur. Hoe het julle gevoel daaroor?

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