

**CONSULTATION AND TRAINING CHALLENGES AT
THE MAMRE COMMUNITY HEALTH PROJECT**

MARION HOLDSWORTH
B.A. (UNISA), B. SOC. SCI. (HONS) (U.C.T)

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Department of Psychology
Faculty of Social Science and Humanities
University of Cape Town
Rondebosch, Cape Town, 7700

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ABSTRACT

South African mental health services are in a crisis. Rural areas are particularly neglected. While shortage of resources is readily acknowledged, there have been various suggestions mooted to address these inadequacies. These solutions include: decentralisation, promotion of primary mental health care, encouraging community participation and involvement of indigenous helpers. Psychological consultation and training is a valuable way of implementing most of these suggestions as it is estimated that many mental health disorders are not diagnosed or treated because front-line workers do not have the knowledge or skill to do so. Although consultation and training is accepted as a useful way of working, it is not without problems. Certain factors make it more or less possible to implement. These factors are discussed. Particular attention is paid to the topic of hierarchical relations inherent in intra- and interprofessional contexts. It is believed that these relations may interfere with the creation of equitable consultant-consultee partnerships, and therefore hinder the consultation and training process.

The present research evaluates factors which facilitate or hinder the consultation and training programme at the Mamre Community Health Project. This project is a non-government organisation aiming to improve of the health of the community of Mamre, a small rural town on the west coast of the Western Cape. Target consultees, including nursing sisters, social workers and paraprofessionals, were interviewed using a semi-structured interview schedule. The aim was to elicit experiences and opinions of consultation and training. Psychological consultants who had worked at the Mamre Community Health Project were also interviewed using a semi-structured interview schedule to elicit their experiences of consultation. A thematic analysis highlights factors which facilitate and factors which inhibit the process. Results are discussed in the light of the literature review, and recommendations are made regarding the future practice of consultation and training.

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CHAPTER ONE: INTRODUCTION AND BACKGROUND

1.1. INTRODUCTION

The dissertation is about mental health consultation and training, and undertakes to explore resistance to this way of working. Mental health consultation has been defined as "the sort of talk undertaken when one person (the consultant) helps another (the consultee - or a group of consultees) to work effectively, but without taking that work over in any way" (Steinberg, 1989: p.1). The relationship is voluntary (Orford, 1992). Mental health consultation is viewed as a valuable activity particularly in areas where there are few trained mental health professionals. The idea is that professionals and paraprofessionals such as social workers, nurses, police, church workers, medical doctors, community health workers and teachers, who already have a care-giving role in the community, are helped by the psychologist to deal with the mental health problems which are presented to them in the course of their daily work. Consultation also aims at helping these care-givers work towards preventing mental health problems and promoting mental well-being (Heller, Price, Reinhartz, Riger, Wandersman & D'Aunno, 1984; Orford, 1992). Unlike supervision or teaching, the work is collaborative, aiming to use and enhance the consultee's existing knowledge and skills without the psychologist taking responsibility for the client or doing the work (Steinberg, 1989). Consultation should, however, always include a degree of training (Heller et al., 1984). Training increases the likelihood that consultation will be successful (Clement, 1987).

Orford (1992) criticises the narrow use of the term 'consultation' which does not always include training and prefers to talk about "sharing psychology" (p.139) which is consultation *and* training. In this document, when the researcher refers to consultation and training at Mamre, the site for this study which will be introduced later, a unitary activity is implied, because, as it is practised in Mamre, training is an integral part of consultation and together they form the means for sharing psychology. Furthermore, the term 'consultation' in this document refers specifically to case consultation and not administrative or organisational consultation. Case consultation is usually client-centred, focusing on difficulties consultees have in dealing with mental health aspects of their clients; but it may also be consultee-centred where the focus is on the shortcomings of the consultee (Caplan & Caplan, 1993).

Much of the literature about psychological consultation seems to have as its point of departure the idea that the consultee is motivated to provide the psychological component of the intervention with the client and approaches the consultant with the aim of gaining specialised skills and knowledge, confidence and an objective point of view in order to deal with the case as opposed to

referring it to the psychologist. The challenge of potential consultees who may resist involvement in the consultation and training process is not frequently addressed in the literature. Generally, there has been a lack of critical reflection on consultation (Orford, 1992). Resistance may even be attributed to potential consultees who "may be so deficient in interpersonal sensitivity and skill that no amount of training will improve their functioning" (Heller et al., 1984: p.275).

It stands to reason that an essential part of the consultation process is entry into the consulting relationship. The consulting relationship and the change of roles it involves is bound to be experienced as novel and may possibly be resisted. My clinical experience at the Mamre Community Health Project (MCHP) was that consultation and training is not always easily and readily accepted by potential consultees. This experience provided motivation for the research.

1.2. BACKGROUND TO THE RESEARCH

1.2.1. The Mamre community health project

Mamre is a small community with a population of 4623 in 1988. It is situated on the West coast 48 km from Cape Town (Klopper & Tibbit, 1988). Development of amenities, for example, electrification in 1987; and the influence of Cape Town; and rapid growth of nearby Atlantis, have contributed towards urbanisation of Mamre. Atlantis was established in the 1970s as part of a State plan to move industry and 'coloured' people from Cape Town (Katzenellenbogen, 1988). Atlantis is about 5km from Mamre and has a population of 68064 (Foundation for Contemporary Research, 1992).

MCHP is a non-government organisation aiming to improve the health of the community (Klopper & Tibbit, 1988). A clinical psychologist service was started there under the auspices of the University of Cape Town in 1991. The service is aimed at preventive rather than curative work. Clinical psychology interns have been placed there since 1992. One of the major roles of the clinical psychologist and intern clinical psychologist in Mamre is to provide consultation and training for health workers and other professionals such as nurses and social workers. Training consists of weekly, morning-long workshops on a variety of topics requested by the consultees. These include basic counselling skills, crisis counselling, grief counselling, conflict resolution, sexual abuse and so on. A wide range of target consultees are invited to these workshops. At the time the research interviews were conducted (September, 1993) clients referred for counselling from Mamre, were assessed and counselled by the psychologist or intern placed there. Initially, the service was not intended or equipped to meet the needs of the population of Atlantis. However, word soon spread that there was a psychologist in Mamre and referrals poured in. It was impossible for the psychologist and intern psychologist to accept these cases. Instead, the

referral agents (usually social workers and nurses) were offered consultation and training. This method of working was in keeping with the spirit of community psychology and the sharing of knowledge and skills.

1.2.2. Motivation for the research

I was working in Mamre as an intern clinical psychologist in 1993. My clinical experience provided motivation for the research. A part of my work entailed providing consultation and training to the community health workers at the MCHP. These workers, mostly paraprofessional, had had some experience as consultees because of the consultation they received to help them run their prevention programmes but had had very little experience of case consultation as they usually referred cases to the psychologists, the intern psychologist or social work student placed there. However, the professional nurses and social workers in Atlantis who wanted to refer clients to the psychologist and interns had almost no experience of consultation and training. I felt unprepared for the level of resistance to this way of working. Offers for consultation and training were often not taken up. Appointments were not kept. One client was referred anonymously from a social work agency which made it difficult for the psychologist not to see the case and impossible to transfer skills to the social worker involved. Consultees did not always attend training workshops. There seemed to be a lack of interest in what was being offered despite an obvious need and despite the reasons for the consultation and training approach being explained clearly to the referral agent every time a referral was made.

I am aware that changing the psychologist's role in the community from case worker to consultant will be a slow process. Reasons for resistance to this change of roles spring to mind easily. It is an unusual way of working and does not fit easily into the typical biomedical model which encourages referral to specialist resources. It is common knowledge that nursing sisters and social workers are overburdened with their existing case loads. The consultation and training approach makes more demands on their time and energy. Because many are relatively untrained to deal with mental health problems, social workers, nursing sisters and paraprofessionals may feel unconfident about taking on the work that is traditionally done by psychologists or psychiatrists. They may not even have an interest in this type of work. I felt a need, however, to examine formally the resistance to consultation and training in order to clarify some of the processes that inhibit it. There were also many examples of successful consultation and training in Mamre which point to factors which facilitate the process. The focus of the research is therefore clarification and explication of factors which facilitate and inhibit the consultation and training process at the MCHP.

1.3. STRUCTURE OF THE DISSERTATION

Chapter two comprises a literature review which aims to introduce the crisis in mental health services in South Africa and consultation and training as a means of addressing the crisis. Factors influencing consultation and training are discussed in detail. The method and aim of the study are presented at the end of Chapter two. Chapter three presents a thematic analysis of the results. Chapter four consists of a discussion of the results and a conclusion to the study.

CHAPTER TWO: LITERATURE REVIEW

2.1. INTRODUCTION

The literature review will begin with a broad overview of the inadequacies of mental health services in South Africa. As Mamre is a rural community, there will be specific attention paid to the neglect of mental health needs in rural communities.

A review of proposed solutions to the inadequacies of mental health services and a brief summary of relevant aspects of the ANC's (1994) national health plan for South Africa, will be followed by a discussion of consultation and training as one way of addressing these inadequacies. Consultation and training will be discussed in general. Thereafter, literature on some of the processes that facilitate and inhibit consultation and training service will be reviewed. A focus on power relations inherent in professional hierarchies is included in the material reviewed, as consultation and training necessarily occurs in an interprofessional context, a context which is bound to have bearing on success or failure of the process.

2.2. THE CRISIS IN MENTAL HEALTH SERVICES

Recent literature (Freeman, 1992; Kriegler, 1993a; Seedat & Nell, 1992) makes it clear that drastic changes are needed in the South African mental health services if these are to be made available and accessible to all members of the population. At present there are insufficient psychologists and other mental health professionals to meet the needs of South Africa. Furthermore, services are distributed so unequally that most people do not benefit from the few resources there are (Kriegler, 1993a). This is because private psychological services are unaffordable to most people in South Africa, and the few state employed psychologists tend to be employed treating hospitalised patients thus making out-patient treatment unavailable (Freeman, 1991). Only 5-10% of people suffering from psychiatric disorders are seen by specialist psychiatric services (Thom, 1990). Furthermore, there is an unequal concentration of psychologists and other mental health care professionals in urban areas, leaving rural populations deprived of mental health services (Freeman, 1991).

Although unavailability of services is a problem elsewhere in the world, for example in rural areas in USA (Williams, 1982) and England (Whittle, 1992); "equity is also denied the majority of South Africans because the process and the content of interventions are alien to them - due to class and/ or cultural diversity" (Freeman, 1991: p.144). Most psychologists are white and work

in the white sector (Seedat & Nell, 1992). State services for the black population are aimed at providing custodial care for psychotic and mentally handicapped people, with medication as the chief form of community follow-up (Freeman, 1992). Facilities are concentrated in white areas (Freeman, 1990b). Throughout the country there have been more beds for white people in psychiatric hospitals and care and rehabilitation centres than for other race groups, and facilities traditionally provided for white patients are superior (Allwood, 1990). Even if services were distributed more equally, "in the public sector there is approximately one psychologist per 304 000 of the population", whereas in the first world there is a ratio of "one psychologist per 4 000" (Kriegler, 1993a: p.64).

Finally, a tricameral parliament system and homelands structure has worsened the existing inequities by fragmenting services into fourteen departments of health. Valuable funding has been spent on administration of these departments and communication between them has been inadequate (ANC, 1994; Freeman, 1989b; Zwi, 1990).

Even if resources were distributed fairly, they are insufficient for meeting the mental health needs of South Africa (Seedat & Nell, 1992). Clearly existing resources have to be used more efficiently if mental health services are to reach more people (Freeman, 1991; Kriegler, 1993a).

2.3. MENTAL HEALTH NEEDS OF RURAL COMMUNITIES

The neglect of mental health needs in rural areas is introduced in this section. Despite a trend towards urbanisation, Mamre's distance from Cape Town and its country lifestyle are sufficient reason to consider Mamre as rural enough to have been affected by the impact of shortage of services particular to rural areas in South Africa.

Internationally there has always been a relative paucity of mental health research and interventions in rural communities (Keller & Murray, 1982). Various ideas have been put forward to explain this. Wagenfeld (1982) proposes that the human sciences have been influenced by a prevailing ideology that life in the country is stress free and idyllic whereas life in an urbanised environment predisposes residents to mental health problems. This, Wagenfeld (1982) believes, is coupled with a myth that there is an extensive network of natural helpers in rural communities which precludes the need for formal services. The end result is that rural community mental health needs have been largely unnoticed and untreated.

Keller & Murray (1982) propose that rural areas are less attractive to mental health professionals than urban areas. Professionals find it difficult to work in rural areas where there is relatively little anonymity and professional roles and boundaries are not always clear. Isolation from supportive

professional networks and major universities plays a role in making rural areas unattractive. Rural areas may be neglected because of the financial cost of providing services over wide geographical distances.

The paucity of services in rural areas has been exacerbated by the international trend towards deinstitutionalisation which has created a greater need for community-based services in both urban and rural areas. Deinstitutionalisation without the appropriate support structures further adds to the burden of already stretched community workers in rural areas (Bachrach, 1982).

The aforementioned international problems apply to the South African rural situation too. The following issues have been cited in recent South African literature as problems in our rural areas that need to be addressed if mental health need are to be met. Rural areas in South Africa have fewer facilities than urban areas for mental health services, for example psychiatric beds. There is also a large disparity between distribution of psychiatrists and psychologists in rural and urban areas. Most mental health care in rural areas is provided by medical officers who are not adequately trained for this work (Freeman, 1990b). Pejorative attitudes towards the mentally ill prevail. Physical illnesses are seen as more deserving of facilities than mental illnesses. There are shortages of staff and nursing staff are overworked and have little job satisfaction (Malebele, 1990). Community Psychiatric Nurses may have as little as five minutes to see each out-patient, and often feel so unsupported that they are reluctant to change medication and diagnoses for fear that patients will relapse. Clinics are inaccessible (Lee, 1990). Transport systems are inefficient. White staff do not always understand and / or acknowledge culturally based explanatory models. Traditional healers are alienated from hospital teams. The homeland system has resulted in a host of problems stemming from fragmentation of services and inefficient administration (Malebele, 1990).

2.4. SUGGESTED WAYS OF ADDRESSING THE INADEQUACIES

Most of the following suggestions have been drawn from Melvyn Freeman's extensive work in the Centre for the Study of Health Policy, Department of Community health, University of the Witwatersrand, Johannesburg.

