AN EVALUATION OF THE EFFECTIVENESS OF THE COUNSELLING SERVICE AT THE PARENT CENTRE

A social work study conducted in Cape Town

by

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"All real living is meeting"
(Martin Buber, *I and Thou*)

ABSTRACT

We live in an 'age of accountability.' Social work literature of recent decades abounds with references to the need for adequate evaluation of social work effectiveness, particularly in the light of the dismal findings of early effectiveness studies. However, it is no easy task to operationalise a definition of service effectiveness. This study seeks to evaluate the effectiveness of the counselling service of the Parent Centre, a primary preventive service of the Child Welfare Society, Cape Town. Counselling is provided in order to meet the stated goal of strengthening the effectiveness and self-confidence of parents by providing them with support and information on child development and child management skills. This is offered in the recognition that parenting, for all that it is a normative life transition, is also a life crisis, and in the further recognition of the significance of the early years in a child's life.

The study was located within a limited overview of research literature pertaining to effectiveness studies. It highlighted, moreover, the significance of client studies in contributing to research into outcome of social work intervention. In order to establish the effectiveness of the counselling service, the research took the form of a retrospective semi-structured telephonic survey of a random sample of 55 first-time clients seen at the Parent Centre between January and June, 1994. The sample was drawn from a population of 501 clients. An interview schedule was devised in consultation with colleagues, clients, professionals and after searching relevant literature. It was pilot-tested before being implemented. Fifty-one usable responses were obtained. Since global satisfaction ratings are of little use in evaluation, information was analysed in terms of four categories: demographic,

management, process, and outcome information. Both closed- and open-ended questions were used, providing quantifiable as well as qualitative results.

Whilst findings need to be interpreted with an awareness of methodological limitations, the results of this survey indicate overwhelmingly that the counselling service at the Parent Centre is experienced by clients to be effective. The question found to be the best discriminator in terms of effectiveness was that asking whether clients' expectations had been met.

Significant associations with the clients' feelings that expectations had been met were found with respect to the client's feeling that the counsellor understood the problem and that the counsellor shared personal experiences of parenting. No apparent association was found between this key indicator of effectiveness and income levels or with the counsellor and client having a shared perspective with respect to the presenting problem.

Some recommendations based on the findings of the study are suggested for consideration by agency decision makers.

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This study was conducted at the Parent Centre, Claremont, where I have worked as a sessional counsellor for ten years. During this period I have been nurtured and challenged as worker, as woman, as person, as parent. I am indebted to all my colleagues who together create the unique space which is the Parent Centre. In particular I should like to thank Hilary Rosenthal who, as manager lives, in the workplace, the values which underpin the work. Her sensitive, empowering, and consultative management style permeate and vivify the agency and as mentor and friend she has encouraged and supported me over many years. I should also like to thank Mireille Landman who with warmth, wisdom and flexibility has juggled many roles - teacher, supervisor, colleague, psychologist and friend.

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CHAPTER ONE

INTRODUCTION

We live in an 'age of accountability.' Social work literature of recent decades abounds with references to the need for adequate evaluation of service effectiveness. (Attkisson et al. 1978; York, 1982; Patti, 1985; Magura and Moses, 1986; Sheldon, 1986; McKendrick, 1989; Cheetham et al. 1992; Smit, 1992; Fourie, 1991). This study aims to evaluate the effectiveness of the counselling service at the Parent Centre, a preventive service project of the Child Welfare Society, Cape Town. It seeks, further, to locate itself within an overview of the literature on social work effectiveness research, and to provide a rationale for the use of client studies as a valid means for establishing the effectiveness or otherwise of a service.

PURPOSE OF STUDY

The overall purpose of this study is to evaluate the effectiveness of the meeting of one of the stated goals of the Parent Centre, namely 'To strengthen the effectiveness and self-confidence of parents by providing them with support and information on child development and child management skills through...counselling.' (Mission Statement, Goals and Objectives for the Parent Centre). Clients approach the Parent Centre for information, and assistance with parenting problems. Many engage in counselling. Management at the Parent Centre wishes to establish the effectiveness/ineffectiveness of this intervention.

The study, moreover, facilitates the meeting of a further goal, namely 'To further ensure the quality and relevance of the service by using our resources effectively and creatively in response to findings in on-going research and in response to the changing needs in the community.' (Mission Statement, Goals and Objectives for the Parent Centre).

Specific issues examined include:

demographic information regarding the client population

management information regarding such issues as sources of referral, accessibility and publicity of service

process information regarding the nature of the intervention, as well as the nature and impact of the client/counsellor relationship

outcome information regarding whether or not clients' expectations have been met, and whether clients have been able to effect changes in their life-situations as a result of the counselling process.

The study aims to contribute to the knowledge base of social work in the area of effectiveness research in parent counselling and support.

RATIONALE FOR THE STUDY

In line with the universal recognition in social work of the need for effectiveness research, management at the Parent Centre wishes to evaluate the effectiveness of the counselling service. I have been a sessional counsellor with the agency for ten years and, along with colleagues, experience the work with parents as mutually empowering, challenging and

rewarding: knowing too, the joys as well as the very real stresses of parenting, adds a personal, particular and passionate interest in ensuring the continuation and expansion of the counselling service.

DISCUSSION OF TERMS

Terms and concepts are presented in order to establish clarity of meaning at an early stage.

Programme Evaluation: Grinnell (1981), holds that programme evaluation is applied research. When the purpose of research is to determine how successful a social service is in fulfilling its mission, what effects the programme is having, or whether it is performing as expected, this research process may be considered to be programme evaluation. It follows that one of the purposes of evaluation would be to modify existing services where necessary (McKendrick, 1989). By objective and systematic methods, evaluation research assesses the extent to which goals are realised and seeks to identify the factors associated with successful or unsuccessful outcomes. The assumption is that by providing 'the facts,' evaluation assists decision-makers in making wise choices among future courses of action (Weiss, 1975). Evaluation always occurs within a political context and incorporates a series of assumptions which are political in nature (Weiss, 1975; Rees and Wallace, 1982; Rees, 1987). Evaluation research asks how effective the programme is in meeting its goals, thereby accepting the desirability of achieving those goals, and the premises underlying the programme. Furthermore, evaluation, as in this case, is usually commissioned by the agency responsible for the service, not by its recipients, and study findings tend to be reported to decision-makers and managers and usually not to programme participants.

Weiss (1975) highlights, too, the fact that no social science study gathers neutral 'facts'. All perspectives entail value decisions and reflect something of the researcher's selections, assumptions and interpretations.

Efficacy/Effectiveness: The Social Work Dictionary defines efficacy as 'the degree to which desired goals or projected outcomes are achieved; in social work, the capacity to help the client achieve, in a reasonable time period, the goals of a given intervention' (Barker, 1987:47). The difficulty of arriving at an operational definition of 'effectiveness' in social work has been hotly debated for decades. A limited overview of this debate is given in chapter two.

Counselling: Patterson (1973:xiv) defines counselling as 'work with less seriously disturbed clients, or with clients who have rather specific problems with less accompanying general personality disturbance, usually in a non-medical setting.' It is concerned with voluntary behaviour change, that is , the client wants to change and seeks the help of a counsellor in effecting such change (Patterson, 1976). These statements would accord with the majority of clients who approach the Parent Centre. They are, in general, not in need of medical or psychiatric treatment (here an exception would be parents with post-natal depression), but they do come with specific problems in the area of parenting. Counselling involves two or more participants, one of whom is mandated, usually by some form of professional training, to facilitate change in the other/s toward improved adjustment or functioning (Brammer and Shostrom, 1968). For the purposes of this study, 'counselling' is interchangeable with 'casework' or 'psycho-therapy' in line with Hunt's (1985) assertion that each word is used by a different discipline to describe a similar process. She argues

that counselling and psychotherapy are on a continuum, with counselling at one end being concerned with conscious, external behaviour, and psychotherapy at the other, concerned with the inner world and the negotiation between unconscious processes and external behaviour. She adds, however, that there is considerable overlap between these two ways of working.

Client: The targeted client population of the Parent Centre is parents. Most often interaction will be with one parent only, but sometimes a couple will be seen, occasionally a teenager, and still less frequently, members of the extended family.

Counsellor: At the Parent Centre, all counsellors are registered social workers or have training in psychology, and all are parents.

Prevention: Primary prevention, the level of prevention in which the Parent Centre is engaged, implies actions taken prior to the onset of a problem to prevent its developing (Morales and Sheafor, 1992). Prevention in social work delivery in the field of family and children's services is congruent with the ultimate goal of providing children with what they need in order to grow and to develop their potential and become contributing members of society. Preventive services are at the opposite end of the service continuum from rehabilitative services. A core quality that sets preventive efforts apart is their intentional targeting of healthy, functioning people - a focusing on strengths rather than on deficits (Huntington, 1979; Price et al, 1988). Themes which emerge in this mode of intervention, and which form part of the value base of the Parent Centre, are listed by Hoffman (1990) as:

any significant human event is viewed as having multiple causes

services are proactive rather than reactive

methods of preventive services typically involve empowering people with new skills to achieve desired goals or to protect their physical/mental health.

Parenting: 'Parenting is a complex function involving relationships, communication, social skills, practical skills and the acquisition of understanding.' (Smith, in press:5). It is a two-way process with interaction impacting reciprocally on parent and child. Since parenting is central to the work of the Parent Centre, this concept will be discussed further in Chapter Two.

Parent Support: Parent support programmes focus on prevention, recognise the significance of the early years in a child's development, have a developmental view of parents, and a belief in the universal value of support. They provide services to empower adults in their role as parents, nurturers and providers. (Weissbourd and Kagan, 1989). This concept will also be further discussed in Chapter Two.

The study has been described and introduced. Some key terms have been discussed. Chapter Two provides an orientation to and context for the study.

CHAPTER TWO

ORIENTATION TO AND CONTEXT OF THE STUDY

BACKGROUND TO THE PARENT CENTRE

The Child Welfare Society, Cape Town, a private, voluntary welfare organization, was established in 1908. Constitutionally, the aim of the society is 'to protect the interests and promote the well-being of children'(Starke et al., 1984:1). Since its inception, it has provided a wide range of services to children and their families, focusing initially on the child protective function. Following an in-depth evaluation in 1978 of the effectiveness and relevance of its casework function, the Society was reorganised in order to provide more opportunity for the preventive and promotive aspects of child welfare. By 1982, services had expanded considerably.