1. There needs to be a focus on primary health care rather than the present curative model (Freeman, 1990a). Social problems such as poverty need to be addressed as part of mental health prevention programmes (Allwood, 1990). The primary health care approach addresses the impact social and economic factors have on mental health. The social action approach, where mental health professionals lobby for socio-political change is a necessary condition for effective primary health care (Freeman, 1989a).

2. Decentralisation follows from a primary health care approach. It is suggested that people should be treated by primary health care workers at local levels, and only serious cases be referred for institutional intervention (Freeman, 1989a) thus ensuring optimal use of resources, as this is more cost-effective (Freeman, 1990b). Primary care medical practitioners also need to be taught to provide for the mental health needs of their clients (Allwood, 1990). Decentralisation means that mental health services will be moved to the geographical areas where they are most needed. Clinic nurses in rural areas should take over the task of adjusting and repeating medication, and should be trained to deal with emergencies. This would free community psychiatric nurses to focus on preventive work and to spend more time with the patients and their families (Freeman, 1990b).

For decentralisation to work, the following ideal needs to be taken seriously:

"The delivery of mental health care should be non-hierarchical in the sense that the people most readily available with appropriate skills be given more responsibility, rather than necessarily subscribing to the medical hierarchy of the doctor as leader of the team [as this leads to] hampering the functioning of other skilled team members" (Eagle, 1990: p.57).

In this respect, Whittaker (1993) points out that it is impossible to justify psychiatric hegemony in a primary health care approach.

3. Services need to be integrated (Freeman, 1989b) and funds spent on patients rather than maintenance of a fragmented service (Allwood, 1990). The split between private and state sectors is also viewed as an example of fragmentation of services. Therefore, nationalisation of health services has been mooted as a means of correcting this present inequity. However, Freeman (1990b) points out that this approach may be foolish in the long run as it may alienate professionals.

4. Freeman (1990b) states that services need to be modified so that they are cost-effective and appropriate. He suggests the following changes for more appropriate mental health care delivery. First, a move away from the Western model towards a model which acknowledges "African and working class experience" (p.6) is called for. Second, a move away from the medical model "which does not do justice to the people being treated and to the complex social and psychological conditions which shape people's lives" (p.6), is suggested. In this respect, Nell (1993) advocates strongly that unless psychology divorces itself from control by the medical profession it will never be effective and nor will other human services. Finally, Freeman (1990b) suggests a move towards time-limited therapies and deinstitutionalisation with the necessary support structures which make deinstitutionalisation possible.

5. Freeman (1990b) calls for the inclusion of indigenous helpers. He points out that involvement of the 150 000 traditional healers in service delivery would help to make care more broadly accessible. However, he does warn against the danger of exploiting these helpers to rationalise inadequate provision of formal resources.

6. Freeman (1990b) calls for a participatory relationship between mental health professionals and the community they serve. Mokhuane (1993) points out that such a partnership would enable the spreading of skills and knowledge, and would have the function of demystifying psychology. It would also mean that community needs will be prioritised.

7. Training needs to be modified so that the mental health skills and knowledge taught are appropriate for the majority of the population in South Africa (Eagle, 1990). It has been suggested that a new category of mental health professionals, psychologists with an Honours degree, could become the basis of the mental health care system in South Africa and that mental health workers should show proficiency in an African language as a prerequisite for registration (Whittaker, 1993). Psychologists need to be trained in community psychology (Swart, 1993). Thirty-five to forty percent of the internship should be devoted to consultation and programme development activities (Kriegler: 1993b). It has even been suggested that consultation and programme development should form the central part of training programmes (Skuy, 1993).

In summary, some of the ways in which the health care services can be changed so that they are more available, accessible and equitable are: A focus on primary health care; decentralisation of services; doing away with fragmentation; modification of services to make them more cost-effective and appropriate; involvement of indigenous helpers and traditional healers; community participation in planning and implementing services and modification of training programmes to make them more relevant than they are at present.

In closing at a symposium on rural community mental health care, held at Tintswalo Hospital in June 1990, Pugh pointed out that we need to accept that we will never have enough resources. The only hope is to use the existing resources in a more cost-effective and efficient way. Likewise, Hayes (1993) cautions that a new government in South Africa is not going to make mental health a top priority because there are so many other socio-economic ills that need attention, and that we are going to have to create our own resources and use the ones we have more effectively. Consultation and training is one creative way of using limited resources effectively.

2.5. ANC NATIONAL HEALTH PLAN FOR SOUTH AFRICA

The ANC national health plan (ANC, 1994: p.7) generally aims to address the inequities of apartheid, the fragmentation of health care services, centralisation, medical hegemony, the present emphasis on curative medicine, lack of community participation and lack of accountability. The emphasis is on the right to health, equity and a primary health care approach with all sectors of health services under one, integrated National Health System. Authority and responsibility will be decentralised to the most local level possible (ibid.: p.19).

More specifically, the mental health policy (ANC, 1994: p.46) has the following aims: Promotion of a range of services at a community level; empowering people and communities; prevention and promotion with priority to those at risk; emphasis on children; focus on rights of the mentally ill and handicapped; and the promotion of awareness of mental health and illness.

Mechanisms for translating aims into action include: Integration of services particularly at a primary health care level (e.g. health and welfare systems); encouraging co-operation between various structures; encouraging community care and support of community care-givers; supporting non-government services; fostering co-operation with traditional healers and development of services which are appropriate to the languages and values of consumers; development and support of prevention programmes in areas such as alcohol abuse and violence; improving institutional care and encouraging consumer participation in policy and decision-making (ibid.: pp. 46-47).

There is a recognition in the policy that psychological well-being is partially determined by social and material conditions as well as other factors, a reality which has been traditionally ignored by previous South African governments (see Seedat & Nell, 1992).

2.6. CONSULTATION AND TRAINING AS A SOLUTION

Surveys show that most individuals with mental health problems seek help from their primary care, front-line worker who may be a traditional healer, a primary health care nurse or general practitioner. In fact, 10-20% of individuals presenting at a primary health level meet the criteria for a psychiatric diagnosis. Disorders in primary care tend to be in the range of anxiety and depression (90%) rather than psychotic disorders and personality disorders. At a primary care level, disorders are often not identified. Psychiatric services tend to cater for those with major psychotic illnesses, personality disorders and substance abuse (Thom, 1990: pp.74-82). The above factors make it clear why Freeman (1990b) advocates decentralisation of services to the primary care worker.

However, although primary care workers are the front-line for disorders such as anxiety and depression, "psychology was unlikely to have been the main priority in their training, nor is understanding and responding to psychological difficulty likely to be the first priority in the organisations for which they work" (Orford, 1992: p.137). This is why one of the most important focuses of community psychology has been to share psychological skills and knowledge. For decentralisation to work, consultation and training needs to be provided for the front-line workers to identify and treat, and where appropriate, refer the individuals who seek their help.

In short, the consultation and training approach makes decentralisation possible. It encourages the involvement of traditional healers, natural helpers and non-specialist health workers such as clinic nurses. It makes it possible for clients to receive care and support in languages and frameworks acceptable to them. It encourages community participation. It is a cost effective and appropriate way of reaching the majority of the population. Although not strictly a primary prevention approach as it often addresses the symptoms rather than the cause, consultation and training certainly enables early detection of and intervention with disorders such as anxiety and depression which may otherwise go unnoticed until they have serious complications. Freeman (1989a: p.14) points out that "there is substantial theory to support the idea that such intervention can improve later mental health", so in this respect consultation and training can be seen as preventing disorders and promoting mental well-being.

2.7. FACTORS INFLUENCING CONSULTATION AND TRAINING

2.7.1. Introduction

In this section I identify various factors which influence consultation and training. Although they are seemingly disparate, I will argue that they are all partly a product of intra- and particularly interprofessional power relations.

2.7.2. Consultation may not be acceptable

A consultation and training approach means that front-line care-givers need to take on a new role as counsellors instead of referring clients to specialist services or ignoring mental health needs. For various reasons, this may be more or less acceptable to these care-givers. For example, Clement (1987) set up a consultation programme (the Salford experiment) to help primary care workers (nurses, social workers, general medical practitioners, probation officers and health visitors) to deal with their clients with alcohol-related problems. Initially the team (community alcohol team, referred to as the 'CAT') offered pure consultation but after discussion with their target consultees they found that this proposal was not acceptable to most target consultees.

Some health care workers felt that work was being taken away from them. Others "saw it as an attempt to foist extra work on them at a point when their resources were already stretched" (p.126). Some saw it as a way of the consultation team avoiding grassroots work and 'getting their hands dirty', as the following quote from a social worker illustrates:

"They come in and advise us how it should be done, that's all very well but it is us that has to do it!
What we need is people who will actually see our clients and do something for them (p.126)."

Because of the feedback they had received the team decided to compromise and offer joint consultation and short-term intervention with the primary health worker. Clement believes that the flexibility of this approach enabled them to avoid the criticisms levelled at pure consultation. Joint assessment and intervention enabled the team to model for primary care workers. It was believed that this way of working was more supportive than pure consultation. At all times, however, the primary care worker remained ultimately responsible for the client, and continued to see the client once contact with the consultation team was terminated. The general medical practitioners approached refused any kind of consultation at all, saying that they had no time to deal with the alcohol-related problems of their patients. The consultation team accepted straight referrals from these medical practitioners because of the team's policy of flexibility and hoped that by being seen as helpful they would build relationships with the medical practitioners and finally sell consultation. In this example of consultation, it appears that pure consultation was not necessarily the appropriate way to "share psychology." Orford (1992) points out that in the Salford experiment, even when general medical practitioner referrals were excluded from analysis, only 26% of all client assessments were carried out jointly in the two years of the evaluation. Thirteen percent were not assessed at all (Clement, 1987). Presumably the remainder were assessed and treated by the team in the traditional way.

The factors outlined below may facilitate or inhibit consultation and training. They have been separated for conceptual clarity but in practice overlap and co-exist.

2.7.3. Support for the consultee

Support for the consultee is considered to be a factor which facilitates the consultation process (Clement, 1987). Hargrove (1982) points out that this is an area largely neglected by administrators and mental health care boards. He advocates support groups and open lines of communication between administrators and community mental health workers. Other writers have also made it clear, however, that consultation is not psycho-therapy (for example, Caplan & Caplan, 1993). The kind of support advocated by Caplan and Caplan appears to be work-related

rather than to do with personal problems. However, it is not always clear where the dividing line is. This issue will be expanded on below.

2.7.3.1. Consultation and personal support

Steinberg (1989) makes it absolutely clear that "support" is focused primarily on helping people cope with their work emotionally, whereas consultation addresses the work itself and how it is handled. Steinberg does not see support as a necessary part of consultation but feels that "if it is also supportive that is fine, and a useful side effect" (p.9). One of the reasons consultation may be confused with counselling is that it has a similar approach to Rogerian-type therapy which acknowledges the client's autonomy and ability to find solutions to problems. Again however, these are supposed to be work-related problems rather than personal difficulties, and Steinberg (1989) argues that the consultant should avoid playing counsellor. Orford (1992) notes that most community psychologists have taken a similar stance with regard to support and consultation. Any increased sense of well-being in the consultee is viewed as a spin-off from the primary work-related task but actual discussion of personal problems is avoided and even cautioned against. One reason is that a focus on personal problems may be seen as intrusive and show a lack of respect for the consultee's integrity and professional standing (Heller, et al., 1984). Heller, et al. even suggest that an inexperienced consultant may be unwittingly drawn into providing a therapeutic collusion with the consultee which helps the consultee avoid taking personal responsibility for difficulties. Caplan & Caplan (1993) believes that if the consultee is allowed to bring personal feelings into the consulting relationship, it immediately disturbs the equity, or "coordinate interdependence" (p.60) of the relationship, putting the consultee in a subordinate position. Caplan and Caplan also point out that doing therapy or counselling in time which is intended for consulting is an abuse of agency (whoever is paying the consultant) funds.

Orford (1992) notes that the tendency to avoid the consultee's personal issues stems from Caplan's (1970) seminal work on consultation. Caplan (1970) does, however, write that emotional support is part of the process:

"The role of the consultee certainly includes dependence on the consultant. The latter gives him emotional support and cognitive guidance through enlarging and deepening his understanding of mental health issues and through clarifying previously unperceived patterns in the dynamics of the case " (p.80).

However, Caplan (1970) goes on to discuss techniques of avoiding discussion of personal issues such as:

"If the consultee spontaneously begins to talk about his feelings, the consultant should as soon as possible interrupt and divert the discussion to some aspect of the client, usually by asking a question to elicit further facts or making a comment about the case. As previously mentioned, the consultant should not talk about the consultees' feelings, even supportively (p.102); ... "If a consultee is obviously tense and upset, the consultant should be especially careful not to allow him to gain control over the interview by embarking on a long and rapid monologue" (p.103) ... "If the consultee manages to elude the consultant's preventive efforts and does begin to talk about his private life, this should be tactfully but quickly interrupted" (p.104).

Caplan and Caplan's 1993 update of Caplan's 1970 publication shows little deviation from the original position. Even consultees' requests for referral to psychotherapy are seen by Caplan & Caplan (1993) as inappropriate, as this would mean some discussion of the personal problems and disturb the balance of coordinate relationship and put the consultee in a 'one-downmanship' position. Even when the consultee's personal experience is relevant to the case, for example, in the case of a bed-wetting child, Caplan and Caplan do not allow the consultee to speak about it. They advise:

"The consultant in such instances must try to convey the implication that most of us professionals have personal problems but that usually we can keep them confined to our private lives, so that they need not intrude into the work sphere..."(p.82).

In general the message in the consultation literature seems to be unequivocally against personal feelings and issues entering into consultation. It is not so clear, however, whether support is deemed necessary and if it is, how one can distinguish between 'personal' feelings and support, and 'work-related' feelings and support.

2.7.3.2. Role support

Work-related support seems to be an element which helps health workers attend to their client's mental health needs and is therefore be seen as a factor facilitating the consultation and training approach. For example, Clement (1987) discovered that the consultees who received a high degree of support from their agency managers for the role they had taken on, were more successful in their work than those who were not supported.

Shaw, Cartwright, Spratley & Harwin (1978) describe lack of "role support" (p.164), a phrase which refers to a situation in which the health worker is not supported by authorities in their organisation, or does not have sufficient personal support or supervision to do the work. This is seen as a factor inhibiting the consultation process.

A local example (Mgoduso & Butchart, 1992 and Seedat & Nell, 1992) clearly illustrates how lack of role support from agency managers undermined a consultation and training effort. Eighteen nurses from the Soweto Community Health Centre System participated in a forty-two hour training programme designed to improve their skills dealing with clients' psychological and social problems. Mgoduso and Butchart (1992) report that "they were enthusiastic about the idea of applying the skills in day-to-day practice but that lack of support from their superiors and role conflict undermined such application" (p.195). It was found that the nurses were frequently moved to different work sites and therefore could not maintain relationships with clients or even be sure that they could keep follow-up appointments. They were not afforded the time, space or privacy to counsel clients. Some reported that they were criticised by doctors, matrons and colleagues for wasting time. Clearly, unless agency managers, colleagues and superordinate professions support front-line care-givers in their role, consultation and training programmes will be undermined.

2.7.4. Consultee versus consultant frame

Spratley (1987) stresses the importance of speaking about the problem which is brought by the consultee to the consultation session, in the consultee's words. Steinberg (1989) states that the consultee's perspective must always be given priority, and discussion should be framed in the consultee's terms. In counselling it has been found that recommendations are more likely to be carried out if matched with the client's presentation of the problem (Conoley, Padula, Payton & Daniels, 1994). It makes sense that consultation will be more successful if the problem and approach is framed in ways familiar and understandable to the consultee.

Another local example illustrates that consultation and training efforts will be undermined unless the service is offered within a framework of values and practices acceptable to both consultees and the clients they serve. Turton (1986) analyses the failure of a counselling centre which was set up in a working class, community near Johannesburg. Although counsellors were drawn from the community they served, they were trained to counsel using an essentially middle-class model. This means that counsellors were trained to frame problems as emotional despite the fact that a high percentage (41,89% as opposed to 6,04% of white counterparts) of clients brought material rather than emotional or interpersonal difficulties to the counselling sessions. Counsellors were trained not to help directly with material problems, as the counselling model assumed that clients would be able to access resources once their emotional problem had been addressed. Counsellors were also trained not to give advice, which became frustrating for clients who often needed advice, for example, about resources available. The end result was that the counsellors were ill-equipped to deal with the community they were serving and there was a high drop-out rate of counsellors. Turton reports that counsellors initially resisted the model imposed on them, but

lacked the confidence and so-called expertise to continue arguing against the model. One can speculate that leaving the service was the only way counsellors could protest against the inappropriate model. One can extrapolate from this example to consultation and training: The consultation and training process is unlikely to work if the consultees do not experience the consultants' framework as being compatible with their own values and with client needs. Turton concludes: "The point is not magnanimously to share *our* (emphasis in the original) knowledge and skills with them, but to share in their knowledge and skills as well as giving what is valuable in ours" (1986: p.99).

2.7.5. Resources: Staff and time

Consultation and training aims to address the shortage of professionals such as psychologists. However, it is well documented that front-line workers themselves are overburdened with work. It has already been mentioned that the Community psychiatric nurse at Tintswalo Hospital has as little as five minutes to assess and treat each patient (Lee, 1990) and that this is considered a typical problem. This is why Freeman (1990a) advocates decentralisation - a shift of the workload to clinic nurses to free the community psychiatric nurse for the more difficult and complex cases. However, as Freeman (1989b) points out, training workers makes no sense unless they have the time to use their knowledge, and even the most efficient interventions require a lot of time. Consultation and training programmes are hindered if there are insufficient resources to avail care-givers of the time to spend attending to their clients' psychosocial needs.

2.7.6. Role adequacy

Shaw, et al. (1978) wrote about anxiety about "role adequacy" (p.164) to describe mental health workers' feelings that they lacked confidence, knowledge and skills to identify and intervene with certain disorders. This perception of their abilities influenced their belief that successful interventions could be made with a group of clients with alcoholism. Even asking for consultation or help may be viewed by the consultee as a weakness reflecting a lack of adequacy and therefore may also contribute to resistance of consultation (Caplan & Caplan, 1993). The consultation and training process will be affected by the consultee's degree of anxiety about role adequacy. It is expected that the process of training will address some of these feelings of inadequacy.

2.7.7. Role legitimacy

Shaw, et al. (1978) found that some consultees faced with alcohol abuse problems felt that they had the right to ask their clients for information about drinking ("role legitimacy"), (p.164). However, some thought they did not have the right to ask questions and that working with

alcohol related problems was not a legitimate part of their jobs. Clearly, the more legitimate the role is in the eyes of the consultee, the consultant, other professionals and especially clients, the more successful consultation and training is going to be.

2.8. HIERARCHICAL PROFESSIONAL RELATIONSHIPS

One issue underlies the aforementioned factors which are seen to inhibit or facilitate consultation and training. This is the issue of professionalisation. Each factor mentioned in the previous section will now be explored in the light of the system of professions and power relationships implicit in professional hierarchies.

2.8.1. Support and professional hierarchies

2.8.1.1. Personal support and experiences

Caplan & Caplan (1993) advises that the consultation relationship should be non-hierarchical. They describe this non-hierarchical, egalitarian relationship as a relationship of "coordinate interdependence" (p.60). Caplan & Caplan (1993) advise that in order to maintain such a relationship a contract should be negotiated prior to consultation:

"The contract should also specify what the consultant will *not* (emphasis in the original) do; for example psychotherapy for personal problems of consultees, discussion of intrastaff problems such as relationships of line workers and supervisors, or intervention in staff conflicts" (p.54).

Of course, consultants have the right to define their role but this is typically a unilateral decision. What if consultees thought it would be helpful to discuss their personal experience, particularly since front-line workers are considered appropriate counsellors because of the very nature of their personal experiences (for example, Karafat & Boroto, 1977), and their status as natural helpers? It seems as if the decision to avoid discussion of personal feelings and to provide support for personal experiences could be made only in the context of an hierarchical professional relationship.

It is possible that if consultants refuse to allow personal experiences and feelings in consultation, they may paradoxically, be unwittingly reinforcing their professional power. Gyarmati (1975) writes that professions maintain their dominance through a university education system which devalues "knowledge acquired outside the formal system by means of practical experience, autodidacticism, etc." (p.648). There seems to be a contradiction in the literature between holding natural helpers in regard for their informal knowledge and personal experience, and not

allowing this to be discussed in consultation sessions for fear of the making the consultee feel subordinate to the consultant as argued by Caplan & Caplan (1993). For example, if a paraprofessional health worker has struggled to help her own child overcome enuresis, she is ideally suited to help other mothers with the same issue. If her personal experience and feelings about the case are not included in the consultation discussions, valuable knowledge is overlooked. To exclude such knowledge may function to support the dominance of university-educated professionals and reinforce inadequate feelings of subordinate professionals and paraprofessionals. The nonhierarchical ideal cannot be achieved in this context, and the consultation and training process may be hampered. If personal experience and informal knowledge of the consultee is included, and seen as valuable, role adequacy and egalitarian relationships are more likely to be fostered.

An unusual deviation in the tradition is described by Spratley (1987) who takes a psychodynamically-oriented approach, and asks consultees questions like: "How does the client make you feel?" and "Who in the past does the client remind you of?" Spratley believes that it is important that the consultee likes the client and that their relationship is not harmed by negative feelings towards the client. He writes that consultees cannot fail to bring their own experiences into the relationship with their clients, and these can be explored in consultation. Nowhere does Spratley write that he has found this a dangerous practice or that the consultee feels intruded upon, or put down. Rather, dealing with these feelings seems to be a necessary part of the consultant's role. How else can the consultee receive emotional support and increased understanding of the dynamics of the case, as Caplan (1970) suggests?

2.8.1.2. Role support

In the study referred to above, Mgoduso & Butchart (1992) concluded that the eighteen nurses they had trained were unable to use their skills in the context of the intraprofessional power relationship between nurses and matrons. The nurses were not supported in the new role they tried to take on and did not have the intra-professional power to make the changes necessary to support their new roles. Mgoduso & Butchart argue that these hierarchical relationships help to maintain the hegemony of the biomedical model which in turn maintains the focus on the individual rather than socio-political roots of illness. The important point for the present study, however, is that consultation and training aims for front-line workers such as nurses to change their roles, and unless agency support is given for these new roles, consultation and training will fail.

2.8.2. Professional politics and frameworks

It makes sense that the more powerful a profession is, the more likely and able it is to impose its framework of theory and practice on a subordinate profession or group of paraprofessionals. Turton's (1986) study has already been mentioned as an example of a more powerful (middle-class, white) group imposing their counselling model on a less powerful (working-class black) nonprofessional volunteers. Turton argued that the trainee counsellors did not have the knowledge or wherewithal to argue with the so-called "expert", professional trainers. They did, however, leave the agency which may have been an expression of their lack of faith in the model in which they were trained. The medical profession has also been criticised for imposing its biomedical framework on less powerful audiences such as the nursing profession and the general population to the exclusion of a psychosocial one (for example, Seedat & Nell, 1992). Abbott (1988) argues that the unequal balance of power which allows imposition of frameworks, rests partly on the knowledge base which the superordinate profession possesses and which defines them as expert, and serves to accomplish legitimation of their jurisdiction. Furthermore, Abbott points out that superordinate professions, like medicine, rarely lose the ability to instruct themselves, whereas subordinate professions such as nursing often lose this ability to dominant professions. The result of instruction by a dominant profession is that the values, theory and practice of that profession are passed on, hence maintaining the culture and therefore power of that particular profession. Rose (1992) describes how the Tavistock institution has managed to spread psychoanalytic "therapeutics" (p.1), which describes the way events are problematised, diagnosed and remedied. Instead of teaching professionals, Rose (1992) argues that training is a matter of:

"transfiguring (emphasis in the original) them, remaking their personhood at a very fundamental level, so that the ways in which they experience the world and their own desires would be indistinguishable from the Tavi's own" (p.2).

Gyarmati (1975) points out that not only is education controlled by superordinate professions, but in order to maintain dominance,

"It is...necessary to draw up a set of rules governing the role of each group, its sphere of competence and corresponding rights and obligations ... the hierarchical relationships between several occupational groups, and so on ... to co-ordinate the activities of the various occupations and to regulate and supervise them" (p.633).

Now, consultation and training is frequently defined as a relationship in which an expert helps a non-expert to do the work (for example, Caplan & Caplan, 1993; Williams, 1982). On the other

hand, consultation and training is about acknowledging the expertise of front-line helpers, and is about the wish to share knowledge and jurisdiction rather than monopolise it (Orford, 1992) so the consultant-consultee relationship should be free of the power imbalances maintained by those invested in professional power. It has already been argued that failure to take into account the consultees' informal knowledge and personal experiences reinforces dominance. There seems to be a tension between Caplan and Caplan's egalitarian ideal and the practice of imparting expert knowledge. No matter how willing psychologists are to create non-hierarchical relationships, their superordinate, "expert" (more educated, more autonomous, usually white) professional status is likely to interfere with the process. This is further compounded by the fact that most target consultees are likely to have experienced an imposed biomedical model and the powerlessness of subordination. Finally, in South Africa most target consultees would have experienced the impositions and controls forced on them by apartheid and the dominant elite. It is possible that consultation and training itself may be seen as a model which is imposed by psychologists on target consultees, most commonly less dominant professionals and paraprofessionals. Louw (1992) has this to say:

"We tend to view what I have called the production of a new audience..., simply as a response to a perceived societal need . My objection to this is that problems do not arise out there in society or in specific client groups, independently from the activities of the professional group and ready-made for their interventions. The profession itself participates in the definition of these problems, if not in their 'social construction' " (p.51).

Consultation and training is a method of working which has been used by psychologists to meet mental health needs. Essentially, however, it requires that less powerful groups of people do the work. It follows therefore, that for consultation and training to be accepted by target populations, it is not only important to enter into the consultees' framework. It is also essential that the process itself is negotiated with target groups to avoid the danger of psychologists being perceived as yet another group of powerful professionals imposing their framework (consultation and training) on less powerful ones. Power in this context may not be a question of overt dominance, but as Rose (1992) describes:

"*action on the actions of others* (emphasis in the original). Such power implies freedom: it works best through shaping the ways in which others construe and enact their freedom. To multiply yourself through transfiguration relieves you of the task of having to calculate for all eventualities. Transfigured individuals themselves will apply, innovate, shape, develop, extend and refashion your programmes in a multitude of multitude of sites and in relation to a multitude of local problems" (p.2).

The question of power, and of psychology imposing frameworks on other groups, will be taken up in a later section in which parallels are drawn between biomedical power and the power of the psychology profession.

2.8.3. Professional politics and resources

Mgoduso & Butchart (1992) found that the nurses in their study were unable to implement their skills because of a lack of resources such as time and privacy. Because of their subordinate professional position and lack of autonomy, they could not make the changes in the system to enable them to create resources to counsel their clients.

In theory however, consultation and training assumes that front-line workers will be able and willing to fill the gap for the shortage of psychologists. Botsane (1990) argues that although there is a drastic shortage of psychologists, psychiatrists and other mental health professionals as well as psychiatric nurses, it is traditionally the nurse, who is not always sufficiently trained and overburdened, who has to fill the gap resulting from this shortage. Vitus (1990: p.35) writes in this respect: "While psychiatrists, psychologists and social workers have fought about who should do the work, nurses have had to get on with it." It follows that unless it is negotiated with the professional or paraprofessional groups who are expected to fill the gap, and unless consultees are empowered to create more flexible working conditions, consultation and training efforts will be blocked by a lack of resources. Caplan (1970) recognised this problem:

"...nurses are particularly sensitive to being given extra burdens, which not infrequently happens when people higher in the public health authority system react to new ideas and add new functions to the agency without being able to supplement its resources " (p.71).

Because of their relative low status in the hierarchy, Caplan (1970) believes that nurses may have to

"...work out ways of resisting pressure from the higher levels of the power hierarchy, who may try to force them to take on all kinds of new responsibilities as the changeable winds of fashion blow. ...Public nurses are...trained to adopt a disciplined compliance with orders from above. The result has been the development of a subtle informal type of passive or hidden resistance to pressure and a cultural suspiciousness of promises of support and extra resources to be given in return for supplementary or new duties" (p.75).

If consultation is viewed by consultees as a powerful imposition of extra work, they may react by passive resistance, thus rendering the consultant powerless. There seems to be a danger in

consultation and training being perceived as a new idea, or fashion which translates into more unrewarding work for the already overburdened consultee.