However, a concern remained that many families being seen by social workers, primarily in a long-term open-ended casework relationship, could have been supported, counselled and educated for parenthood long before family inadequacies had caused severe family problems and the children had suffered abuse and neglect. Accordingly a feasibility study was conducted by a senior social worker in 1981. This included a literature study, a review of existing services for parents and children in Cape Town, contact with a wide range of professionals and community members, and the formation of a multi-disciplinary working group (Starke et al., 1984). Based on the findings of this study, a primary preventive service, namely the Parent Centre (formerly Family Focus), was established in the southern suburbs in May 1983. The

Parent Centres Athlone and Khayelitsha were opened in 1992 and 1993 respectively in line with the agency's policy to be accessible to all citizens of Cape Town. The mission statement was and is: 'to prevent the physical and emotional abuse of children by promoting their self-esteem and well-being through the provision of support and preventive education for parents.' (Mission Statement, Goals and Objectives for the Parent Centre)

Management at the Parent Centre is aware of the need to evaluate the effectiveness of services/programmes offered. Ongoing monitoring is conducted in respect of courses, groups and workshops. However, despite much anecdotal evidence of the effectiveness of one of its central services - short-term counselling - no systematic research has previously been undertaken regarding this service.

THE COUNSELLING FRAMEWORK AND THE VALUE BASE OF THE PARENT CENTRE

No counselling is value-free (Smith, in press). The value base of the Parent Centre incorporates a commitment to the support and empowerment of parents; to mutual respect between people and in this context particularly, respect for children, and for parents in their often difficult task of parenting; to the building of positive self-esteem in parents and children; to a recognition of the vital importance of feelings and their impact on behaviour; and to effective, non-punitive discipline of children (The Parent Centre, 1992).

The theoretical framework for the *educative* function of the counselling offered has its roots in the parent education of Alfred Adler as expanded by Rudolf Dreikurs (Fine, 1980). The principles of democratic parenting espoused by them and by others such as Haim Ginott (1965,1969), Don Dinkmeyer (1973) and Thomas Gordon (1976) have provided a rich pool from which the Parent Centre's parenting programme **Positive Parenting** has evolved. In its earlier days the Centre ran groups using the **Systematic Training for Effective Parenting** (STEP) developed by Dinkmeyer & McKay (1976). Whilst these groups were evaluated positively by participants and facilitators, the need was recognised for the development of an indigenous programme, better suited to the needs of South Africa. The principles and values (mentioned above) underpinning **Positive Parenting** also underpin the counselling engaged in by counsellors with clients, and counselling frequently includes informing/teaching parents new skills of interaction, particularly in relationship with their children.

Fine (1980), and Smith and Pugh (1996), list the primary theoretical frameworks from which parenting programmes in the USA and in Britain have developed:

- *the behavioural approach* which focuses on observable and measurable behaviours. In the context of parent education, the model assumes that parents can be instructed in methods of encouraging desired behaviour and discouraging undesired behaviour in their children. This method has been effectively operationalised by, among others, Patterson (1975) and Guerney (1969).

- *humanistic theories* flowing from the work of Carl Rogers (1965). This approach stresses the importance of empathy and intersubjectivity in the definition and resolution of problems and forms the framework from within which Gordon (1975) developed his **Parent Effectiveness Training** (PET). This parenting programme includes the skills of listening to feelings, of taking responsibility for feelings and for negotiating solutions of problems which are satisfactory for parent and child (van Rensburg, 1992).

- *psychodynamic theories* which acknowledge the significance of the unconscious, of an inner world of dreams and fantasies, and which attribute great significance to early relationships and events, and their impact on subsequent development.

- *family systems theory,* the theoretical framework for family therapy, which views the family as an interactional system and locates problems within this system, rather than identifying an individual as having/being the problem (Minuchin, 1974; Hoffman, 1981).

- *Adlerian theory* which evolved out of the writings of Adler and was further articulated by Dreikurs and Soltz (1964) and Dinkmeyer and McKay (1976), the last-mentioned of whom developed the **STEP** programme referred to above.

Whilst the stated therapeutic orientation of the counselling is that of rational-emotive therapy (when we *think* something is bad, we *feel* bad about it because of our *belief* about it - Corey, 1977; Dryden, 1990), it would be true to say that elements of all of the above frameworks are eclectically appropriated in the work at the Parent Centre. Family therapy *per se* is not practised, but the family is certainly viewed as an interactional system; fundamental to the work is the recognition that a change in the behaviour of even one parent will impact for better or worse on the homeostasis of the system and therefore on the children in the system. Social learning principles are not routinely applied, but the situation may arise where tasks are set and practised, consciously to reward desired behaviour in children. Psycho-dynamic therapy is not practised, but all counsellors work with an awareness of the power of the unconscious, and of the immense significance of early events in a child's (and parent's) life. As in all counselling, empathy is central - empathy for the client(s) in the room, as well as empathy for the 'hidden' client - the child(ren); and skills of listening to feelings, of negotiating, of taking responsibility for feelings and communicating them effectively may be dealt with - core concepts in the humanistic framework. The Adlerian focus on motives also forms part of the therapeutic framework, and parents may be assisted in recognising how they are unconsciously reinforcing negative behaviour. By becoming aware of the motives behind children's behaviour e.g. attention-seeking, they can shift the giving of attention to positive situations. Dreikurs, whose work evolved out of and expanded that of Adler, emphasised the values of mutual respect and equality - equality in the sense of *worth* rather than sameness in parenting (Christensen and Thomas, 1980). These, too, are upheld as values for the Parent

Centre - both in terms of a model for parenting and in terms of the process of counselling.

Counsellors have life-experience of parenting, have professional qualifications relevant to the field and, further, undergo an in-house training course before being accepted as workers. Staff development and training are ongoing, with monthly counsellors' case conferences/meetings and quarterly team-building meetings. Counsellors are also in regular supervision. At the time of this study there were 6 members of permanent staff and 8 sessional staff. Management style is consultative and inclusive and has an emphasis on empowerment of workers (Gowdy and Freeman, 1993).

Counselling at the Parent Centre embraces the following principles:

- the client's right to self-determination, other than when the welfare of a child is at stake.
- time-limited contracts with clients - usually between 1 and 6 sessions will be contracted, although further sessions may be contracted if necessary. This precludes long and extensive intake procedures. As Epstein (1976) notes, assessment is not separated from the intervention process.
- a focus on the present, although with an awareness of the impact of the past, and particularly an awareness of how the birth and nurture of a child can reactivate past issues/losses for the parent. (Farrell and Rosenberg, 1981; Weissbourd and Kagan, 1987).
- a focus on the conscious rather than the unconscious

- where appropriate, the setting of tasks
- recognising and building on strengths rather than deficits.
- a focus on goals which increase parents' confidence in and satisfaction with their task of parenting via supportive counselling rather than restructuring of personality or family via confrontation and conflict (Wandersman,1987).

PARENTING AND THE FAMILY

It is generally accepted that the family is a uniquely placed social institution. It faces inward toward the individual and outward toward society (Sewpaul,1993). As the world's oldest form of expression of human relationship, the family has survived for thousands of years, adapting itself to demographic, socio-economic, cultural, and technological changes. No other social institution has adapted to such a wide variety of social changes over such an extended time period (Karpowitz, 1980). For humankind, relatedness is both a biological and a psychological imperative. The infant cannot survive without the loving care of adults which must continue over a long period of socialization and integration into wider and wider circles of interaction (Hartman,1981). Families are one of the most important places where children's self-esteem, behaviour and attitudes are shaped. Through a loving and stable relationship with their parent(s), they can first be introduced to the balance between personal responsibility and inter-dependence which enables wider society to function (Utting, 1995). Despite its many shortcomings, the family has not been bettered as a matrix for the rearing of children (Black, 1990).

Given the universally accepted centrality and significance of the family as a container for the nurture of the child, there is, however, no single definition of or form for the family. The family does not exist in isolation, but always within an historical, a social, a political, an economic and a cultural context. South Africa is a multi-cultural society and perhaps nowhere is the expression of cultural difference more deeply felt than in the experience of family which is itself a fundamental expression of a world-view - the collective versus the individual (Tau, 1989). The divide occurs most obviously, perhaps, between the nuclear family which has evolved out of industrialization, colonization and westernization, and the extended family or kinship network, which is the family form of primarily indigenous people, but also of some immigrants and their descendants.

Whatever the prevailing world view, the family is a dynamic, adapting and evolving system, one which is vulnerable to social, economic and political influences. Modernization and urbanization have led to the breakdown of the 'traditional' way of life, whether that be kinship network or nuclear family.

The 'ideal' of the nuclear family (which in South Africa is perhaps increasingly a phenomenon of middle-classness rather than of a particular cultural grouping), of a first-time married husband and wife with dependent children, living in a home of their own provided for by the husband's earnings as the main breadwinner, and emotionally united by the wife's exclusive concentration on the home (Barker, 1981; Fine, 1980; Karpowitz, 1980; Kagan and Shelley, 1987), and having a predictable lifecycle (McGoldrick and Carter, 1982; Scanzoni, 1988), increasingly recedes into distant

history. Family structures are changing as cohabitation, divorce and remarriage, blended or lone parenting are experienced by increasing numbers of people; fewer children are born to perhaps older parents who may or may not be married; and partnerships, gay or straight, are increasingly companionate, dual-career relationships (Weissbourd, 1987; Stacey,1990; Pugh et al., 1994; The Economist, 1995). Family *structure* is not the issue. Research on marriage, cohabitation, divorce and lone parenting (and indeed on the support of kinship networks - Reynolds 1995), supports the view that 'children thrive in any kind of family where there is consistent love and nurturance, support and discipline, and in no kind of family where those qualities are missing'(Hewitt and Leach, 1993, in Pugh et al. 1994: p.54). However, it is also widely recognised that parenting is deeply challenging even when two parents can offer each other support. When one parent has to bear the brunt of economic and child-rearing responsibilities, stress increases exponentially (Karpowitz, 1980).