A recent article (Schaufeli & Janczur, 1994) contains a list of factors positively correlated with burnout in nurses. These include: time spent in direct contact with patients, emotional demands of patients, patients with poor prognosis, a heavy workload, poor personal support and role conflict and ambiguity. Consultation and training requires that care-givers have more direct contact with patients, and are more in touch with the emotional demands of patients who may also have poor prognoses or insurmountable social problems. All of this in addition to an already heavy workload in the context of poor support and role conflict adds up to high risk for burnout. Nurses and other care-givers may avoid the psychosocial needs of clients and resist consultation and training in order to protect themselves from burnout. Consultants need to acknowledge the risk and include protective measures in their work in order to facilitate the consulting process.

2.8.4. Role adequacy, legitimacy and confusion

This section is based on the argument that subordinate professions and paraprofessionals are more likely to experience role inadequacy, lack of role legitimacy and role confusion than members of more autonomous professions.

Paraprofessionals may be particularly prone to experiencing role confusion. The paraprofessional movement has grown in response to personnel deficits in health care systems. It has been argued that paraprofessionals have also proved to be more efficient in delivering mental health care because they bridge the gap between consumer and professional, and because of their knowledge of communities (Karafat & Boroto, 1977). It is also a commonly held belief that better mental health care can be provided by an 'ethnic' or 'racial' equal, but this is an hypothesis which has not been conclusively demonstrated (Sue, 1988). Their training and employment is also less expensive than professional training and employment, the "least noble" factor giving rise to the movement (Morell, 1979). Their usefulness as natural helpers makes them obvious target consultees.

Community psychology often concerns itself with psychologists moving away from front-line work to new roles such as "administrator, trainer, consultant, researcher and conceptualiser" (Karafat & Boroto, 1977: p.9). Paraprofessionals are one group that can provide front-line, direct services. However, Karafat and Boroto point out that their roles are not always clearly defined. This results in lack of identity and low morale as paraprofessionals are not always sure where they fit in the overall scheme of mental health care provision (role legitimacy and role inadequacy). Role confusion may lead to friction with professional members of the team over

who does what. Finally, paraprofessionals may be evaluated (presumably by professionals, consumers and themselves) by unfair professional criteria which would further reinforce role inadequacy. Tensions between professionals and paraprofessionals resulting from differences in status, power and salary and conflict over who really does the work makes the consultant's task difficult to achieve (Morell, 1979). Although roles are more clearly defined in professions such as nursing, friction may arise if psychologists are seen to be redefining them by giving away the work (Hollister, 1982).

Abbott (1988) argues that traditionally professions have been defined partially by the body of abstract knowledge that they possess. The more members of a profession are associated with pure abstract knowledge, the higher the status they have (for example, academics in medicine). The practical work which actually legitimises a profession tends to compromise abstract knowledge with practical realities and therefore tends to be delegated to low-status professionals (for example interns within a profession or nurses) or paraprofessionals, particularly if it is unrewarding and routine work. Sometimes when unrewarding and routine work is given away it loses its worth and actually serves to reinforce the degradation of the group of people doing it (Abbott, 1988).

If Abbott is right, psychologists may be reinforcing their higher status by taking on roles such as consultant and researcher and giving away 'hands - on' work. Therefore inadequate feelings amongst both subordinate professionals and paraprofessionals may be reinforced. This is particularly so when one considers that hands-on work is time-consuming, emotionally draining and does not bring financial rewards (except in the private sector where psychologists are unlikely to relinquish their jurisdiction to paraprofessionals or subordinate professionals). This is probably why Orford (1992) suggests that consultants must be experienced in areas in which they consult, and continue to have hands-on experience with the work in order to maintain credibility with the consultee.

Magical powers are often attributed to psychologists. For example, Seedat & Nell (1992) describe responses to the presence of a psychologist in a clinic in Soweto. These include fear that the psychologist could read minds and other anxieties that the psychologist could intrude uninvited into the intrapsychic worlds of the clinic team members. Seedat & Nell (1992) suggest that the magic powers attributed to psychologists may arise from the expectation that clients surrender their inner worlds to the psychologist, 'the expert', and that psychologists are seen to have special powers of observation which can be employed in interactions beyond clinical encounters. It is possible that the lay perception that psychologists have magical powers may arise from the professional knowledge which psychologists possess and paraprofessionals and subordinate professions do not. It is possible that this knowledge (perceived as magic) may be

associated with being professional rather than be seen as something that can be attained by learning and training. Not having the same professional status and autonomy as psychologists may leave consultees feeling that regardless of how much training and experience they have, they will never be as legitimate or as adequate as nor possess the same "magic" as the consultant does. One of the ways Spratley (1987) tries to make the relationship more equal is to recognise that the consultee feels threatened by exposing work and mistakes. Spratley advises consultants to share the experience of their own mistakes as this helps the consultee feels less insecure.

In short, role confusion, role inadequacy and role illegitimacy may be unwittingly reinforced by the psychologist's status as consultant. This means that the consultation and training process has obstacles due to the inherent inequity in the consultant-consultee relationship which ought to be addressed in order to facilitate consultation and training.

A further problem may arise from a lack of role boundaries. One of the often cited advantages of paraprofessionals and other target consultees is that they belong to the community from which they are drawn (for example, Morell, 1979). This, however, has the negative result of contributing towards role confusion. Fellow-community members do not have the same professional distance from clients as psychologists usually do, and have to perform multiple roles such as neighbour, counsellor and whatever other role they fill in the community, as described by Hargrove (1982). Their legitimacy as counsellors may be questioned by community members who know them in different roles. Their ability to maintain confidentiality may be more easily questioned and they may not be trusted as easily as a professional because they do not have the formal system of ethics which is definitive of professions and serves to legitimise professionals in the public eye. Multiple roles may make it difficult for consultees to set limits as to when they are available or not, and they may find clients making intrusive demands on them outside of working hours and working places. Both professionals and paraprofessionals in small, rural communities are expected to be generalists, knowing a little bit about everything (Hargrove, 1982). This generalist function may serve to reinforce role inadequacy in consultees who may feel insecure about not being "expert" at anything.

Finally, the power of a profession to define their own role legitimacy depends on their position in the inter-professional hierarchy. When consultees found Clement's (1987) offer of pure consultation unacceptable, it was the general practitioners who refused the offer altogether and insisted on a system of traditional referral for their clients with alcohol-related problems. It can be speculated that it was because of their position at the top of the hierarchy, that the general practitioners had the power to maintain the *status quo*, i.e. not to take on counselling as a legitimate part of their work. In contrast, the other, less powerful professions and paraprofessionals compromised and took on the role of counsellor and the consultation and

training approach. It is possible that professional nurses, social workers, paraprofessionals and other health care workers may not see counselling as part of their work (role legitimacy), particularly in view of Abbott's (1988) observation that routine and financially unrewarding work tends to be delegated to subordinate professions. However, it may be more difficult for them than it is for general practitioners, to refuse the work and the re-definition of roles it entails. If counselling is taken on as work but not really seen as legitimate, consultation and training is likely to be difficult to implement.

In conclusion, usually there is competition for work in the professions, but only when the work comes with reward. Consultation and training may be viewed as a way of getting rid of unrewarding work to people that do not feel that it is legitimate for them to do that work. Furthermore, in South Africa, work may seem impossible to do, as the public is seen as culturally and linguistically unavailable to psychologists. This may be another reason for giving away work. Obviously, the resentment that results from this will have an undermining effect on consultation and training.

2.9. POWER, BIOMEDICINE AND PSYCHOLOGY

2.9.1. Introduction

So far, certain obstacles to consultation and training have been identified. It has been argued that these obstacles arise in the context of intra- and particularly interprofessional power relations. In this section I will discuss the marginalised status of psychosocial issues within biomedicine, and the concomitant subordinate position of psychology and other occupational groups (such as traditional healers) to the medical profession. I will then argue that there is a parallel in terms of power between the medical profession in relation to psychology and psychology in relation to subordinate professionals and paraprofessionals. I will try and understand why power relations are maintained and continue to influence practice, despite progressive psychology's genuine desire to democratise psychology and create egalitarian consultant-consultee relationships.

2.9.2. Biomedicine and power relations

2.9.2.1. Criticisms of biomedicine

An understanding of the status that psychosocial issues have within biomedicine may explain in part why counselling might not be seen as legitimate work by health workers. It has been argued that biomedicine is the dominant paradigm in Western health care systems (Gordon, 1988). Biomedicine has been criticised for its metaphysical roots in Cartesian dualism which results in a

world view of a natural split between mind and body (Kirmayer, 1988). Cartesian dualism permeates Western thought and is uncritically accepted as the truth about existence. Biomedicine perpetuates this view by giving "epistemological grounds for conventional beliefs about society" (Young, 1980: p.144). Kirmayer argues that biomedicine is concerned with having rational (mind) control over an irrational body, the object of disease. Psychosocial causes, explanations and effects of illness threaten the illusion of rational supremacy of mind over body and are therefore marginalised. Once it has become apparent that an illness is not treatable and amenable to biomedical intervention, biomedicine tends to blame the patient for not being compliant, or attributes failure of treatment to emotional (psychosomatic) causes. This is when physicians may wash their hands of the problem and sometimes refer to psychology or psychiatry. Kirmayer gives an example of a patient who had an operation for a compressed nerve root. Further complaints of pain resulted in the surgeon suggesting referral to a psychiatrist because the surgeon was convinced that "the biological machine has been set right" (p. 61). Later investigations revealed that there was indeed a compressed nerve and the patient's pain was deemed 'real' again. Kirmayer points out that the reluctance of the surgeon to take cognisance of the patient's experience shows how demonstrable, biological lesions are seen as 'real' and rational, whereas subjective accounts of illness are not.

2.9.2.2. The biopsychosocial approach

In an apparent attempt to correct biomedicine's one-sided approach, which marginalises psychosocial issues, Engel (1977) conceived of the biopsychosocial model. This model, based on systems theory and borrowed from biology, claims to give equal weight to all systems contributing towards illness. Engel's model has been widely hailed as a revolutionary improvement in approach to causes, consequences and responses to illness. Some views are: The biopsychosocial method should be the essential teaching philosophy in modern medicine (Neghme, 1985); the biopsychosocial model is a way of achieving the WHO's vision of complete mental, physical and social well-being (Ataudo, 1985); and the biopsychosocial approach is a new universal model which cuts across race and ethnicity (Lolas, 1985).

Armstrong (1987) however, argues that the biopsychosocial approach is anything but a genuine attempt to give the social sciences a voice in discourse about illness. Armstrong criticises Engel for clinging to the idea that there is a "fundamental truth" which is "the biological basis of disease" and for simply tacking on the psychosocial 'system' (p.1215). Armstrong points out that biomedicine maintains its position by marginalising competition/ threats as it has done in the past with social sciences, or incorporating them. The biopsychosocial model is seen by Armstrong as mere assimilation of the psychosocial threat, thus giving the impression that there is no conflict

between biomedical and psychosocial paradigms. In reality, the biomedical lesion continues to be held up as the ultimate 'true' factor in illness. Medical hegemony is secured.

2.9.2.3. The multi-disciplinary team

Like the biopsychosocial model, the concept of a multi-disciplinary team purports to give a voice to the psychosocial aspects of illness (for example, Papaikonomou, 1991). In reality, however, as Miller & Swartz (1991) report, the presence of a psychologist in a multi-disciplinary team in a hospital setting, legitimises marginalisation of psychosocial causes and effects. The 'difficult' and 'non-compliant' patients are referred for psychological intervention with the expectation that the psychologists will return the patient changed and adapted and willing to comply with biomedical requirements. This is clearly shown in the expectations eighty general medical practitioners were seen to have of psychologists' interventions in Papaikonomou's (1991) study:

Improvement in the quality of life and realistic approach to life and illness (43,2%); Better handling and identification of problems (16,2%); Emotional stability and self-confidence (12,2%); Insight, understanding and acceptance of their own condition (10,8%); Improved communication and compliancy (8,1%); No fixed expectations (5,4%) and symptoms and anxiety should disappear and the patient should function normally (4,1%) (p.99).

Like the biopsychosocial approach, the multi-disciplinary team model drives conflict between biomedicine and the social sciences underground. This may be understood by viewing power in terms of Gramsci's concept of cultural hegemony described by Jackson Lears (1985). Gramsci believed that power functions not by open manipulation but rather by hegemonic consensus, a legitimation of power relations by subordinate groups. One of the ways in which hegemony operates to legitimise inegalitarian relations is by "divided consciousness" (Jackson Lears, 1985: p.577). By this Gramsci meant "the tendency of public discourse to make some forms of experience readily available to consciousness while ignoring or suppressing others" (ibid.). Jackson Lears points out that divided consciousness can be observed in the conflict people have between believing in the dominant ideology of democracy on the one hand (public discourse); and on the other hand, their everyday experience that things are not equal. The ideology of democracy suggested by the multi-disciplinary team in a hospital setting, may serve to undermine experiences that there are indeed networks of power relations and interprofessional conflicts within these relations. In this setting however, because the reality of these relations are silenced by the apparent democracy, the struggles "are likely to be waged indirectly through patient care" (Miller & Swartz. 1990: p.51).

2.9.2.4. The case of traditional healers

If biomedicine views the psychosocial as an area to be marginalised or incorporated, it follows that the people dealing with it are to be similarly marginalised or incorporated, thus reinforcing subordination in the system of professions. A case in point can be seen in the relations between the medical profession and traditional healers. Kottler (1988) points out that despite the advantages of professionalisation, proposals for professionalisation of traditional healers tends to come from the dominant elite rather than from the healers themselves. Kottler suggests that resistance to these proposals by the healers stems from a realisation that professionalisation would mean incorporation and control by the dominant elite and result in powerlessness. In South Africa (for example, Schlebusch, 1990) there are suggestions to include traditional healers in the team because, according to Schlebusch they are seen to naturally have a biopsychosocial approach. It seems unlikely that Western medicine will give up the 'bio' part of biopsychosocial, so it can only be assumed that these proposals are further instances of attempts to marginalise and incorporate the psychosocial, in a similar fashion to the incorporation of psychology into the South African Medical and Dental Council (SAMDC) in 1951 (described in Louw, 1990). Louw notes that in the 1940's, the medical profession, "clearly vigilant for any encroachment onto their territory" (p.63) became interested in the activities of psychologists and invited them to discuss registration on an auxiliary register of the SAMDC. Although psychologists wanted to form an independent register, the minister of health, a medical practitioner, rejected this and psychologists had to register with the SAMDC. Present interest in traditional healers and a desire to professionalize them seems like a similar desire to control encroachment on the medical profession's field of jurisdiction. An article by Ataudo (1985), from Nigeria, illustrates how the biopsychosocial model is used to pay lip-service to psychosocial issues. Traditional healers are incorporated into the 'team' and the psychosocial issues are delegated to traditional medicine. The low regard for services provided by traditional healers (and by implication psychosocial matters) held by the medical profession is reflected by the way Ataudo defines traditional medicine:

"[Traditional medicine] refers to those beliefs and practices founded in tradition and which are generally accepted uncritically by the people [and have a] 'placebo effect' where the client's faith in the healing art of the traditional doctor induces him/her to believe that whatever the traditional doctor does to counteract the evil plans of the enemy or of the spirits or the offended ancestor will surely work" (p.1346).

The more scientific work in Ataudo's scheme is kept for the traditional healer's "sophisticated technologically educated brother", the medical practitioner (p.1347).

Another article from Nigeria (Aminu, 1985) reinforces the above point. Here the writer praises the 'team' members for allowing the medical doctor to work, for "without their supporting services he is reduced to a bedside mediaeval practitioner, hardly different from the traditional doctor" (p.1352).

2.9.2.5. Effect on consultation and training

It is possible that potential consultees working within the framework of biomedicine (such as nurses) may reject the consultation and training approach because it means doing work traditionally marginalised by biomedicine. The requirement of taking psychosocial issues seriously does not fit in with biomedicine. If, as Eisenberg (1986) argues, psychosocial issues are not seen as the 'real' and important object of attention, this kind of work may be seen as something extra to be fitted in once the 'real' work is done. If there is limited time and other resources are scarce, biomedical diseases are likely to be given priority. Furthermore, dealing with the patient's subjective experience in counselling situations may threaten an already tenuous sense of expertise and sense of control on the part of care workers because it may bring contradictory and inexplicable elements into the picture, unlike the 'objective' facts of biology. Resistance to consultation and training may also be understood as a reluctance to take on tasks which result in the marginalisation of the people doing them.

2.9.3. Psychology and power

In the preceding section I have argued that biomedicine excludes or controls psychosocial issues. The exclusion and control extends to psychologists and other occupations such as traditional healers. The power wielded by the medical profession is not overt but is exercised through hegemonic processes. These include incorporation of the psychosocial, purported to be an equal 'system' to the biological system in the biopsychosocial model; and incorporation of psychologists and other occupations under the umbrella of the 'democratic' multi-disciplinary team. Traditional healers in South Africa may resist such incorporation and control. I have posited that the marginalisation and control of psychosocial issues and the professions or occupational groups which deal with them, will have a bearing on consultation and training. In this section, I will draw parallels between the medical profession and its relations to psychology; and the psychologist's relationship to the consultee in consultation and training.

Psychologists are acutely aware of the marginalisation or incorporation of psychosocial issues by biomedicine, and their own position subordinate to medicine in the interprofessional hierarchy. Progressive psychology is characterised by a desire to flatten hierarchical relationships between psychologists and clients. In an attempt to democratise psychology, progressive psychologists

may attempt to reject their professional identity. However, as Swartz, Gibson & Swartz (1990) point out:

"To reject the professional power of one's role ... is to imply simultaneously that one in fact has something powerful to give up, and that one is all the stronger for being able to reject the professional trappings that might otherwise cushion one. In this sense, the explicit decision to reject one's professional role adds to rather than detracts from the power of being a professional..." (p.259).

If progressive psychology is concerned with creating egalitarian relationships, and actively attempts to overcome the power imbalances inherent in professionalism, why do power relations continue to influence practice? Some insights from Foucault's understanding of power may help to throw some light on the question.

Foucault understands the mechanisms of power relations to be far more complex than simple domination, coercion and manipulation. He believes that power is not simply a question of dominance, although dominance may be present in power relations. Instead, power exists in a relational network and is exercised on both dominant and subordinate parties (Dreyfus & Rabinow, 1982). Although Foucault (1981) sees power as "intentional", i.e. as having calculated aims, he also describes it as "nonsubjective" i.e. not the result of the conspiracy of a subject against another party (pp. 95-96). Foucault (1981) challenges the "juridical" notion of power as simply repressive, the idea that "what it produces, if anything, is absences and gaps [and] limit and lack" (p.83). Instead, Foucault (1984) argues:

"What makes power hold good, what makes it accepted, is simply the fact that it doesn't only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse. It needs to be considered as a productive network which runs through the whole social body, much more than as a negative instance whose function is repression" (p.61).

From this point of view, psychologist consultants are as much caught up in a web of power relations as the consultees. This is because of their position in a social network by virtue of their professional and socio-economic status. In South Africa consultants are usually white professionals. Consultees are usually black paraprofessionals or subordinate professionals. To say "let us make the consulting relationship egalitarian" is to ignore the context of the relationship, the double context of professionalism and apartheid and the effects of apartheid, which also cannot be removed simply by declaring democracy. There is a parallel between progressive psychologists and medical practitioners who, in order to improve compliance "offer therapeutic partnerships to patients, not vice versa" (Trostle, 1988: p.1305). In the case of medicine there may be a genuine

desire to create partnerships but to be in a position to offer a partnership is indeed a powerful one. It is also comparable to the relationships offered by medical practitioners to other professionals in the multi-disciplinary team. Insisting that relationships are equal may be in accordance with the ideology of progressive psychology, while silencing the real experience that in professional and socio-economic status they are not. At worst, conflict may be driven underground and played out through client care. In the relational network of power, consultants and consultees may be caught up in Gramsci's (Jackson Lears, 1985) divided consciousness, where their belief in the existence of theoretical and ideological equality is contradicted by everyday experience. This may leave consultees feeling bewildered and even angry, as the clients described in Swartz et al. (1990) who were attributed with power by progressive psychologists due to their status in the struggle against apartheid, but did not necessarily feel powerful in relation to the professional psychologists.

I do not mean to imply that there is a conspiracy or a subject plotting to dominate another party, but if the practice is intentional, as Foucault claims, consultation and training will produce forms of discourse. If power is creative, what is created by the discourse of consultation and training? Foucault (1984) argues that power needs to be analysed by examining its *concrete* mechanics in the context of social relations:

"In the seventeenth and eighteenth centuries, a form of power comes into being that begins to exercise itself through social production and social service. It becomes a matter of obtaining productive service from individuals in their concrete lives...power had to gain access to the bodies of individuals, to their acts, attitudes, and modes of everyday behavior" (pp. 66-67).

Mental health consultation and training as a method has evolved to meet the mental health needs of populations where there is a shortage of mental health professionals. If one examines the concrete mechanics of the discourse within the social relations of the parties involved, the following becomes apparent. Firstly, consultation and training serves the clients. They have access to services they have not hitherto been offered. This in turn will serve industrial-capitalistic society at large, since mental health is viewed as "a national asset, an economic advantage, a social necessity and a personal desire" (Miller & Rose, 1986). Secondly, consultation and training serves psychologist consultants. They have found a useful way of using their skills and satisfying a need to be progressive by sharing their skills and attempting to create egalitarian democratic partnerships. Thirdly, however, it is not clear how consultation and training serves consultees. Giving away psychological knowledge and skills does serve not consultees if it simply adds to their existing workload. Unless something is changed in the work days of consultees to make counselling a rewarding activity and not an extra burden, the practice of consultation and training may be a way of appropriating labour with the intention of "obtaining productive service from individuals in their concrete lives" (Foucault, 1984: p. 66). Finally, as

Foucault (1981) notes, there is no power without resistance. Consultants, like myself, may be surprised to find their offers of sharing psychology and forging democratic relations are rejected by consultees. Underlying this response may well be resistance towards very real power issues. By this I mean the possible experience of consultees that their labour is being appropriated, an experience which is overtly denied by well-meaning psychologists functioning from within a framework of democratic ideology. The current study is concerned partly with exploring these issues in the context of the MCHP.

2.10. AIM OF THE STUDY

The research is an investigation of issues concerning the consultation and training programme at MCHP. The aims are multiple. It is hoped that the discussion and results will provide ideas for future work at Mamre and Atlantis. Results may be generalisable and thus applicable to other projects where consultation and training is being practised. Community psychology approaches need to be evaluated in response to Freeman's (1989a: p.17) point that there is a need in South Africa for "concerted effort and research...to test the limits of first-line mental health care." Finally, the research aims to examine critically the discourse of consultation and training itself. It seeks to examine some of the concrete mechanisms of power within the consultant-consultee relations. Butchart & Seedat (1990: p.1093) write that "a central task for South African psychologists is to engage in critical self-reflection with the aim of identifying and eliminating oppressive forms of social and psychological discourse, thereby empowering themselves and contributing to the construction of a coherent counterideology." The consultation and training process may be unwittingly reproducing existing social inequalities which are embedded in both the hierarchical relationships inherent in interprofessional contact, and the legacy of the apartheid system. An important aim is to examine the possibility of reproducing such inequalities.

2.11. METHOD

Semi-structured interviews (Appendix A) were conducted with twelve consultees and potential consultees from Mamre and Atlantis. Community health workers (paraprofessionals), nursing sisters and social workers were chosen as they were the most common target groups for consultation at Mamre and Atlantis. There were five paraprofessionals and two professional nurses from Mamre. There were two social workers and three professional nurses from Atlantis. It was intended to include more social workers from Atlantis but attempts were repeatedly foiled when the individuals involved did not keep their appointments. It was decided, as suggested by Sorensen & Hargreaves (1982), that more information would be elicited by key informants than respondents chosen randomly. Informants were chosen because of their experience and

knowledge of the Mamre and Atlantis communities. Interviews were designed to answer two principle questions: What kinds of mental health problems were respondents commonly faced with; and secondly, the respondent's understanding of, experiences of, and opinions of consultation and training. For the first question, interviewees were asked from a list of common complaints such as depression, anxiety and marital difficulties (for a full list see Appendix A) to say how often they came across these problems and how they dealt with them. It soon became apparent, however, that these categories were not really valid to the interviewees. They would report, for example, that they rarely came across depressed people, but frequently encountered marital difficulties amongst their clients. When this was explored, it emerged that the clients described could well be depressed, but that the care workers involved were more likely to frame the problem in terms of social problems such as unemployment, marital difficulties, overcrowding and poverty than in terms of a psychiatric nosology. The data from the latter part of the interviews, pertaining to consultation and training, is presented in this dissertation.

As well as interviews with the consultees, semi-structured interviews (Appendix B) were conducted with the present consultant psychologist at Mamre, and two of the interns who had been placed in Mamre to date. These aimed to elicit reports of successful and problematic experiences of consultation and training and recommendations for improving the service. By interviewing both the consultants and consultees it was hoped to gain a fair and broad view of how consultation is perceived and what is likely to facilitate or interfere with the process of "sharing psychology." Finally, personal experiences during my internship placement in Mamre are included where relevant.

2.1.2. METHODOLOGY

This section contains a brief explanation of why semi-structured interviews were chosen. I was interested in the subjective experiences of the respondents. Semi-structured interviews seemed to be an appropriate way to provide space for the respondents to demonstrate the complexities of their subjective experiences. Massarik (1981) describes 'depth' interviews which seemed to be a good way of achieving my objective:

"In this context, the level of rapport is significantly elevated; the interviewer is genuinely concerned with the interviewee as a person, going beyond search for delimited information input. In turn, the interviewee sufficiently reciprocates this feeling, valuing the interviewer's motives and seeking to respond in appropriate depth. Though still time limited, the time frame is not tightly constrained, and the interviewee in turn may ask questions of the interviewer, exploring intent, seeking clarification and otherwise actively participating in the process of seeking understanding" (p.203).

This method has the advantage of fostering relationships, and enabled me to explain consultation and training. I believe that this method communicates a respect for the respondents opinions as valuable, and was therefore in keeping with the ideals of community psychology.

CHAPTER THREE: THEMATIC ANALYSIS OF RESULTS

3.1. INTRODUCTION

This chapter comprises a thematic analysis of the results from the interviews. Discussion of the results is presented in Chapter four.

3.2. THE NEED FOR SUPPORT

3.2.1. Lack of work-related support

The paraprofessionals and professionals interviewed who received formal support for the work they were doing, were those (3) in a consultant-consultee relationship with the psychologist in Mamre, the paraprofessionals supervised by the project co-ordinator at Mamre (3) and a social worker in Atlantis who was in a supervision group. The others from Atlantis (4) relied on informal peer support and support from family and friends, but felt that this was insufficient. One professional nurse who sees approximately 500 patients a month and has no formal support structure said despairingly:

"Sometimes you feel you are walking into a brick wall. You can't do anything. You don't know what to say. You yourself feel depressed. You feel you can leave the job because of all these people."

It is clear that provision for support has been made in Mamre, but is not the norm in Atlantis. The results seem to be due to the fact that the MCHP is a progressive organisation strongly influenced by the input of the psychology team there. The psychology team was also strongly influential in designing the service at Mamre. It is unusual for psychologists to have such influence in an organisation and not common in health care teams (as discussed in the literature review.) Presence of support provided for those at the MCHP by the psychologist and the interns is probably unusual. As mentioned in Chapter one, the work at Atlantis has been 'tacked on', as the resources at Mamre were not intended to serve Atlantis, and could not do so without approaches such as consultation and training. Lack of support at Atlantis is more likely to represent a norm since there has not been a strong influence of psychology in setting up and maintaining the services there. Presence or lack of support is obviously also a question of resources.

3.2.2. Enthusiasm about support

All target consultees, i.e. professional nurses and social workers (7) and paraprofessionals (5) interviewed expressed the need for more work-related support when they deal with their clients' emotional and behavioural problems, for example, needing to be reassured that they were doing the right thing, "on the right track". Suggested support from the psychologist or intern in individual case consultation for those (9) who were not receiving it was considered a good idea. Suggestions for staff support groups and case conferences, neither of which was offered at the time of the interviews to any of the target consultees, were unanimously met with enthusiasm. All of the consultants interviewed placed high priority on their role as support-giver.