Modernization and urbanization have had no less an effect on the traditional way of life of kinship networks, the primary family form of blacks in this country. These, however, have been profoundly exacerbated by colonization initially, and until recently by institutionalised apartheid, a process of deliberate calculation and policy by the State to destroy family life via forced removals, migrant labour and influx control, amongst numerous other dehumanising laws and practices (Campbell, 1992). Apartheid has, moreover, ensured an unequal distribution of resources and has erected barriers to social and economic advancement, so that children born black, are predisposed to experiencing a range of adverse life conditions which might not have arisen had they been born white. Literature on risk factors for psychological

development acknowledges that growing up in poverty is the single most powerful and multifaceted negative influence on psychological development (Dawes and Donald, 1994). The chronic stress, material hardship and all too frequent dehumanization that define the experience of poverty, exert a negative potentiating influence on other parenting determinants. Poverty increases the likelihood that numerous risk factors will be present simultaneously (Halpern, 1990):

- in the *child*; low-income mothers are twice as likely to have low-birthweight babies with the attendant challenges and stresses for parenting
- in the *parents;* low-income parents are more likely than other parents to begin child rearing during adolescence, are less likely to be married, and when married are more likely to experience more marital conflict, thereby undermining a key source of social support; low-income women are more prone to depression than other groups in society, and mothers who are depressed are generally less responsive and nurturing, less aware of their children's moods, and are more restrictive with their children (Belle, 1982, in Halpern, 1990; Dix, 1991)
- in the family's *informal support system*; other potential sources of social support are themselves likely to be struggling with poverty-related stresses, undermining their ability to provide practical and emotional support for parenting

As a corollary, poverty reduces the likelihood that protective factors will be present somewhere in those systems (Halpern, 1990). Similarly, growing up under conditions

of violence constitutes a developmental risk and rates of violence in South Africa are amongst the highest in the world (Dawes and Donald, 1994).

Karpowitz (1980) holds that it is important to view the family as a process, not as a static entity. It is constantly being affected by external stresses and support systems. The family, in turn, is an active agent in the creation of some of these stresses and support systems. The family is in the process of developing, of becoming. It is also holding on and resisting change.

And what of parenting? Parenting is more than the sum of a set of behaviours. Eldridge and Schmidt (1990) quote Kempe and Kempe (1978) who state that:

> Parenting is the ability to recognize (with or without clear understanding) the needs of a child for first, physical care and protection; second, nurturance; third, love and the opportunity to relate to others; fourth, bodily growth and the exercise of mental functions; and last, help in relating to the environment by way of organizing and mastering experiences. In addition to recognizing these needs, a parent must be able to meet them or at least facilitate their being met (p.343).

Despite recognition of these fundamental needs of all children, there is no absolute blueprint for parenting, just as there is no blueprint for being a child. Most parents want to do their best for their children (Ginott, 1965; Pugh et al., 1994; Landman,1995). It was Winnicott who, in 1960 first coined the term the 'good-enough' parent. What facilitates this 'good-enough' capacity to parent? What are the determinants of parenting? Parental behaviour occurs in the context of a relationship,

as does the child's. The infant is a source of stimulation and feedback which influences and guides parental behaviour and shapes the parent's image of the baby as well as of the parental self. The capacity to parent develops in conjunction with the growth of the child (Eldridge and Schmidt, 1990). Available theory and research on the aetiology of child abuse and neglect highlight three general sources of influence on parental functioning:

(1) the parents' ontogenetic origins and personal psychological resources (emanating significantly, in part, from their own experience of being parented);

(2) the child's characteristics of individuality and the consequent 'goodness-of-fit' between parent and child; and

(3) contextual sources of stress and support in which the parent-child relationship is embedded - specifically marital relations, social networks and occupational experiences of parents (Belsky, 1984; Mash and Johnston, 1983).

Perhaps the most emotionally charged area of human existence is our relationships with our children (Goetting, 1986). And again, parenting is an emotional experience - raising children involves more joy, frustration, affection, anger and worry than do most other endeavours. Strong emotion is a daily concomitant of parenting - conflictual interactions between parents and children occur from 3 to 15 times an hour in families with young children, and even more in families with children who are ill, disabled or aggressive. Positive emotions are even more common - parents report 2½ times as many positive as negative interactions with their children (Dix, 1991). Many researchers place the adult capacity for empathy at the centre of the parental role

(Lamb et al., 1980; Belsky, 1984; Eldridge and Schmidt, 1990; Dix, 1991; Bavolek, 1990 in Pugh et al., 1994).

For both men and women pregnancy, childbirth and new parenthood awaken old, even pre-verbal issues related to dependence/independence. To become a parent is a step that revives memories of one's own infancy and childhood and early relationships with parents. It also provides opportunities to rework earlier developmental issues and to arrive at a new resolution of them. Many parents look at parenthood as a chance to do things differently with their own children, to do them 'better.' However, the reality is that often they find that they are jolted out of control of their lives (Hansen and Jacob, 1992).

For all that becoming a parent is a normative life transition, no amount of anticipatory preparation or socialization can quite prepare a person for the challenges and surprises that a first new-born infant brings (Pearlin and Turner, 1987). The transition to parenthood represents a life crisis (Wandersman et al., 1980; Ginsberg, 1989; Koeske and Koeske, 1990) which is often associated with a decline in personal and marital well-being (McHale and Huston, 1985; Umberson, 1989), a crisis in which fundamental, irreversible and decisive changes take place requiring major adjustments which take time and effort to negotiate. Some of these adjustments include:

- accepting responsibility for the life of another human being
- learning to tolerate and contain often difficult, infantile and ambivalent emotions which may be evoked by the baby

- learning to tolerate the frustrations, doubts, failures and disappointments that accompany parenting
- negotiating the demands of partner, family and others
- renegotiating relationships with own parents and parents-in-law
- dealing with exhaustion, loss of independence, loss of affirmation and recognition which might previously have been gained from work, or alternatively, coping with the stresses of combining multiple roles
- accepting the identity of 'mother' or 'father' or 'family' (Landman, 1995).
- reallocation of financial resources
- shift of a dyadic communication system to that of a triad (Wandersman et al., 1980).
- loss of control (Hansen and Jacob, 1992).

Weissbourd (1987) quotes Anthony and Benedek (1970) who state that being a parent is a specific stage of adulthood, reflecting childhood experiences, but also having its own developmental stages. Parenthood should be a creative, self-growth period that requires sensitivity and responsiveness to the next generation while at the same time permitting, even necessitating the expansion of the parents' own competence, emotional attachments and coping skills. The disequilibrium of this period presents opportunities for positive realignment of relationships as well as dangers of increasing conflict and estrangement (Hansen and Jacob, 1992).

It is generally assumed that the role of parenting is natural and instinctive and that parents somehow intuitively know how to function and respond in ways which facilitate their infant's optimal growth. However, the work of the all-party parliamentary group on parenting and International Year of the Family, UK, 1994 (cited in Buttigieg, 1995: p.225) 'clearly showed that parenting is not something that just happens, and that society has a responsibility to teach, guide and support parents, especially the young and disadvantaged.' For many parents with a solid sense of self, and sufficient contextual support, resources internal and external suffice for good-enough parenting. However, *all* parenting has its stresses, and it is in recognition of this, as well as of the fact that parenthood represents a phase in which individuals are open in new ways to change and growth, that the Parent Centre was established to act as an educative and supportive facility.

PARENT SUPPORT

Parent support falls within the ambit of the broader concept of 'family support' which strives for an holistic, contextual and empowering practice, bringing to life social work's concern with the person-in-environment, and revitalizing the profession's historic commitment to the family as the crucible for the nurture and socialization of the child. Family support programmes are relatively new to the spectrum of services available to families, in first-world countries having been initiated only in the 1970s (Lightburn and Kemp, 1994). These programmes embody a commitment to family-centred practice. Parent and/or child issues are integrated and reframed as family issues, and intervention has the potential to serve all family members. Central

assumptions are that parents are the most significant influence in the lives of their children and that they have strengths which can be supported and developed - they may be empowered to be 'agents of change' (Cone and Sloop, 1974; Shah, 1974; Abidin, 1980). Interventions acknowledge and work with family and community culture and with coping styles, and embrace an empowering, preventive and enhancement-of-competence-and-resources approach, rather than one which focuses on deficit, dysfunction and treatment (Kagan and Shelley, 1987; Lightburn and Kemp, 1994). They recognise the immense significance of the early years in a child s development, have a developmental view of parenting, and have a commitment to and belief in the universal value of support. Family support programmes are committed to flexible, non-stigmatizing service delivery (Weissbourd, 1987). They are also trans-cultural/culturally sensitive (Dominelli, 1988; d'Ardenne and Mahtani, 1989).

Utting (1995) holds that the provision of support services at an appropriately early stage for families may not only avert an impending crisis, but may also remove the need for more intensive and expensive intervention subsequently. Davie (1990), speaking in the context of the prevention of violence in South Africa, states that the strengthening of a community begins with the empowerment of parents. She continues by saying that unless parents are enabled to take control of their own lives and those of their children, no amount of effort on the part of care-givers and teachers will achieve results of any significance. This concept of primary preventive support of families is also congruent with the principles of family empowerment espoused in the White Paper for Social Welfare, 1995.

Bringing up children is perhaps the most challenging and important task most people perform. It is a lifelong commitment and the impact of parenting is felt throughout a person s life as well as for succeeding generations (Pugh et al., 1994). Yet despite the significance of this task, it is one for which parents receive little or no preparation, training or support other than their own experience of having been parented. However, the world in which today's parents are raising their children is a very different one from that in which they themselves were raised; many parents are lonely and isolated, and for many, their own experiences of childhood simply serve as a model of how they would wish *not* to bring up their children (Pugh and De'Ath, 1984). Whilst isolation may be the experience of many, there also is no lack of 'advice' via the media or social networks, much of it contradictory and undermining of parents; and parent-blaming (and especially mother-blaming) when problems in families occur, is a well-documented phenomenon (Caplan and Hall-McCorquodale, 1985; Walters, 1990). Society has huge expectations of parents, whilst simultaneously undervaluing the role of parenting; the pressures on parents to perform, to bring up 'perfect' children and not to make mistakes are severe and may induce guilt and anxiety (Smith, in press).