3.2.3. Joint assessment and intervention

Most (11) target consultees thought that joint assessment and counselling is a more supportive way of working than pure consultation, mainly because of feelings of role inadequacy. One paraprofessional however, preferred pure consultation and felt that the presence of the psychologist in the session would be anxiety provoking and undermining:

"I have my ways of working with the client. If someone else is there, I don't know if I am doing the right thing."

An intern psychologist interviewed, felt strongly that:

"you can't sit back and say to them 'you do the work and I'll supervise you', you have to model or co-counsel."

3.2.4. The role of management in support

Only one social worker and one professional nurse mentioned superiors/ managers as a source of work-related support. The paraprofessionals and professionals at the MCHP were reportedly supported by one another and the psychologist or intern and did not mention management as a source of support.

Three professionals actively complained about the lack of support from management. One social worker reported that she sees her supervisor only once a month and most of the time is spent checking files and statistics rather than offering support and discussing the case-load. A professional nurse felt undermined by her employers (lack of role support), and her informal role as counsellor and innovations within her organisation were not sanctioned or appreciated by

management. For example, she was nominated to represent the West Coast committee in her field of work but :

"it was my turn to organise the meeting and I needed something for tea, and I couldn't go to them (management) for help...even if I have to go to a meeting in Paarl or Atlantis they won't give me money for petrol."

Another complained about lack of role support when she tried to counsel clients:

" Dr X said we spend too much time on social problems than on our own work...but what I explain is that you can't separate social problems from illness...if a man has got T.B., if he has got no job, no food, how is his T.B. going to heal?"

The consultant psychologist at MCHP gave another example in which a professional nurse rarely saw her supervisor and contact was limited to tasks such as checking statistics. Although the counselling aspect of her work was officially sanctioned, this nurse felt that the value of her work was unacknowledged by the supervisor. In this case the consultant, as advocate, met with the supervisor and the consultee and pointed out the value of the nurse's work. Although the supervisor agreed, not much changed, and the consultee continued to feel unsupported by the supervisor.

3.2.5. Support for peers

Colleagues were mentioned as a source of support by all those interviewed. Support seems to take place informally at lunch-times and in passages. Three professionals said however that some colleagues were at times derisive of attempts to meet psychosocial needs of clients. For example, one professional nurse described efforts to counsel a woman with post-natal depression, and her colleagues' reaction:

"They think I am spending my time with nonsense while they must do the work. She (the client) had such a big problem they were getting fed-up with me."

The consultant psychologist at MCHP spoke enthusiastically about a recent development in which potential consultees from various different disciplines (including policemen and teachers) who had attended a training workshop at the MCHP, had decided to form a peer support group to help them cope with shared problems in their work such as sexual abuse and teenage suicide. The consultant mentioned an added benefit in that a network of inter-professional/ occupational relationships may facilitate the handling of particular cases. An example was given in which a

policeman and school nurse had met at the training workshop and were subsequently called upon to intervene together in a case of sexual abuse. Because they had shared the workshop, there was a sense of increased co-operation and team work, and it is likely that the client benefited.

3.2.6. Support for personal problems

Staff at the MCHP(6) all used the psychologist or intern for support for their personal problems, and found this useful. One professional who has been in the role of consultee for two years with the psychologist at Mamre, said that support and counselling from the clinical psychologist for her personal problems was the single most helpful factor enabling her to counsel other people. Her understanding of consultation is that personal support is an integral aspect of it:

"Sometimes I have got such problems, I don't know how I would face them...just knowing that X is there makes me feel I can face the day. Although it is not part of my job description I will always help other people with their depression, I know what it feels like and that's why I do."

Personal success in overcoming a problem seems to enable care-givers to counsel others with similar problems. One professional nurse explains how she counselled the mother of a truanting teenager:

"I talked to the mother. I understand teenagers, I've got my own. From my experience I could relate to her. I invited her to come any time and talk."

A social worker interviewed gave an example of how speaking about personal matters in consultation with an intern helped her. She had related her present lack of confidence to childhood feelings of worthlessness evoked by a highly achieving cousin. Once the intern and social worker had spoken about this, the social worker felt that she could counsel a particular client with less fear of being flooded by unrealistic feelings of worthlessness.

An intern interviewed felt it was essential to give the consultee an opportunity to deal with personal issues in consultation:

"It is not therapy. It is just the normal sort of thing people do with each other: bitch about the day...they are not going to get it anywhere else, they are in the helping profession and if they don't get it they are going to grind to a halt."

The same intern believed that when potential consultees were invited to training workshops they attended in order to make contact with the psychologist for their own personal needs. She cited

an example where the psychologist and intern were approached by several distressed health care workers after a workshop on conflict resolution:

"They heard that there was a psychologist there and they are so desperate for someone to talk to...it (the workshop) could have been about any topic."

The consultant psychologist at Mamre gave a case example to illustrate how helpful it is for consultees to discuss personal feelings:

"In consultation and training things have come up for her [the consultee] so she has talked about things in her life. It has kind of verged on therapy. In her training [nursing] these things haven't been dealt with...the notion of countertransference and carrying feelings, she needed to know that it happens, and to be given permission to have feelings. I never tread in that area but when the person brings it up...its OK if the person is in therapy, you can say: take it to therapy... but in the community, people are really struggling...They keep the boundaries...I don't have the mandate to open things unless they choose, they know they can talk to me, clients trigger their issues and I feel that it has to be dealt with somewhere. I once counselled someone [a professional] who had been sexually abused...OK it wasn't consultation...but if it had been [consultation]...it [the sexual abuse] would have come up as an issue."

Another example given by the consultant psychologist illustrates how experience of being helped by counselling can motivate care workers to take up a counselling role. A teacher had had personal difficulties for which he received therapy. He had always wanted to do counselling but was not given the chance at his school. Because he had good relationships with the children at school a child who had been sexually abused confided in him. The teacher was sent to a workshop on sexual abuse at the MCHP and took on the role of consultee with alacrity.

In summary, it appears that both consultants and those who have experience of being consultees, feel that it is necessary to make space to talk about personal difficulties and experiences. These seem to be evoked by the client's experiences which are often similar to the consultee's own experience. Furthermore, successful resolution of their own problems or emotional difficulties seems to provide care givers with greater motivation and confidence to help others. The latter point is an accepted principle of psychodynamically oriented therapies where it is seen as part of normal counter-transference. For example, Money-Kyrle (1988) writes that the therapists tools include:

"theoretical knowledge about the unconscious, and... personal acquaintance with its manifestation which he has gained in his own analysis. [The latter] consists in his ability, by means of a partial

identification with his patient, to apply his acquaintance with his own unconscious to the interpretation of his patient's behaviour" (p.30).

3.3. DIFFERENCES IN FRAMEWORK

3.3.1. Advice and counselling

One intern interviewed believed that counselling should be flexible enough to include advice-giving with regard to "networking and putting people in touch with other agencies", although she pointed out the danger of becoming prescriptive. She also argued that advice is not actually excluded from all traditional counselling models.

Four paraprofessionals at Mamre who had had regular in-service training on counselling, and three professionals at Atlantis, had difficulty with the distinction between advice and counselling. The fifth paraprofessional at Mamre reported that she had no problems with counselling but her examples of 'counselling' were about educating and prescribing to clients, for example:

"I said to her "If you want to commit suicide, don't do it in front of your husband and children. Suicide doesn't help. You and your husband, before you go to bed at night, you and your family must come together and all of you must pray. If you want to take your life, take your life, I am not going to stop you." ...That gave her a shock. She didn't expect me to talk to her like that. And she stopped drinking."

The four paraprofessionals all gave examples of listening to clients and eliciting feelings, but felt that this was not sufficient to help the client, and reported that clients expected to be told what to do i.e. given advice. It appears amongst these paraprofessionals that the Rogerian counselling model which refrains from telling clients what to do (for example, Rogers, 1957) was not entirely accepted. The paraprofessionals felt more comfortable when they could give advice prescribing action and they felt that this is what clients required and expected.

These four paraprofessionals had special difficulty when it came to the kind of advice (acceptable within the Rogerian (Rogers, 1957) counselling model) that involved referring clients to specialist agencies such as legal aid because they felt that their knowledge of these agencies was scanty and identified this as a training need. They tended to refer the client to the psychologist in order for the psychologist to refer the client to the appropriate social agency.

The consultant psychologist at the MCHP said that the advice/ counselling issue is a difficult one:

"It has been a huge issue in the counselling skills courses. People feel that they must give advice. They feel that they are not doing anything. There is a space for it if the client is so desperate they can't think of solutions and need control to be taken out of their hands. I believe the problem solving approach is best. Its not so different [from giving advice] but at least the client has a choice."

3.3.2. Consultation as an imposed model

Two target consultees (professional nurses) expressed their feelings directly that consultation and training did not seem a fair way of working. Both understood the rationale for it but felt that it was unfair for psychologists to want to withdraw from hands-on work and expect them to fill the gap. For example,

"I don't think it is fair to the community, because there is a service, there is supposed to be a service, and people can't make use of it...on the other hand I know it is too much work for you, so I feel in the middle somewhere. There is no other place to refer people to, so if I didn't make time to help, I would feel sorry about it afterwards, I would blame myself for having the skills and not using them."

The implication here seems to be that psychologists have skills which are not being made available to the community when they offer consultation and training instead of case-work.

One could not expect all those interviewed to be open about reservations about consultation and training. All but one of the target consultees interviewed said in a guarded way that they felt that it could be useful, but no-one was unequivocally enthusiastic about it. Consultation and training seemed to be grudgingly accepted as a poor alternative to the traditional referral system. One professional person had had the experience of not being able to refer a client to the psychologist at Mamre but had been offered joint-assessment and consultation and training instead. Her response at the time was a frustrated "but aren't you a psychologist?" After one session of joint-assessment, further appointments had not been kept and the intern's telephone calls went unanswered. Invitations to training work-shops were not answered.

At the research interview with this particular professional, I re-explained consultation and training and the rationale behind it, thinking that the process may not have been clearly explained in the first place. I then tried to explore what had gone wrong with this particular consultation experience but the consultee insisted that there had been no problem and that she had simply not needed the consultation. The consultee then told me in similar words to the my own explanation of consultation, about a new way she had decided to work:

"I had such a lot of work, it was getting too much. I am just one person. I can't deal with it all. Now I have changed that. I shouldn't be the one responsible. I am not going to see the clients individually anymore. I am going to see them in groups. I am going to help them in groups. I need other professional people to help me with it. I can't do it by myself. I am going to be the consultant but they (the other professionals) are going to do it. All they need to do is to come to me and I will give advice."

In this scheme, the psychologist was asked to run a group. I felt strongly that the professional involved was expressing extreme resentment towards the consultation framework, and needed to show the psychologist intern what it felt like to be imposed upon. Unfortunately, despite many attempts, the professional involved did not discuss this openly so the speculation that she felt resentful cannot be confirmed.

3.4. THE QUESTION OF ROLES

Role confusion, role legitimacy and role adequacy are dealt with together since lack of role legitimacy and lack of role adequacy seems to be partly a function of poorly defined roles.

3.4.1. Counselling and legitimacy

Two paraprofessionals and two professional nurses definitely did not see individual counselling of clients for emotional and behavioural problems as included in their job descriptions. Two social workers and one professional nurse agreed that it was an integral part of their job description but set their own limits of what they did and did not do. The others (5) were not sure whether they should be doing counselling or not, and if they should, the nature of the counselling was unclear. However, all of the target consultees in practice tried to do some counselling regardless of job description. Examples given by the majority (8) showed that this was more often on the side of advice-giving than traditional counselling although the paraprofessionals at Mamre were aware of the need to listen, something that had impressed them from their training workshops.

One intern recounted a failure of a support group she tried to start in Mamre in response to a request from a professional nurse. Part of the problem was that expectations and roles were not clarified and agreed upon from the start. The professional nurse saw the intern as "taking over the preventive side of things" in this clinic, whereas the intern wanted to be consultant and expected the professional nurse to participate in the groups and eventually take them over herself. The intern believes she should have laid down clear conditions such as: "Yes, I will do it but provided you are there", and recommended that role expectations from both sides be made unequivocally clear from the start.

One professional nurse felt that her role as counsellor would not be seen as legitimate by other professionals. For example, she felt that she could not refer a suicidally depressed woman to a hospital, but a psychologist could:

"I can just tell the doctor that this person is depressed, that she is suicidal...but you can...all the symptoms, you can put it out on paper for the doctor to see what is really wrong. The doctors in Atlantis are so busy, I would feel happier if I knew this person was going to hospital with a letter from the psychologist."

The consultant psychologist at the MCHP pointed out that trying to do consultation is fruitless unless the consultee is interested in counselling, i.e. sees counselling as a legitimate and desirable part of their work. At the recent workshop (already mentioned) an interesting turn of events occurred. The consultant psychologist and others running the workshop had focused on inviting the usual target consultees. These included guidance teachers, professional nurses and social workers. It was thought that training would be successful for this group. This belief was based on the ideas that they would already have some skills to build on and counselling seemed to be a legitimate part of their work. However, there was poor attendance of the guidance teachers and social workers. To the surprise of the MCHP there was an unexpectedly enthusiastic response from policemen and subject teachers. One policeman was so keen to do counselling he had made his "office all nice" for that purpose. In this instance it appears that the consultees' subjective perception of counselling as a legitimate and desirable role is an important motivating factor to take into account. The assumption that certain roles are legitimate in certain professions such as the counselling role for social workers, nurses and guidance teachers may be not be borne out in reality. Another explanation could be that policemen and subject teachers may have no experience of the long-term difficulties of counselling-type work. This may make them more enthusiastic than their weary nursing, social work and guidance teacher counterparts.

3.4.2. Counselling and referral

Only a few (3) target consultees saw some of their counselling as an end to itself, although these three still felt the need to refer some cases to a psychiatrist, psychologist, psychiatric nurse or social worker usually because they felt inadequate in training and skills rather than a particular need for specialist resources such as medication. The remainder (9) tended to counsel patients as a pre-cursor to referring the clients to other limited resources rather than an end in itself. A typical example from a professional nurse:

"To tell you the truth, it is not my job. We are a multi-disciplinary team and we must make use of other resources. We see the patients, we counsel them, we do home visits, and then we see where they can be referred to."

When asked who she refers to:

"We can't refer them to professionals in town because of the expense, the psychiatrist in Atlantis only sees adults...we need a service here. The psychiatrist only comes once a month and teenagers must go to Lentegeur."