Pugh et al. (1994, p. 66) define parent education and support as:

> - a range of educational and supportive measures which help parents and prospective parents to understand their own social, emotional, psychological and physical needs and those of their children and enhances the relationship between them; and which creates a supportive network of services within local communities and helps families to take advantage of them.

They continue:

- they should be available to all parents and prospective parents, boys as well as girls, young men as well as young women, fathers as well as mothers.

- the emphasis should be on individuals' roles and relationships in the here and now, as well as on their future roles and relationships.

- The overall aim of parent education (and support) is to help parents develop self-awareness and self-confidence and improve their capacity to support and nurture their children.

The notion of supporting parents with a view also to supporting the child, which is the primary *modus operandum* of the counselling at the Parent Centre, is not new. One of the earliest recorded examples of vicarious working with the child through the parent was that of 'little Hans' whose father was supported by Freud (1909) to assist Hans in working through his conflicts and fears in resolution of his phobia (Hicks, 1988; Schaefer and Briesmeister, 1989). This was therapy, rather than parent support, but was seminal in facilitating the awareness of the systemic nature of family relationships and the possibility of working with a parent in order to effect change in a child. 'Since this time, in the more directly therapeutic field, parents have been 'trained' to work as co-therapists either with a behaviour modification approach (based on principles of learning and conditioning) or with a relationship enhancing approach (based on the strengthening of parent-child relationships by means of

positive communication, problem-solving skills and corrective emotional experiences. Patterson's work (1975) would be typical of the former approach, whilst Guerney's 'filial therapy' (1969) would be an example of the latter.

Counselling is merely one of the methods of parent support employed at the Parent Centre. In line with family support initiatives elsewhere in the world, the Centre is also engaged in parent education via groups, workshops and lectures for parents and professionals, in coffee mornings, support groups for new parents and those with post-natal depression, in creative, concurrent work with parents and children, in community and developmental work and research with mothers at risk of abusing their babies, and with considerable networking.

CONCLUSION

An orientation to and context for this study have been presented. The concepts of 'parenting' and 'parent support' have been elaborated since they are at the core of the work of the Parent Centre. Chapter Three moves on to offer an operational definition of 'effectiveness' in social work practice.

CHAPTER THREE

AN OPERATIONAL DEFINITION OF SOCIAL WORK EFFECTIVENESS

INTRODUCTION

Is social work effective? What does it mean to be 'effective?' These questions have been debated extensively in social work literature for decades. Pressure for managers and practitioners to clarify the effectiveness of their work has increased in recent years both from within and without the ranks of social work (Maluccio, 1979; Cheetham et al., 1992). There are no simple or clear-cut answers. Fundamentally, effectiveness has to do with *whether or not programme goals have been achieved* (Phillips et al., 1994). However, establishing this is no easy task, since programme goals so often are unspecific, global statements of intent which are difficult to evaluate.

THE COMPLEXITY OF SOCIAL WORK

The field of social work itself is contentious (Cheetham, 1992). Social workers are charged with tasks which range from comfort and practical assistance to surveillance and control. It is also an eclectic discipline (Sheldon, 1978), drawing theory from its own knowledge base as well as from a variety of other sources. Patti (1987), delineates 5 broad areas of social work based on social purpose or function:

(1) Social control agencies whose primary purpose is to protect society from "deviant" or "disorderly" people (e.g. child protective services, services for sexual offenders, correctional services).

(2) Social care and maintenance agencies which exist to care for people who are unable to care for themselves.

(3) Socialization and prevention agencies, concerned primarily with promoting the normal emotional and social development of their clients - the services of the Parent Centre would fall into this category.

(4) Rehabilitative and restorative agencies whose principal purpose is to effect change in the cognitive, emotional or interpersonal inadequacies of clients (e.g. community mental health facilities).

(5) Advocacy and social change organizations which seek to promote or protect the interests of people who have been neglected, stigmatised or otherwise denied opportunity in society. The Parent Centre performs an advocacy function, and offers support to vulnerable people e.g. mothers with post-natal depression, single parents.

Within these broad frameworks, social workers assume a variety of different roles - caseworkers, group workers, community organizers, family therapists, couple counsellors,

therapists, advocates, managers, planners, policy makers, coordinators and agents of social change, to name some.

It can therefore be seen that, given the broad spectrum of social work activity, effectiveness is, of necessity, context-specific. It further depends on what criteria are regarded as valid for establishing whether programme goals have been achieved or not. Moreover, different stakeholders have different perceptions of what constitutes effectiveness (Rees and Wallace, 1982; Goldberg, 1987; Cheetham et al., 1992; Pugh 1995): *politicians* would be preoccupied with the congruence between the objectives of a service and the social policies of their parties; *managers* or *administrators* would question cost-effectiveness of services; *practitioners* would be concerned to know whether their activities are impacting positively on the lives of their clients; and *clients* seek the corollary of satisfaction with services. Whose definition of needs is to count as valid, and who is to judge whether or not those needs have been met? How universal is the applicability to social work of a concept of effectiveness, borrowed from medical research, which assumes a model of the curing of social ills? Some kinds of intervention, for example assessment, referral, the prevention of deterioration, or the creation of potentialities rather than final states, do not easily lend themselves to the 'treatment and cure' model and require a more flexible consideration of what constitutes an outcome. (Cheetham et al., 1992).

It can be seen that effectiveness derives from a variety of perspectives and assumptions, and itself forms part of one or more of a range of different rhetorics, for example the language of value for money, of professional accountability, of meeting consumer demand or of maximising satisfaction. These considerations are central to the understanding of how

concepts of effectiveness are currently understood, and what and whose purposes they may serve. They need to be taken into account in choices regarding the focus of research, and thus of the data to be collected and the methods used. The challenge is to arrive at operational definitions of effectiveness in specific contexts and at context- and resource-appropriate methods of assessing it (Cheetham et al., 1992).

Cheetham et al. (1992) continue by pointing out that effectiveness is separate from, but linked to the practice of evaluation. The *effectiveness* of a programme may be established without proceeding to a statement about what *value* might be ascribed to it by various stakeholders, but a programme cannot be evaluated without some knowledge of its outcomes and effectiveness. Evaluation therefore goes beyond the identification of effectiveness - it may conclude that an intervention has been successful in terms of objectives achieved, but argue that these are trivial, inappropriate or misconceived. To evaluate social work effectiveness, therefore requires assessing it within the broader context of social policy.

Goldberg and Warburton (1979) hold that the scepticism which has led to the ongoing preoccupation with social work effectiveness derives from three main sources: research; scandals (for example deaths of children at the hands of abusive parents); and socio-political ideologies. The first of these, research will be expanded below.

A LIMITED REVIEW OF LITERATURE PERTAINING TO EFFECTIVENESS RESEARCH

The effectiveness of professional social work intervention has been a matter of concern for many years. As early as 1931, Cabot in his presidential address to the American National Conference on Social Work, urged the profession to begin evaluating the results of its programmes (Mullen and Dumpson, 1972). "I appeal to you...measure, evaluate, estimate, appraise your results in some form, in any terms that rest on anything beyond faith, assertion and the 'illustrative case'" (Cabot, 1931 cited in Sheldon, 1986:p.223).

On the basis of methodological and practice-input differences, Sheldon (1986) differentiates between what he calls the first and second 'waves' of studies of effectiveness. The first group of studies stretched from the late 40's through to the early 70's, and attempted to answer the global question, 'does social work work?', whilst the second group comprises work begun in the 70's extending to the present and focuses on more specific questions. Among the best-known, perhaps, of the former group were those gathered by Mullen and Dumpson (1972) and those reviewed by Fischer (1973) and Wood (1978). The dismal conclusions by Fischer (cited by Sheldon, 1983: p.478) that '...the bulk of practitioners in an entire profession appear, at worst, to be practising in ways that are unhelpful or even detrimental to their clients, and at best, operating without a shred of empirical evidence validating their efforts' caused shock waves to reverberate throughout the profession. Goldberg (1987) holds that intervention was largely unspecified and was described in global terms such as 'casework' or 'group work' and that descriptions of what social workers do with and for their clients were rare - and still are. Also lacking were

hypotheses about what kinds of approaches seemed to work with what client populations in what kinds of situations. Moreover, objectives were often so vague that it was hard to know whether or when one had been achieved. As Sheldon (1986) points out, clearly identified negative results have a very important function in science - they indicate what *not* to do. However, this learning can occur only if reasons for prior failure can be isolated.

Two studies from this first wave which did have clearly identifiable interventions were those by Reid and Shyne (1969) and Goldberg (1970, cited in Sheldon,1986). The former seminal study aimed at assessing the relative effectiveness of two significantly different forms of casework intervention in alleviating family problems: planned short-term service (PSTS) limited to eight sessions, and open-ended, continued (CS) service, which had no limit as to number of interviews. In practice, CS was often of short duration due to premature client termination. Results indicated that families receiving PSTS progressed according to measures used more than those receiving CS. This improvement held for follow-up testing as well. Goldberg's study compared effects of services provided to elderly people in the community by trained workers with those provided by experienced, but untrained staff. Interventions by trained personnel were found to be more effective.

Post-1972 social work experiments have been reviewed by Reid and Hanrahan (1982), and by Macdonald et al. (1992), whilst Thomlinson (1984) reviewed over six hundred effectiveness studies. The last-mentioned included outcome studies in the field of social work as well as in related disciplines involved in psychotherapy, marital therapy, family therapy and behavioural therapy. Reid and Hanrahan required amongst their criteria for studies to qualify for review, that they be equivalent-group experiments in which clients

were randomly assigned to service or control (non-intervention or other treated) groups. Twenty-two such studies were identified. Sheldon (1986) and Rubin and Babbie (1993) point out that there are methodological differences in this newer work: samples are generally smaller, clients more highly selected, and the preparatory work done prior to the setting up of a study is of a much better quality - increased attention is being paid to defining accurately the nature of the therapeutic inputs which results in more clearly being able to identify what it is that is effective. Reid and Hanrahan concluded:

> 'Perhaps the most striking point is that the outcomes of most of the studies were positive. That is clients in experimental groups tended to show more gains than their counterparts did in the control groups. ... All but two or three of the twenty-two studies yielded findings that could on balance be regarded as positive.' (1982:p.330)

Fischer (1983) in turn criticises their review stating that almost all the studies had one or more serious flaws regarding internal or external validity, or the appropriateness of the statistical measures. Epstein joins him even more vociferously stating that 'their criticism of existing studies was tepid, their literature search was incomplete, and their implicit review design was not up to current standards of evaluation summaries' (1983). And Macdonald et al. (1992) highlight the criticism levelled at the studies reviewed by them that the challenging of social problems had been exchanged for methodological rigour.