Lentegeur is a large psychiatric hospital in Mitchell's Plain, Cape town. Until recently it served 'coloured' members of the population of the Western Cape and therefore the people of Atlantis. As Lentegeur is approximately 80km from Atlantis, its services are particularly inaccessible, especially since public transport is erratic and expensive. Offering teenagers a service at Lentegeur is tantamount to no service at all.

A paraprofessional who did not see counselling as part of the job description, but spent a considerable amount of time listening to other people's problems said: "I don't want to do the work of a social worker because I am not a social worker...I listen and then I refer." This particular paraprofessional seemed to be afraid of over-stepping a professional boundary:

"I don't interfere with other people's work. I don't want to do the work of a social worker, taking over her work. People might make appointments with me and not the social worker. I don't want to interfere."

In this case referrals were made to the clinical psychologist or social work student in Mamre.

A professional nurse interviewed had had over twenty-five years experience in her field. She reported that she was allowed to assess and diagnose patients in the initial interview as long as a medical practitioner ratified her diagnosis. She was also allowed to prescribe medication in emergencies as long as a medical practitioner countersigned the prescription within seven days. This example is slightly different from previous examples of interventions not being seen as an end to themselves. Here the lack of autonomy is enforced by professional limitations. In other words, this nurse was bound by professional limitations not to perform her intervention as an end to itself. She had to refer her client to the medical practitioner with whom she worked regardless of how successful her interventions were. I was struck by the unquestioning acceptance this nurse had of this state of affairs. It is possible that limiting nurses in this way creates a situation in which interventions are always seen as precursors to referral to specialist resources.

3.4.3. Psychologists and "magic"

In all target consultees interviewed there was an tacit assumption that psychologists had skills and powers to do counselling inherent in the profession itself rather than something learned. Attempts to deconstruct this belief led to statements such as: "It is because of the profession...professionalism. The names...being professional." It was as if there was some intangible and inexpressible power and ability being named a psychologist brought which was not available to anyone else regardless of training and experience. One paraprofessional believed that clients would rather see the psychologist at Mamre for counselling than a paraprofessional because of the so-called 'magic' psychologists possess:

"In dealing with, for instance, sexual abuse, the picture of a clinical psychologist...it is a picture painted that the clinical psychologist will solve the problem...you read in the paper what a clinical psychologist said, and the soap serials on T.V...if there is a problem you go to a clinical psychologist, something magical is offered and the clinical psychologist is a strange phenomenon."

The consultant psychologist confirms that this response is common. She offered consultation to a consultee:

"I tried to explain consultation. She wanted to give it [the case] to us, saying "I am not professional. I don't know how to do this." and I said I believe you need the backup...you are just as effective as we are. She was quite resistant. She didn't know what we were getting at."

3.4.4. The natural helper and multiple roles

All target consultees interviewed saw themselves as natural helpers. However, it seemed difficult for many of them place their help in high esteem. For example, a professional nurse said shyly: "I don't want to put myself on a pedestal but a lot of people come to me for help." Three target consultees said that being a community member made it more difficult for clients to trust that confidentiality would be maintained: "People will only open up to a certain extent, I can see she wants to talk to a stranger. Maybe it's the magic again." For this reason, they believed that clients would rather see a psychologist, who is a professional. One paraprofessional felt that people would think their problems were taken more seriously if they were referred to a professional rather than receive help from a paraprofessional.

Most (10) target consultees said that their work was not limited to the work-place and working hours. Community members approached them after hours and over the weekends at home and even in the supermarket. One paraprofessional did not mind this at all. The others (9) tried to

help and indeed felt obliged to help, but felt that the intrusions were difficult for themselves and their families.

3.4.5. The role of the generalist

Out of all the target consultees interviewed, only one paraprofessional felt frustrated by her role as a generalist. She felt that she would like to become proficient in one particular area, and felt dissatisfied with the training workshops because they covered such a diverse range of topics. This paraprofessional's primary function was to head a prevention and promotion programme for the youth. She felt reluctant to take on any counselling at the MCHP because it seemed yet another skill that would not be developed in depth.

3.5. LACK OF RESOURCES

There was overwhelming consensus that lack of resources was the biggest reason not to do counselling. Every target consultee interviewed was concerned that s/he did not have sufficient time. A psychiatric community nurse said that often she only has three to five minutes to see a patient to give them their medication and injection. She felt that if she had to do less dispensing she would have more time to talk to the patients and their families. This issue was at the time of the interview being investigated by the authorities. Some (5) target consultees complained that there was too much administrative work to be done. A few (3) felt the pressure of queues of clients waiting while they were trying to spend some time counselling. Two complained that there was no privacy and escape from people (both clients and colleagues) barging in and the telephone ringing. One professional nurse felt that counselling is time-consuming because of the need to follow-up on initial interviews. Making time for follow-up and home visits was the issue at stake here. Even after target consultees had accepted that consultation and training could be helpful, all of them added they did not have the time to spend time with clients.

3.6. SUMMARY OF RESULTS

The aim of the research was to explore factors which facilitate or inhibit a consultation and training approach. It was noted that care workers would have to take on a new role as counsellor in this approach. The degree to which they are able and willing to take on this role will influence consultation and training. The results of the interviews have been set out in Chapter three. In summary, it appears that the following factors are facilitative:

- (i) The presence of work related support for consultees.
- (ii) The presence of role support for consultees.

(iii) The presence of personal support, and space for exploration of personal feelings, experiences and counter-transference issues.

(iv) Successful resolution of personal problems which increases the confidence and desire to help others.

On the other hand, the following factors are inhibitive:

(i) Lack of role support, particularly from managers.

(ii) Consultees' experience that the consultation and training approach is imposed by unhelpful psychologists who are unwilling to use their skills in case-work.

(iii) Consultees' experience of being overburdened and the concomitant perception that consultation and training means extra work.

(iv) Consultees' non-acceptance of a counselling approach which does not permit advice giving.

(v) Feelings of role inadequacy and lack of role legitimacy.

(vi) Lack of resources.

The following chapter consists of a discussion of the findings and recommendations regarding the future practice of consultation and training.

CHAPTER FOUR: DISCUSSION AND RECOMMENDATIONS

4.1. INTRODUCTION

Salient points from the thematic analysis of results are taken up for discussion in Chapter four. Recommendations are made regarding the future practice of consultation and training. In the conclusion, areas for further research are suggested.

4.2. THE CASE OF SUPPORT FOR PERSONAL PROBLEMS

The expressed need for work-related support is not unremarkable and supports Hargrove's (1982) contention that this is a much neglected area. What is striking however, is the value attached to personal support and the use of personal experience in consultation and training by consultees who have used the consulting service at Mamre. It has been noted that this level of support is unusual and probably due to the influence of psychology in the design of the services at the MCHP. Usually in health care teams psychology is not accorded enough power to have the influence it has in the MCHP.

As far as personal support and the inclusion of personal experience in consultation and training goes, it appears that the guidelines given by Caplan & Caplan (1993), Heller et. al (1984) and Steinberg (1989) are not necessarily appropriate for the situation in Mamre and Atlantis. This is not to say that these guidelines are not appropriate in situations where there are resources for consultees to obtain support for their personal problems. Neither are the disadvantages of providing support and including personal experience in counselling to be ignored. There is clearly a possibility for the abuse of power, and the possibility of placing the consultee in a subordinate position. However, the difference in contexts needs to be taken into account. The way of working needs to be tailored to meet the specific context. It is recommended that in areas (such as Mamre and Atlantis) where there are no resources, consultants need to be flexible with regard to the inclusion of the consultee's personal material, even if this means taking on the role of counsellor and consultant interchangeably. The results of this particular study suggest that this can be done if the consultee has the power to decide what may or may not be discussed.

Consultants in effect need to take on multiple roles if the situation requires it. There does not seem to be room for strict boundaries and role definition in Mamre and Atlantis. Caplan & Caplan's (1993) advice that consultants should not be involved in activities such as conflict resolution in agencies also needs to be revised in this context. Again consultants may need to

fulfil a variety of roles, particularly if an issue like staff conflict is interfering with the consultee's capacity to work with the client. Advantages of making space for personal material include the following: Consultees are more likely to meet their clients' psychosocial needs if they feel supported and have their needs met in the consulting relationship, particularly bearing in mind that there usually are no other resources for the consultees to use. Providing counselling for the consultee is an excellent way to model skills. Successful resolution of own difficulties, for example, depression, is likely to increase the consultee's ability and desire to be empathic towards the client and to make meaningful interventions. Validation by the consultant of the consultee's informal knowledge acquired from personal experiences is likely to increase the consultee's sense of adequacy and legitimacy, and to flatten the inter-professional hierarchy. Obviously psychologists need to be clear that they are serving the consultee and the client by discussing personal experiences and providing support for personal problems.

4.3. AMBIVALENCE ABOUT CONSULTATION

When consultation and training was presented as a nurturing experience in which the consultee would be given support for difficulties dealing with clients' psychosocial problems, the target consultees responded with keen interest. Later in the interviews when it became apparent to the interviewees that this meant taking on the role of counselling and not using the psychologist as a referral source, consultees were not so keen, as it seemed to them that they were being given extra work to do. To recap, the service in Mamre was not initially intended to cope with Atlantis and its population of 68064. Even the consultation and training offered was a compromise from an already stretched psychology team. Unfortunately, often the first contact the care givers from Atlantis had with the MCHP was when their referrals to the psychologist were turned down and they were offered consultation and training instead. It can be postulated that a necessary condition for consultation to be found acceptable is the consultee's perception of consultation as primarily helpful and supportive. If the service had been intended to cover Atlantis as well as Mamre, it is likely that first experience of the concept of consultation and training would have been encountered in a training workshop or relationship building contact. Instead, the first experience was often that of a service withheld. The former introduction would make the consultation and training approach more palatable. Consultation and training was introduced in Mamre in a more gradual, supportive way. However, there were also feelings that a service was being withheld there. It appears no matter how gradually and supportively introduced, consultation and training needs to be negotiated in a different way or it is perceived as an imposition. This leads to the next point.

4.4. CONSULTATION, TRAINING AND NEGOTIATION

In the wake of their intervention in the Soweto Health Care System, Seedat & Nell (1992) advise:

"Democratically informed psychological interventions may not be imposed. In order to maximize the success of their programmes, psychologists would therefore do well to negotiate the processes and mechanisms through which to insert their proactive modalities into the health care system. It is necessary to gain consensus on how to initiate, implement and incorporate psychological services..." (p.192).

Maybe even negotiating and then 'inserting' modalities is too much like an imposition. Even one of the most eager consultees at Mamre, who felt extremely supported by the service, felt that there was an element of the psychologists withholding their services by offering consultation rather than case-work. It is likely that consultation and training would be more acceptable if not imposed as a unilateral decision by the psychology profession. It is recommended that, in the future, before offering any service at all, the problems of providing mental health care in South Africa be presented to possible target consultees in a workshop situation. This would mean giving a detailed account of the crisis of mental health services in South Africa similar to that presented in chapter two of the dissertation. For example, statistics on the ratios of professionals to the public, the inequities of the present system, and possible solutions could be included. If target consultees are involved in a process of making decisions about the problems that pertain to their particular areas, they may offer creative solutions hitherto unthought of. If target consultees are included in the broad picture and have a part in deciding upon solutions it more likely that consultation and training, (or whatever way of using the psychologist's skills is negotiated) will seem to them like an acceptable way of working. This approach would allow for consultation and training to be offered within a framework that is acceptable to consultees. Attention could be paid to the specific state of resources or lack thereof in particular groups of consultees. For example, a programme could be specifically designed to deal with a problem of lack of space if that was an issue for that particular group.

In short, too often subordinate professional or occupational groups, and low-ranking members of professions have been told how to work without having an idea of where their work fits into the broader picture thus creating a sense of lack of control and alienation. Democratising psychology implies including consultees in the decision making process. It is postulated that including them in the aforementioned way, will impart a greater sense of autonomy and control, thus increasing role adequacy and role legitimacy and flattening the interprofessional hierarchy.

4.5. THE QUESTION OF GIVING ADVICE

A flexible approach to the advice - counselling issue is needed if psychologists are to avoid imposing inappropriate frameworks on consultees and ultimately clients. In a community like Mamre, where every meeting is opened by prayer, and there is a culture of being prescribed to by the church, the Bible, employers and the State; and there is daily experience of material adversity, it is extremely difficult for consultees to refrain from focusing on material adversity and wanting to prescribe a course of action. The consultant psychologist mentioned the problem-solving approach as being "like giving advice", but also giving options. It is recommended that psychologists work with advice-giving rather than against it. Perhaps a focus on the problem-solving approach framed as a way to give advice may seem less alien to care givers than a traditional Rogerian reflection of feelings described as inappropriate by Turton (1986). Furthermore the question of material adversity needs to be taken seriously. Psychologists need to re-assess the idea that once clients have had their emotional needs addressed, they will find the resources to deal with material difficulties. As Turton points out, this just doesn't hold true for disadvantaged, working-class communities. As part of advice-giving consultees need to be well informed of all possible resources for material help, and need to be encouraged to be proactive in helping address social ills (social action approach) as well as merely responding to individual cases.

4.6. WORK WITH MANAGERS

Clement (1987) and the consulting team in the Salford experiment found that role support from an external agency was not effective if internal role support from managers was missing. Mgoduso & Butchart (1992) found the same thing in the Soweto health system. Seedat & Nell (1992) report on an attempt to include managers (matrons) in the training programme in Soweto which was thwarted by mistrust and a desperate attempt to maintain the status quo. Seedat & Nell (1992) recommend:

"Centralized bureaucratic organisations, characterised by resistance to change, require interventions to fail in order to maintain their organizational status quo. It is therefore imperative for psychological intervention programmes to speak to the fear and uncertainty that shrouds organizational transformation by way of creating the psycho-emotional and structural conditions which convey the message that change can be managed proficiently and that innovations do not imply the loss of control and power" (p.192).

It is difficult for psychologists to introduce change without imposing their frameworks. Again, change is less likely to be resisted if methods are proposed by the health workers who are going

to implement them rather than imposed by an outside profession. It is recommended that psychologists invite managers of agencies and other professions to form interprofessional partnerships, and negotiate mutually acceptable solutions. When working with management, psychologists need to engage with them as power-brokers so that intra-professional influence can be used co-operatively for the benefit of clients. If power issues, and fear of loss of control, were openly acknowledged and discussed there would be less chance of programmes being sabotaged.