Macdonald et al. (1992) included in their review not only experimental and quasi-experimental studies, but also studies which sought the views of *clients* which, whilst 'lacking the challenging structure and the quantitative rigour...contain the qualitative richness of good market research, and give us valuable insights into how clients understand

what social workers are trying to achieve.' (p.620) Ninety-five studies were identified which complied with their criteria for selection. They were examined along the following dimensions: research design, client population targeted, adequacy of sample, intervention used, results, methodological quality, whether or not a follow-up period was included and the relevance of the study to mainstream social work. Seventy-five per percent of studies subjected to this scrutiny emerge as clearly positive; 17% produced mixed but worthwhile results; 8% produced clearly negative results from which much can be learned and 7% had to be excluded on methodological grounds.

Thomlinson's (1984) review identified over six hundred effectiveness studies. He does not give his criteria for selection, but, given the large number, presumably the parameters for inclusion are broader, and, as stated above, are not limited to social work only. However, his conclusions include the fact that '...the weight of the research evidence...indicates that planned, systematic effort at facilitating change in individuals, married couples and family units leads to more positive outcomes than does unplanned, informal help, i.e. no treatment control groups. He also concludes that 'behavioural therapies were more effective than the verbal therapies', and that, depending on the nature of the problem, 'structured, time-limited intervention is at least as effective as less structured, open-ended intervention.' (p. 52-53).

And so the debate continues. However, the above reviews cover primarily studies adhering to fairly rigorous scientific criteria - the approach which has become identified as the 'positivist' stance (Smith, 1987). What of the rest? Cheetham (1992) refers instead to the need for a pragmatic approach to evaluative research, stating that this approach is based on

the assumption that there is no *one* research method that is to be preferred above all others, and that 'evaluating the effectiveness of social work has, therefore, to be pursued as the art of the possible, with full recognition that what is possible is also limited.' (p.272).

THE POSITIVIST VS THE PRAGMATIC/ECLECTIC APPROACH

Introduction

In the world of social work research, the domain of effectiveness research is extremely limited - only approximately 1/10th of research effort (Jenkins, 1987). Probably the major reason for this is its extreme complexity, as explicated above, as well as the immense resources required for robust studies requiring large samples of clients receiving a variety of interventions and studied over long periods (Cheetham et al., 1992). In South Africa there is no less a paucity of effectiveness research. Very few studies were located in the databases consulted.

The Positivist Approach

In the post-World War 11 years, the quantitative approach became dominant in the social sciences and in social work research (Karger, 1983). This occurred in part as a result of the excitement generated by rapid advances in the physical and informational sciences as well as by the development of advanced methods in statistics and an increasingly sophisticated computer technology. The social sciences could now work more precisely from 'hard data' rather than relying on the 'soft abstractions' of history, philosophy and social theory.

Karger (1983) focuses on three major arguments favouring the scientific method: (1) the need to establish greater *legitimacy* within the profession; (2) the assumption that the use of empirical theories and measurement will lead to more effective social work *practice* - indeed, in this regard, Fischer (1981, p.200) states that '...social workers can begin to harness the technologies of the social and physical sciences to build a greater degree of systematization, objectification and precision into their selection of knowledge for practice'; (3) the belief that empirical evaluation is the *only* valid method of assessment of effectiveness. In stark contrast, Goldstein (1992, p.49) asks: 'But who benefits from this plethora of information aside from publishers and authors who may improve their chances for tenure? Is there any assurance that theoretical literacy actually translates into ingenious down-to-earth practice?'

Central to experimental design are the notions of cause and effect and of control (Cheetham et al., 1992). The experimental unit receives some form of input designed to effect change. Outcomes are compared with those of a control group identical to the experimental group on key dimensions, but without the input/intervention. Thyer (1989) expands further, stating that first principles of practice research demand random sampling, assignment of subjects to experimental and control groups, validated assessment methods and extensive follow-up periods. A major problem in managing the experimental design in social work research is the control of the input under scrutiny. Thus even if change is observed, it may be difficult to be exact regarding to what this change should be attributable. (Cheetham et al., 1992; Smith, in press)

A further problem is the ethical dilemma created around the issue of using control groups. How ethical is it to withhold treatment from a group of clients in need of intervention? Sometimes wait-listed people are used for control purposes which is ethically more acceptable since they would have to wait for treatment regardless (Sutton, 1995). Yet another ethical problem is whether or not to inform clients as to whether they form part of the experimental or control groups (Smith & Pugh 1995), as well as the issue that some studies deliberately mislead clients regarding the facts of the situation being studied in order to preserve the internal validity of the experiment (Saleebey, 1979) - for example Tessler in an experiment to determine relationship- vs. problem-centred satisfaction, deliberately misled subjects regarding the length of experience and level of qualification of clinicians.

Broader issues of power and control in experimental research are explored by Saleebey (1979, p.270): '(the one) who controls the information controls the situation', and by Karger (1983, p.203): 'All research is political and ideological: by the choice of the subject and design of methodology, the researcher creates a context for understanding social phenomena'... and... 'The primacy of the scientific paradigm in social work suggests that research...is synonymous with quantitative methodology.'

Davis (1986) explores the power theme further by looking at social work research from a feminist perspective. She contends that much of social work research uses a 'male model of knowledge' (p.32) and that dissatisfaction with much research has in part to do with the fact that social work is a profession practiced primarily by women, but led by men. 'To counteract the perception of social work as a profession of soft-hearted and soft-minded

women who rely on caring and intuition, social work academicians have firmly adopted the male research model' (p.44). She sees the 'male' perspective as primarily quantitative, as 'separating' (researcher and subject are separate, roles are clearly delimited and prescribed) and as 'context stripping' (people are studied as though they can be separated from the contexts in which they live). In contrast, the primary theme of a 'female' methodology is connection. Relationship between researcher and subject is egalitarian and 'involved' and research is contextual and qualitative. Saleebey (1979) also focuses on the dimension of relationship when he says: 'while the experimental paradigm exalts control, prediction, measurement and focus, it desiccates the possibilities of relationship' (p. 278).

Perhaps an extreme expression of the 'male' perspective is that of Hudson (1978) who states that of the working tools for conducting evaluative research, the role and function of measurement is most important. He formulates two axioms of treatment: 'If you cannot measure the client's problem, it does not exist' and, 'if you cannot measure the client's problem, you cannot treat it.'

The Pragmatic/Eclectic Approach

This approach is that espoused by the Social Work Research Centre (SWRC) at the University of Stirling which has been studying the effectiveness of social work since 1986 using a wide range of quantitative and qualitative research methods (the Social Work Research Centre, undated) and explicated by Cheetham et al., 1992. It is the Centre's opinion that the demand for evaluative research and its relative scarcity, encourages a pragmatic approach in which problems confronting social work, the methods by which they

are tackled, and their outcomes can be studied in settings small and large which previously may not have been regarded as adequate contexts for researching effectiveness. In line with Davis' (1986) feminist stance above, it is interesting to note that three of the four founding fellows of the SWRC, which espouses a more 'Feminine' approach, are women.

Cheetham (1992) indicates that the scarcity of evaluative research is, in part, a result of the 'too-ready espousal of scientific principles, particularly positivism, which may be inappropriate to some, though certainly not all social work practice' (p. 268). She holds that the experimental method does not have a monopoly on disciplined analysis and that if research designs *have* to incorporate random sampling and experimental and control groups, then not only will studies of effectiveness often be narrow in scope and superficial in analysis, but they will also be eliminated from all but the best resourced academic centres and from most social work agencies. The effectiveness of much day-to-day practice will thus be unresearchable which, she asserts is a dangerous position, because it both undervalues practice and protects it from critical scrutiny.

> The challenge for the evaluative researcher is thus to find the ways and means of assessing effectiveness in all the contexts in which social work is seriously practiced - ways and means that respect and capture its diverse tasks and stakeholders that speak to the different audiences that have legitimate interests in its activities (Cheetham, 1992: p.273).

Apart from the SWRC there have been many others who, over the years have indicated dissatisfaction with the narrow scientific evaluative method. Among these are England (1986: p.47) who notes that 'there is, it seems, at the centre of social work a difficult area

that deters or even precludes analysis; it is noted, sometimes with enthusiasm, sometimes uneasily, and left.' He is here referring to the social worker's use of self, of intuition, which has been consistently recognised as a core and distinct aspect of effective practice. He develops an argument for the 'artistic', essentially personal nature of social work, whose requirement is for a mode of evaluation more akin to art or literary criticism than to a scientific model of evaluative research. Jordan (1978) expands on the 'use of self' concept by pointing out that the social worker has to rely on disciplined use of self, on skills of communication, and on the emotional interaction between self and client. A consequent understanding of interpersonal processes, which may not lend themselves to strict scientific rigour, is of primary importance. He also concurs with Cheetham et al. (1992) regarding the fact that much social work *is* concerned with problem-solving, but, equally, much is to do with problems that cannot be solved. 'Being a child in care, physically or mentally handicapped, or old and frail, does not constitute a set of difficult but, changeable behaviours....what the social worker offers them is something to do with sharing, possibly with loving.' (p.24) And Smith (1987) states that research founded on traditional positivist assumptions should be recognised as being capable of generating a certain kind of potentially useful information and should be welcomed alongside *other* research approaches founded on different assumptions, using different methods and therefore generating different kinds of information.

Finally, Macdonald et al. (1992) state that there is no doubt that randomly-allocated equivalent group designs provide the most persuasive and potentially irrefutable evidence of effectiveness. However the realities of social work are such that this approach is difficult to realise routinely. It is by no means always possible randomly to allocate clients to

different services or wait-list control groups. Reasons (as stated above) encompass ethical as well as practical concerns. It is inappropriate to examine only those studies which fall within the experimental paradigm. What is needed is an overview of research coupled with an understanding of the degree of attributive confidence that studies can command.

As Fuller & Lovelock (1987) point out, there seem to be some fundamental divides among researchers which will not go away - those which aspire to imitation of the methods of the natural sciences (positivist) and those which reject them on the grounds that the nature of social work makes such methods inappropriate. The former position implies that the social sciences are methodologically perfectible with ever more rigorous specification of ends and means leading to findings of both explanatory power and generalisability. The pragmatic/eclectic approach, whilst embodying its own form of rigour, points to a more context-bound and situation-specific mode of evaluative research, which is the mode appropriated for this study.

CONCLUSION

Chapter Three has provided an historical overview of effectiveness research and a context for *this* pragmatic effectiveness study. The following chapter expands the particular context by viewing client studies as a means of effectiveness research.

CHAPTER FOUR

THE CLIENT PERSPECTIVE IN EVALUATION

INTRODUCTION

Why use client studies as a means of evaluating effectiveness of service? Client *participation* in the processes of social work intervention has traditionally been accepted as a central professional tenet and a fundamental requirement for effective practice (Maluccio, 1979; Prager and Tanaka, 1980). Contracts are agreed, problems defined, goals and tasks identified in consultation with the client and with particular sensitivity to the client's context, and the client is viewed as an active and equal agent for change in the intervention process. Yet until the seminal work of Mayer and Timms (1970), there was very little emphasis on or research into the client *perception* of services. However, in recent years, the significance and the centrality of the client perspective in informing practice has increasingly been recognised.

THE PAUCITY OF RESEARCH

Many authors (notably Mayer and Timms, 1970; Hoshino, 1973; Giordano, 1977; Maluccio, 1979; Lebow, 1982; Hunt, 1985; McLeod, 1990), offer several reasons for the paucity of research into the client perspective:

(1) There are strong institutional pressures on researchers to follow the assumptions and practices of natural science as discussed in Chapter Three. From this perspective, the subjective views and experience of the client are not researchable.

(2) The influence of psychoanalytic thinking has had a powerful effect on practice. From this point of view, clients' views may be interpreted as evidence of defensiveness, fantasy or transference.

(3) Similarly, for behaviourists, it has traditionally been more important to focus on *behaviour,* rather than to be concerned with client experience or feelings.

(4) There are ethical and practical difficulties - research might interfere with the ongoing process of counselling, whilst retrospective probing might reawaken painful issues.

(5) The desire of social workers for professional status may add to the lacuna of client studies - the worker is regarded as the one with the professional (and, by implication, more accurate) judgment of effectiveness of intervention.

(6) Practitioners tend to be cautious of research and its methods, and fear its reflecting badly on their practice - particularly in the light of early effectiveness studies.

(7) The structure of social work services tends to militate against the voice of the client being heard. Clients are typically isolated from one another and grievances or satisfactions, may remain private and unexpressed.

THE INCREASING USE OF CLIENT STUDIES

Despite point no. 7 above various writers (Giordano, 1977; Maluccio, 1979; Sheldon, 1982) highlight the fact that in recent years there has been an increase in efforts by clients to have their collective voice heard in relation to human service delivery. This is in part a result of a greater emphasis on consumerism, and the rights of consumers in (Western) society in general, as well as of the increased need for accountability in human services. Moreover, in the wake of the apparent failure of some treatment modalities, it has increasingly been recognised that the client is an essential source of useful and significant information. Lebow (1982) holds that despite their limitations (see Chapter Five), the consumer's view in client studies remains essential. The client has a unique view of the treatment process and of the quality of service.

Even when the client view may be affected by characterological or perceptual problems, or by the intensity of the treatment experience, this view remains important since it exerts a profound influence on treatment, particularly to the extent that it determines use or premature termination of the service. Insofar as intervention cannot occur without the participation of the client, minimal satisfaction is a necessary condition for treatment success. Shaw (1984) draws attention to the fact that client studies, with their emphasis on rationality

and common sense, are part of the reaction against the medical model and are evidence of a greater interest in what people *do* rather than in what they *are*.

Mayer and Timms (1970p. 11) quote Sacks, Bradley and Beck (1970):

> Actually there is a great deal of logic in using [clients] directly rather than workers or research interviewers as the chief judges of outcomes. They are the consumers of the service. It is they who define their problems and choose where to go for help. It is they who directly experience the helping process and live daily with the results of that help. Only they can really say whether as a result they are or are not better able to cope with their particular problems... Clients can also report what went wrong, if anything, and why they terminated. They can likewise report what more they needed and did not receive.

Sainsbury (1987) points out that client studies have already been successful in directly influencing practice, for example in the recognition of the importance of working with the *client's* definition of need and problem, the value of periodic reviews with clients, and the importance of integrating practical assistance with emotional support.

CLIENT SATISFACTION

With the growing concern regarding effectiveness of social work intervention, researchers increasingly turn to measures of client satisfaction as a means of assessing the general effectiveness of a service (Gutek, 1978). Studies of service satisfaction tend to report high

levels of satisfaction - higher than would possibly be hypothesized (Beck and Jones, 1974; Gutek, 1978; Shaw, 1984). In the USA, Beck and Jones (1974) found that 80% of their vast sample of users of family service agencies reported services to be helpful or very helpful. Heinemann and Yudin (1974) in a study of a multi-purpose neighbourhood counselling service, found in their three samples drawn from different populations, levels of satisfaction of 81%, 80% and 71% - the last-mentioned sample was from a population of clients who had dropped out of treatment. Woodward et al. (1978) in their study of consumer satisfaction with brief family therapy, reported that 64% of their sample were satisfied or very satisfied. In Britain, McKay et al. (1973) and Glampson and Goldberg (1976), whose studies were carried out on behalf of the National Institute for Social Work, reported levels of 71% and 73% respectively. In a study of client perspectives in a general practice attachment, Corney (1981) found a satisfaction level of 85%. Finally, in a review of client studies, the Barclay committee (Barclay, 1982) reported an average satisfaction level of 66% and a dissatisfaction level of 20%.

Gutek (1978), Rees and Wallace (1982) and Shaw (1984) caution against the uncritical incorporation of satisfaction findings into prescriptions for policy in social work services. They make the following points:

(1) People seem to be satisfied with everything that social scientists research. Individuals in all walks of life seem satisfied with their jobs, their lives in general, their

experience with social work agencies. It seems unlikely that people in widely disparate life situations should express high levels of satisfaction with virtually everything.

(2) Viewing levels of satisfaction more generally than only in the sphere of social work, satisfaction measures do not show high levels of dissatisfaction in areas in which it is 'common knowledge' that people are dissatisfied such as assembly line workers and people living in ghetto neighbourhoods.

(3) Satisfaction with service may co-exist with criticism of that service.

(4) Verdicts of satisfaction are influenced by the frame of reference within which they are reached. Client perspectives occur relative to context, to knowledge of services available, to expectations, to help previously received from other sources and the experience of that service, to perceptions of the social worker. Unless such factors are considered, it is not possible to know if the high rate of client satisfaction is related to factors like lack of knowledge or limited expectations rather than to the quality of the actual service provided (Reece and Wallace, 1982). An example of the significance of context is demonstrated in a study by Bush et al. (1977) where children when asked if they wanted to remain in their present foster home replied affirmatively, whilst when asked who they would like to live with expressed a preference for a family member or friends. This discrepancy may reflect the respondents' perceptions of what is possible as against what is ideal.

(5) Despite the increasing amount of research into the concept of client satisfaction, there is little research which attempts to demonstrate what such satisfaction really *means*, and therefore how assessments should be used.

In spite of the many shortcomings of studies of client satisfaction, satisfaction is a worthy subject of study in its own right, regardless of its relation to objective measures. We live in a subjective world as well as an objective one, and therefore a significant dimension of service effectiveness is the subjective view of clients' perceptions of that service. Satisfaction cannot take the place of objective indicators, but neither can objective indicators take the place of subjective indicators like satisfaction (Gutek, 1978). Indeed, Berger (1983) in Cheetham et al. (1992, p.77) states that 'client satisfaction has evolved into a viable outcome measure ... satisfaction data present a dimension of the outcome of therapy as viable as symptom reduction.'

The use and significance of the client perspective in the evaluation of social work services has been reviewed. The method developed to evaluate the effectiveness of the counselling service at the Parent Centre will now be presented.

CHAPTER FIVE

RESEARCH DESIGN AND METHODOLOGY

INTRODUCTION

The research design and methodology used to conduct this evaluation will be presented. This will be followed by a discussion of the difficulties and limitations inherent in the methodology.

RESEARCH OBJECTIVE AND QUESTIONS

The central objective of this study is to evaluate the effectiveness of the counselling service at the Parent Centre. As stated in Chapter One, specific issues examined include:

demographic information regarding the client population

management information regarding such issues as sources of referral, accessibility and publicity of service

process information regarding the nature of the intervention, as well as the nature and impact of the client/counsellor relationship

outcome information regarding whether or not clients' expectations have been met, and whether clients have been able to effect changes in their life-situations as a result of the counselling process.

RESEARCH DESIGN

This study utilizes a quantitative-descriptive research design (Tripodi et al. 1969), although qualitative comment is also given. Such a quantitative-descriptive study should provide for 'the systematic collection of data for the purpose of accurately describing relations among variables' (p.88). It should further have the purpose of description of quantitative relations among variables included in the research. The primary research technique employed in quantitative-descriptive studies is the survey. Data for this study were gathered primarily via semi-structured telephone interviews, whilst some demographic information was taken from clients' files.

PLANNING THE STUDY

The study was initiated after consultation with management at the Parent Centre in pursuit of one of the agency goals, that of 'using our resources effectively and creatively in response to findings in on-going research...' Initial planning, therefore, comprised discussion with management and supervisors regarding the kind of research envisaged. It was decided to utilise a retrospective, semi-structured telephonic interview as the principal means of data gathering.

Cheetham et al. (1992) point out that although theoretical orientations and sometimes audiences may influence the choice of methodology and data collection, such decisions will

usually reflect clearly pragmatic concerns such as the purpose and objectives of the evaluation and the practical constraints imposed by the research environment

LITERATURE REVIEW

A Dialog search was done to identify literature relevant to the study. The Psych INFO database was searched, however most references were to dissertations located in the United States and were therefore not practically accessible. Similarly, the Centre for Science Development database was searched and yielded a few tangentially related studies (Naran, 1982; Eloff, 1982; Gathiram, 1987; van Rensburg, 1992). The Child Welfare, Stellenbosch University and University of Cape Town library databases were searched and provided a number of useful articles. A key client study by Hunt (1985) and a longitudinal study of parent needs by Pugh and De'Ath (1984), facilitated the snowballing process of useful bibliographies which ultimately was the most fruitful means of accessing relevant information. Via this means, contact was made with the Social Work Research Centre in Stirling, and with the National Children's Bureau, London both of whom were very helpful in making their resources available.