4.7. THE NEED FOR ADVOCACY

In the conclusion to the report on the Salford experiment, Clement (1987) reflects on the consulting process. The reader is reminded that the consulting teams (CAT) were initiated with the belief on the part of the consultants that much could be done to improve community care using the existing resources rather than lobbying for more resources. This hope is very much like that expressed by Pugh (1990) and Hayes (1993) cited in the literature review of this dissertation. Clement, however, ends up modifying the belief that much can be done with existing resources:

"...it is also apparent that such an approach alone cannot facilitate a comprehensive community-based service. Until sufficient resources are made available to primary care agencies...the CAT [or any consultation service] can only be seen as an additional tier of specialist services, bringing specialist services into the community rather than facilitating a truly community-based response at the primary care level" (p.143).

Lack of resources was cited by all those interviewed as an overwhelming obstacle to the consultation and training method. While working with existing resources, it is recommended that community psychologists also lobby for more resources and increase involvement in health and welfare policy making, or there will never be enough time and space for health workers to meet the mental health needs of their clients and as Freeman (1989b) points out, no amount of training will make a difference.

4.8. LACK OF ROLE LEGITIMACY

Reluctance to take on role as consultee and expectations that there *should* be a multi-disciplinary team may be a function of inculcation of biomedical values in the process of socialisation and education. Maybe talk about a multi-disciplinary team is appropriate in Europe and North America where there are resources for specialist services. However, it does not seem appropriate in third world countries such as South Africa, as it seems to create expectations which are simply not realistic to fulfil. There are no specialist services for psychosocial needs to be met, and complaining that they should be is unrealistic. It is recommended that psychologists continue to

challenge the dominance of biomedicine and the priority given to the biological lesion, and encourage critical evaluation of conventional beliefs in training and consultation sessions. Again there seems to be a need to include consultees in the broader picture. Discussion of specific techniques and particular cases could be supplemented with opportunities to introduce and discuss the philosophical issues at stake. Consultees may be more inclined to include mental health interventions if they are acting on an intrinsic belief in what they are doing rather than an external directive.

However, part of the problem with consultation and training is that it tends to be brief and context specific. The broader issues tend to be left out. It may be that part of the psychologist's perceived "magic" is an ability to understand the broader picture. This ability is partly the product of a broad education in the social sciences. There seems to be no way of addressing this problem. Perhaps consultants need to acknowledge their professional advantage in this respect and introduce the philosophical issues into specific contexts when it is clear that it is causing the consultee difficulties. One way to do this is to validate the consultee experience that interprofessional relations really are the site of power, rather than reinforce the illusion that everyone belongs to a democratic multi-disciplinary team. There really is an element of unfairness that consultees are doing front-line work while consultants are not. Their feelings of lack of role legitimacy may not be so "illegitimate" after all, particularly bearing in mind that they function within a biomedical framework.

4. 9. JOINT COUNSELLING

The results of the research indicate that pure consultation is not acceptable to most potential consultees, a similar finding to that reported by Clement (1987). Joint assessment and counselling is seen as a supportive way of working. It is recommended that consultation begins with joint counselling and assessment unless the consultee is uncomfortable with this arrangement. Joint counselling has the advantage of demystifying psychology and flattening the interprofessional hierarchy by placing psychologists' work under scrutiny. This is likely to lessen role inadequacy, and foster an equitable consultation partnership. Obviously joint work cannot be a long-term arrangement, or there would be no point in consultation and training; it is probable that in the context of a relationship that has been built up on joint experience, withdrawal of involvement will seem less withholding than an initial offer of pure consultation.

4.10. RETHINKING TARGET CONSULTEES

One of the weaknesses of this research project is that interviews were limited to three categories of potential consultees, i.e. nurses, social workers and paraprofessionals. Like the assumptions made regarding the invitations to the workshop described by the consultant psychologist, it was assumed that health workers with existing skills and knowledge would be the most obvious target consultees. To the MCHP's surprise, there was an enthusiastic response from policemen and teachers (who were not guidance teachers) when they offered consultation at a training workshop. It is possible that people in occupations that do not necessarily carry the expectation of providing concern for mental health needs, find counselling a novel and interesting variation to their work and occupational identity, like the policeman who made his office "all nice." This may be in contrast with burned-out social workers and nurses who view counselling as yet another activity, imposed from without, which makes demands on their already depleted resources. An important criterion for choosing target consultees may be that the work is novel and exciting (even if it is not financially rewarding) and represents a deviation from daily drudgery rather than an addition to it. The flip side to this coin, as mentioned in the results, is that the policeman and subject teachers don't know what they are letting themselves in for. However, there is no reason not to respond to enthusiasm as long as support is provided when the going gets rough.

4.11. PEER SUPPORT/ CONSULTATION GROUPS

Since peer support seems to be an important source of sustenance for the consultees interviewed, it is suggested that consultation can be offered in the form of groups. Apart from the benefit of support and cost-effectiveness, a case conference approach could be instituted with consultees sharing their experience and knowledge. It would be important in this situation for the consultant to share cases, particularly difficult ones where mistakes were made. This would help to demystify psychology, flatten the hierarchy and increase role adequacy. Such groups would be a good forum for preventing and resolving conflict between workers. They would also be useful for workers to give role support and foster role legitimacy if they belonged to agencies where legitimacy was in question. The only disadvantage or possible difficulty is, as Spratley (1987) warns, is that consultees can be easily threatened by exposing their work to a group.

4.12. THE CONCEPT OF THE NATURAL HELPER

As Wagenfeld (1982) points out, life in the country is idealised and there is a myth that there is an extensive network of natural helpers in rural areas. This results in a paucity of services to these areas. A similar situation may arise if the myth of the natural helper in South Africa is allowed to detract from the fact that there are shortages in mental health care, and if natural helpers were so

effective, there wouldn't be a figure of 10-20% of individuals presenting at a primary health level suffering from diagnosable psychiatric disorders (Thom, 1990). The figures from Mamre are even higher. (Rumble, 1994). The results of the present study also show that so-called natural helpers have the same needs for boundaries as professional psychologists do, and that the majority find intrusions into their private lives over the weekends and at night difficult. There was also concern expressed that in Mamre and Atlantis, clients do not find it as easy as proposed by the literature to trust a neighbour to maintain confidentiality. These issues need to be borne in mind to prevent an idealisation of the concept of 'natural helper'. The danger of such idealisation is that it may lead to a situation which Freeman (1990b) warns against i.e. that these helpers may be exploited to rationalise inadequate provision of resources.

Furthermore, an assumption that psychosocial problems are dealt with by natural helpers may legitimate biomedical focus on the biological lesion. It may result in a situation of further marginalisation of psychosocial issues as unimportant. Finally, it would be a mistake to put the responsibility for addressing mental health problems onto natural helpers because this may reinforce avoidance of taking a social action position and addressing socio-political issues. Saying that a community is responsible for healing itself may imply that it is responsible for its socio-economic ills in the first place. This is similar to locating the cause of distress in individuals without taking the broader socio-economic determinants into account. Butchart & Seedat (1990) remark in their criticism of the mental health model:

"The mental health model locates the origins of psychosocial distress and the means of their eradication primarily within 'communities', and tends to divorce such factors from the wider context of social and economic problems. The 'community' is both the pathogen and antigen, so it must be assisted to heal itself. The mental health model therefore complements images of community in South Africa's discourse of domination, since the former can be used to provide scientific justification for the division of mental health risk factors and health care resources into 'own' and 'general', in the same way as the latter are used to legitimate inequalities in the allocation of resources in general" (p.1097).

It would be a pity if progressive psychology's desire to "share psychology" resulted in reinforcing a discourse of domination which holds communities responsible for their own mental health. Critical evaluation of the ideology of the natural helper is necessary to prevent this from happening.

4.13. CONCLUSION

The point of departure for the dissertation was that South African mental health care services are in a crisis. Various solutions have been mooted to overcome the deficits in service provision. Consultation and training is one approach which makes many of these solutions possible. It was noted that there are factors which facilitate or inhibit the process of consultees providing mental health services using consultation and training to empower them. These were listed as follows. The degree to which support for the consultee is present or not was seen as an influencing factor. A distinction was made between support for personal problems and work-related support. Whether or not consultation was delivered in a framework acceptable to consultees was mentioned as a factor. Feelings of role legitimacy, role adequacy and role confusion were mentioned. Lack of resources was discussed. Each one of these factors was discussed in the light of intra- and particularly interprofessional power relations.

In the final section of the literature review, the power of biomedicine was discussed. It was argued that progressive psychologists wish to create egalitarian consultee relationships and democratise psychology. However, in doing so it was suggested that there are parallels between the medical profession and psychology profession. The medical profession was criticised for driving interprofessional conflict underground by offering partnerships in a "democratic" multi-disciplinary team. Similarly, by declaring relationships democratic, psychologists were seen to be denying the reality experienced by consultees that they are in fact not democratic, and that there are indeed power issues interfering with consultation and training. Foucault's (1984) point that there is no power without resistance led the way to an exploration of the views of both consultees and consultants regarding consultation and training.

Salient features of the discussion include the following. It was argued that support for personal problems was valued by the consultees and made consultation and training more acceptable. Including personal experience and resolution of personal problems in consultation and training was seen as a validation of consultees' knowledge. It was argued that acceptance of consultation and training is facilitated if it is perceived as helpful, rather than withholding. It was pointed out that successful consultation at the MCHP for health workers in Mamre was in part due to presence of support and presentation of consultation and training as helpful. Health workers from Atlantis on the other hand did not have the same resources for support, and often their first experience of consultation and training was as a service withheld. It was pointed out that the influence that psychologists have at the MCHP is unusual and is generally not present in other health care teams. However, it was noted that even in Mamre, there was some experience that psychologists are withholding a service by advocating consultation and training. It was proposed therefore that consultation and training as a method also needs to be negotiated. In this respect, it

was recommended that consultees are included in the decision making process when deciding how to use psychologist skills most economically. It was suggested that the value attached to advice by consultees needs to be taken into account when attempting to frame counselling in an acceptable way. It was recommended that psychologists work with managers as well as consultees so that intra-professional power is not used to subvert service provision. It was argued that lack of role legitimacy may not seem so illegitimate when it is understood that many consultees work from within a biomedical framework. Joint counselling and peer support groups were suggested as ways of reducing role inadequacy and flattening the interprofessional hierarchy. Finally, it was argued that psychologists need to be critical of the notion of the natural helper.

In conclusion, I would like to return to the beginning of my experience in Mamre. I believed that consultation and training was useful. A year has passed and I still believe that. When I went to Mamre, I had hopes of "sharing psychology". I believed that consultees needed to be convinced that they were capable of helping clients with distressful feelings such as anxiety and depression, and I had a desire to demystify psychology. I really believed that relations could be democratic. I was unprepared for, and surprised at, the level of resistance I encountered. In retrospect I was embarrassingly naive about the context of interprofessional domination and even broader context of apartheid, despite the fact that I had been on the receiving end of interprofessional domination as a nursing sister and then an intern psychologist in a hospital setting. I have found Foucault's (1982) advice useful and believe it should inform future research in this area:

"I would like to suggest another way to go further towards a new economy of power relations, a way which is more empirical, more directly related to our present situation, and which implies more relations between theory and practice. It consists of taking the forms of resistance against different forms of power as a starting point. To use another metaphor, it consists of using this resistance as a chemical catalyst so as to bring to light power relations, locate their position, find out their point of application and the methods used. Rather than analyzing power from the point of view of its internal rationality, it consists of analyzing power relations through the antagonism of strategies.

For example, to find out what our society means by sanity, perhaps we should investigate what is happening in the field of insanity.

And what we mean by legality in the field of illegality.

And, in order to understand what power relations are about, perhaps we should investigate the forms of resistance and attempts made to dissociate these relations" (p.210-211).

The resistance to consultation and training led me to an awareness of the power relations involved. I believe that progressive psychologists will be able to share and democratise psychology only if they are fully aware of the power relations involved and not if they drive conflict underground by denying these relations.

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APPENDIX A: SEMI-STRUCTURED QUESTIONNAIRE (CONSULTEES)

- What is your present post title?
- What are your qualifications?
- For which agency do you work?
- How long have you been working there?
- What kinds of emotional and behavioural problems do you come into contact with?
- How often do you come into contact with clients or their families who (each one asked individually): Abuse alcohol, abuse drugs, are depressed, are suicidal, are anxious, experience marital conflict, experience other family and relationship conflict, are sexually abused, are physically abused, have scholastic difficulties at school, school refusal, are frankly psychotic, are recovering from a psychotic episode, are in a crisis situation (explain)?
- Do you think it is part of your job to deal with any of these emotional and behavioural problems? Discuss answer.
- Do you feel that you have adequate training to deal with these issues?
- Where do you think further training should take place and how?
- Do you presently receive any ongoing supervision or training for the work you do now?
- Would you like to deal with your clients' emotional and behavioural problems without referring them to a psychologist or a psychiatrist?
- I'd like to talk about the contact you have had, in relation to clients' problems, with the psychologists in Mamre. What was the reason you contacted the psychologist? Describe what happened.
- How do you understand the role of the psychologist in Mamre?
- How do you understand your role in relation to the psychologist?
- How do you feel about working with the psychologist in a relationship where you discuss the clients' emotional and behavioural problems in order to help you to deal with them, without the psychologist taking the case over? (Respondents who have already experienced consultation and training, are asked to discuss their experience).
- How do you feel about doing counselling in your job? Do you feel confident enough? Do you have enough time?
- What do you think would make it easier for you to do counselling in your work?
- Dealing with people in your kind of work can be very stressful. Where do you get support? Do you think you could benefit from more support? What would make you feel supported?
- Any suggestions, further discussion.

<p>APPENDIX B: SEMI-STRUCTURED QUESTIONNAIRE (CONSULTANTS)</p>

- (Interns) When were you placed at Mamre?
- (Psychologist) How long have you been at Mamre?
- Explain your perception of your role there (e.g. ratio of project work, case work, consultation, training).
- What was your experience of the consultation process? Give examples.
- Who were your consultees?
- Please describe successes and difficulties?
- How did the consultees respond to consultation?
- Any thoughts you may have about consultation and training, and community psychology in general. Discuss.
- Do you have any ideas about overcoming the difficulties posed by the consultation and training process?