After many months of reading, it became clear that the initial pursuit of literature in the sphere of parent counselling was proving somewhat fruitless. Increasingly, the issue became one of effectiveness in social work, specifically in the area of counselling/casework, and of the legitimacy of using client studies as a means of obtaining data.

THE STUDY POPULATION

During the early planning phase, the intention was to take as the study population all first-time clients seen at the Parent Centre throughout 1993. This would have yielded a larger population than that eventually used. However, it was assumed that recall was likely to be more accurate for clients seen more recently, and that, on balance, accuracy of recall was more important than a large population. Moreover, it was felt that the population of 501 clients eventually used, being those seen from January to June 1994, was large enough from which to select a sufficiently representative sample.

A further important factor favouring a 1994 survey was that services had been extended to Khayelitsha at the end of 1993. This meant that clients from this geographic area could be included in the population, thereby facilitating greater social and cultural diversity within the sample. This in turn means that results of the survey are more likely to have greater generalizability to other comparable counselling services within the broader South African context.

The study population comprised all first-time clients seen at the Parent Centre between the 1st January and the 30th June, 1994. This yielded a population of 501 clients. Since counselling is short-term - usually between 1 and 6 sessions - and since the survey was conducted in October/November, 1994, it was assumed that cases would be closed and that the survey would therefore not prejudice ongoing counselling practice.

THE SAMPLING PROCEDURE

Systematic sampling with a random start was used to select the sample (Rubin and Babbie, 1993). This method requires that the first element from the population is selected at random which, for purposes of the study was a number between 1 and 9. Thereafter, every 9th element was selected. Slightly more than 10% were drawn against the event of some clients being untraceable. The arrangement of elements in the population was such that bias caused by periodicity was not a factor for consideration. If elements are arranged in a cyclical pattern which coincides with the sampling interval, a grossly biased sample caused by periodicity may be drawn (Babbie, 1992). Clients who come to the Parent Centre are generally self-referred and phone randomly for appointments. Systematic sampling, therefore, was felt to be the most appropriate sampling method. Of the 55 cases randomly selected, 4 were uncontactable after up to 12 phone calls made at various times during the day and on different days of the week and weekend. This resulted in a sample of 51 valid interviews.

As stated above, for purposes of the study, a 'client' may be one parent or a couple - that is, a couple coming together about parenting issues was regarded as one unit of analysis. Of the sample, 6 cases fell into this category. This presented an unanticipated difficulty when it came to a decision regarding which member of the couple to interview. A simple drawing of the names out of a hat method was used.

The 55 cases were drawn by the manager and supervisors. This ensured that no links could be made by the researcher between counsellor and client, thereby eliminating this form of possible bias. It also ensured anonymity for the counsellors, a significant factor when research is undertaken by a peer, and a sensitive issue frequently cited as a reason for not undertaking evaluative research (Mayer and Timms, 1970; Olin, 1986; Sainsbury, 1987; Cheetham et al., 1992). In this regard a meeting was held with management and counsellors to talk through the counsellors' feelings regarding having their work evaluated. Since the counsellor population has been relatively constant over a number of years, and since regular team building and counsellors' meetings are held fostering a culture of openness and trust, feelings of apprehension and exposure could be expressed and addressed. All who were employed at the time of the survey remain in employment. The number of sessional staff has increased from 8 to 11, however. The fact that my own work as a counsellor was also being evaluated contributed to a sense of egalitarianism. Moreover, all counsellors acknowledged the objective need for accountability as professionals.

THE SEMI-STRUCTURED TELEPHONE INTERVIEW

Various factors influenced the choice of the semi-structured telephone interview as the primary source of data collection and the development of the schedule as the means to do this:

- the literature search had yielded information leading to the selection of the semistructured telephone interview as the most appropriate means by which to gather

data for the study (Cozby, 1981; Grinnell, 1981; Grinnell and Williams, 1990; Babbie, 1992). It also provided a broad framework from within which to begin formulating relevant questions (Maluccio, 1979; Hunt, 1985; Hicks, 1987; Hill, 1987; Becker, 1988).

- it was felt that a semi-structured telephonic interview would be preferable to a mailed questionnaire for the following reasons:
    + the sample was sufficiently small to be managed via interviews and interviews would be likely to have a significantly higher response rate than would a mailed survey.
    + many people are more comfortable expressing their opinions verbally rather than in writing, and potential problems of illiteracy were thereby obviated.
    + the interview has the advantage that participants respond with immediacy, thereby avoiding the self-censorship often encountered in written responses
    + flexibility is a further advantage of the interview over the mailed questionnaire; if a question is not understood by the respondent, it may be rephrased by the interviewer thus avoiding unanswered questions
    + given that some clients approach the Parent Centre without their partner or other family members knowing, the telephone seemed more protective of this privacy than a mailed item.

- numerous authors (Weiss, 1975; Grinnell, 1981; Babbie, 1992; Rubin and Babbie, 1993) list advantages of the telephonic interview over the face-to-face interview of which the most significant are perhaps cost and time - a telephonic interview is much less costly in time and resources than a face-to-face interview. Moreover, respondents possibly feel at greater liberty to respond more honestly on the phone than face to face, and indeed one respondent in the survey spontaneously mentioned this as a factor contributing to her ease of response. Conversely, there is no access to the rich source of non-verbal communication which is available in a face-to-face interview. There is a likelihood of a much higher response rate and an ability to ensure that no questions are omitted - both advantages over, for example, survey research. Physical safety for interviewer and respondent is a further advantage in using the telephone. If a respondent is unavailable at a particular time, unlimited call-backs are possible at different times of the day or week - in this study, a limit of 12 calls was set. A limitation, of course, is that only clients with access to a telephone may be interviewed. In the study under discussion no client was without access to a phone - a comment perhaps on the clientele not being reached by the Parent Centre.

THE SCHEDULE

The questionnaire (see appendix A) was devised in consultation with colleagues, other professionals and with reference to literature (see above). It was written in English only as all interviews were conducted in this language. This was not ideal as English was not the first

language of all respondents. On a few occasions questions were translated into Afrikaans to facilitate greater ease of understanding for some respondents. This jeopardises reliability, although care was taken in the translating. Questions were posed in such a way as to avoid ambiguity and to be accessible to all respondents.

A compromise was decided upon regarding the use of closed- versus open-ended responses. It was recognised that closed-ended responses would provide greater reliability as well as relative ease of data analysis, whilst open-ended responses would offer qualitatively richer information. Open questions hedge against misconstruing respondents' replies (e.g. 'satisfaction' may mean different things to any two people), and allow new information into the study. However, too many open, narrative answers which have to be deciphered and coded are inefficient (Weiss, 1975). Accordingly, both closed- and open-ended responses were used.

PRE-TESTING THE TELEPHONIC INTERVIEW

Giordano (1979) and Prager and Tanaka (1980) suggest that in an attempt to equalise the power imbalance in survey design, clients should participate in the drawing up of a schedule. While this was not done, three clients were consulted regarding the issues they felt should be covered and their suggestions were incorporated into the design.

The schedule was pilot-tested on five willing clients known to the researcher, with a view to assessing its appropriateness and content validity. All provided helpful feedback and

ambiguous material was modified. Pretesting the schedule provided opportunity for assessment of the time it would take to conduct the interview. When contacting respondents it seemed important to be able to inform them that the interview would take 10-15 minutes of their time.

COLLECTION OF DATA

As stated above, the sample was drawn by the Parent Centre manager to ensure anonymity of the counsellors. For the same reason, identifying details and demographic information for Section A of the questionnaire were taken from file face-sheets by the counsellors' supervisors. Demographic information not given on the face-sheets was obtained during the course of the interviews.

Forty-five of the fifty-one interviews were conducted during a four-week period in October and November, 1994. The six clients drawn whom I had personally seen for counselling were interviewed by the manager after careful discussion to prevent a loss of reliability in the asking of questions.

Respondents' names were recorded on the questionnaires in pencil and were erased when all data had been collected, so as to ensure confidentiality. Thereafter, only numbers were used.

Hence despite the feeling of dehumanising clients by referring to them by number, they are 'numbers only' in Chapter Six.

Before identifying myself as a researcher mandated by the Parent Centre to conduct an evaluation of effectiveness of counselling, I clarified that the person to whom I was speaking was indeed the client concerned, again to honour confidentiality boundaries.

After introducing myself, I outlined the nature of the survey and explained the reasons for its being undertaken. I further explained that the respondent's name had been randomly selected, and the measures taken to ensure confidentiality were elaborated. Respondents were invited to participate in the survey and, if necessary, an alternative, suitable time was negotiated. All 51 respondents contacted willingly agreed to be interviewed, giving 100% response rate for those contactable. In those interviews where ongoing problems were expressed, where appropriate, a return to counselling was encouraged, at the conclusion of the interview. At least one respondent is known to have returned.

The above measures were taken in line with the code of ethics for social work research drawn up by the United States National Association of Social Workers quoted in Grinnell and Williams (1990). These include a statement to the effect that 'the social worker engaged in a research study should ascertain that the consent of participants in the study is voluntary and informed ... and with due regard for participants' privacy and dignity' (p.11).

DATA ANALYSIS

On completion of the interviews, the data were captured on computer using Microsoft Excel and a spreadsheet was obtained. In the case of open-ended questions, categories of response were devised to facilitate quantitative interpretation of results. Responses were listed and allocated to appropriate categories (see Appendix B). However, qualitative comment is also given. The *Statistica* data analysis package was used to categorise and otherwise analyse the data. In particular, cross-tabulations were used to explore meaningful associations and differences. In that the data was most frequently coded in categories on a scale of 1-5, this was an appropriate means of analysis. A significance level of 0.05 was used to test associations.

LIMITATIONS OF THE STUDY

The method of data collection used in this research was that of a retrospective self-report survey of clients seen at the Parent Centre. There are limitations inherent in this method:

1. The data collected for the study were retrospective to the six-month period, January to June, 1994. This meant that respondents were required to remember an event which could have occurred up to ten months previously. Whilst in no interview was this mentioned as a problem, there is knowledge of instances where recall involved blurring of details; for example in the question regarding number of sessions attended, some clients under- and others

over-estimated the number. This is one known example of error of recall which may have been repeated in other instances in the research.

2. The survey comprised self-report responses to a semi-structured telephone interview. Grinnell (1981) quotes Bailey (1971) who highlights four major sources of respondent error and bias in self-report data. Respondents may:

(i) deliberately lie because they do not know an answer

(ii) make mistakes without realising it, often because they are unable to admit socially undesirable feelings or attitudes, even to themselves

(iii) give inaccurate answers by accident simply because they misunderstand or misinterpret the question

(iv) be unable to remember, despite their best efforts - they may even blend truth with fiction to cover up their memory gaps.

Lebow (1982) counters this point by saying that although distortion may occur, the client should not be presumed to distort. In most instances the client can be expected to make a reasonable judgment regarding the adequacy of the service.

3. Whilst reliability is relatively good for Section B of the questionnaire since all respondents were presented with standardized questions, Section A relied on archival material which was gathered by five supervisors. These factors could have resulted in some inaccuracies or inconsistencies. Moreover, the very advantage of reliability created by the standardized questions suggests a further disadvantage pointed out by Maluccio (1979) - that

the questionnaire precludes a free and spontaneous evaluation of the service, and may omit to cover dimensions of the service which are of relevance to the client. Giordano (1977) expands this further by pointing out that an 'organizational perspective' is maintained i.e. the organization typically defines what is important, and power and control remain with the agency. In order to minimise this possibility, clients were consulted along with professionals and literature in the devising of the interview schedule.

4. Weiss (1975) points out that evaluation research poses particular problems. Unlike many other studies, in evaluation research the hypothesis of the evaluator is clear to many respondents; that is, that the programme (in this instance the counselling) 'worked.' Co-operative respondents, realising the intent of the questions, are apt to emphasise the positive. This can affect the validity of the responses.

5. The predisposition of the respondent may also influence validity of response; for example if the respondent is deferential to authority and wants to present in socially acceptable terms, or wants to make a good impression, or to make the intervention look good (Weiss, 1975; Lebow, 1982).

6. Self-report data can also be misleading, since client response is inevitably linked to satisfaction with service, which can be different from effectiveness of service (McKendrick, 1989; see also Chapter Four).

7. There is a danger of a 'halo effect' affecting the validity of research conclusions (Lebow, 1982). This has been defined as 'a general orientation of goodwill toward the service-providers concerned, rather than a reliable picture of people's real life, day to day encounters with the services' (Robinson, 1978 in Rees and Wallace, 1983: p. 83).

8. The lack of precise meaning for terminology is a further limitation. Terms such as 'satisfied' or 'very satisfied' mean different things to different people. For some ' satisfied' means a minimum level of acceptability of services, whilst for others it implies near perfection. Moreover, such terms may vary in meaning for the same individual over time (Lebow, 1982).

9. Language in interviews is of central importance. Many clients may be from different language groups from the researcher (which was the case in this study); some may be poorly educated, others labouring under multiple stresses. Any of these factors may inhibit optimal communication. Since the validity of data depend in part on the respondents' ability to understand the questions and give relevant replies which need to be grasped by the researcher, commonality of language and meaning is vital (Weiss, 1975).

10. My being both practitioner and researcher in the agency had advantages and disadvantages. Advantages included familiarity with the means, goals and tasks of the Parent Centre, a personal interest in and commitment to the work and to the values of parenting espoused, having a measure of credibility among workers, and, by association with the Parent Centre, among clients. Moreover, client information does not extend beyond the boundaries of

the agency in such an instance, thereby safeguarding confidentiality. A further advantage is one alluded to by Hunt (1985) who, as a result of extensive experience of client studies has come to feel that it is somewhat irresponsible to enquire into a distressing time in someone's life without being in a position to and being prepared to respond to an ongoing difficulty. Survey interviews may well evoke painful memories for clients. This happened on some occasions during the survey when clients, as well as being listened to on the phone, were encouraged to return to counselling. Disadvantages include lack of researcher objectivity as well as the issue of fear of some form of repercussion for the client from the agency (Lebow, 1982). This raises the issue of power in the worker-client relationship (Hasenfeld, 1987) - clients may be extremely reluctant to criticise the agency if they expect to have future contact.

CONCLUSION

The overall research design and planning of the study have been presented. The methodology used to implement the study has been described and discussed. Limitations have been highlighted so that the results presented in the following chapter can be assessed in the light of those methodological limitations.

CHAPTER SIX

RESULTS

INTRODUCTION

The results of this study will now be presented. Substantively significant data will be discussed. The data falls within the four broad categories mentioned in Chapter One, namely *demographic* information, *management* information, *process* information and *outcome* information. Despite the fairly considerable reading done prior to the finalization of the questionnaire, these four useful categories clarified in this form only subsequent to the process of interviewing. Accordingly, the interview schedule (see Appendix A) is not structured specifically around these issues. However, the four categories are nevertheless contained within the format as it stands.

Questions in Section A of the interview schedule (Appendix A) are referred to as Qa1, Qa2, etc. Questions in Section B of the interview schedule are referred to as Q1, Q2, etc.

Due to the quantity of data gathered, only that central to the study is detailed in tabular form in this chapter; here the tables are labelled Table 6.1, Table 6.2, etc. For the rest, tables are presented in Appendix C. Unless otherwise stated, all tables referred to in this chapter as for example, Table 1, Table 2, are to be found in Appendix C. Where qualitative comment is given, clients are referred to by their schedule numbers, e.g. (1).

Since particular questions (Q15, Q30, and Q43 to Q47) are at the core of the study, these are presented after the demographic information to provide a focus for the remainder of the chapter.

DEMOGRAPHIC INFORMATION

It is necessary to obtain a demographic profile of the client population in order to ascertain who the service is or is not reaching in order to highlight areas which may need targeting.

Demographic information was captured in Section A of the schedule and most was taken from file face sheets. In a few instances information is missing, notably in the areas of income bracket and educational level. This information is not recorded on the face sheet, and was one area in which communication was not sufficiently clear in liaising with the manager - the missing information was not specifically requested and was therefore omitted in the few clients interviewed by the manager, since Section B was the focus of the interview.

Client's Geographic Area

This information was obtained in order to ascertain the geographic spread of clients approaching the Parent Centre from January to June 1994. Implicit in the asking was whether the service is accessible to the community of Cape Town as a whole.

The three offices are situated in localities draining rather different areas in terms of socio-economic status (SES). The longest established Claremont office attracts primarily, but not exclusively, middle- to upper-income clientele; the Athlone office middle- to lower-income clientele; the Khayelitsha office, generally lower-income clientele. The Claremont office, located in the southern suburbs, draws the largest number of clients at this stage. (See Table 1) However, since the study was done the trend is shifting (see below).

Racial Classification:

Such has been the sensitivity regarding issues of ethnicity and racial classification in South Africa, that it has been common in years past for those opposed to the previous status quo of apartheid consciously to omit such classifying data from demographic information due to the pejorative uses to which such information was put. As a result, clients coming to the Parent Centre have not ever been classified according to race. Ironically, it would seem that those at the vanguard of anti-racist social work hold that such lack of classification works against an anti-racist stance, for it is important to know who is, and more importantly who is *not* in receipt of services and to be able to modify services to accommodate differences. It is inappropriate to adopt a 'colour-blind' approach, since this denies or minimises the insidious, pervasive and constant impact that racism and discrimination have on the lives of black people (Boyd-Franklin, 1989). Dominelli (1988, p.37) points out that 'only those belonging to the dominant group enjoy the privilege of discounting the difference 'race' makes to the quality of service available to them and their access to it.'

Since racial classification is not available on Parent Centre face sheets, this data has not been gathered. However, as we live yet with the heritage of the Group Areas Act of 1950, suburbs continue to be largely segregated. On the basis, therefore of geographic area, a breakdown of racial classification is assumed and given. Of note is the fact that services had only very recently been extended to Khayelitsha (an area occupied primarily by black African people) at the time of the survey, and since this time too, a Xhosa-speaking auxiliary social worker and a receptionist, both of whom do intake screening and referral, have joined the Xhosa-speaking social worker who works in this area.

Allowing for some blurring of data, since the Group Areas Act has long since been defied, it can be seen (Table 2) that those forming the sample for this study were mostly white - 63% as against 27% (coloured) and 10% (black African).

(**Note:** This has shifted somewhat since the study was done, but nevertheless the picture still holds. A breakdown of clients seen in October, 1995, indicates that services are increasingly becoming known and used in Khayelitsha:

Claremont	94	drawing all race groups, but mostly coloured and white clients
Athlone	22	drawing primarily coloured clients
Khayelitsha	64	drawing primarily black African clients)

Age of Client

As indicated by Table 3, 78% (40 respondents) of the sample falls in the age group 26 to 45, with 16% above that and the balance between 21 and 25. There is nothing surprising about the distribution.

Client's Marital and Family Status

Table 4 sets out the marital status of the sample. Fully 42% appear to be on their own (Separated, Widowed, Divorced, or Single), the balance being predominantly married as opposed to cohabiting. Some 46% of all clients in the sample were in their first marriage at the time of the survey, 48% if the cohabiting couple is included; 12% were blended families. This perhaps reflects universal trends of the shifts occurring in family life (See Chapter Two).

Tables 5 and 6 set out the numbers and ages of children in the sample client families. Of the total of 100 children, 63% were under 13, and 83% under 19. When looking at the index child, 90% are under 19. (Table 5) Again, this is not surprising and reflects the target the Parent Centre sets for itself.

Table 6 shows that, at the time of seeking help, 78% (40) of the families had 1 or 2 children. Only 4% had more than 3 children.

Socio-economic Factors

Educational levels reached by the parents: it is clear that the majority of those in the sample are well educated, with 42% reporting post-matric levels. (Table 7) If the missing information is discounted, this becomes 54.5%, a figure almost identically matched with the

number of parents with occupations recorded as 'skilled' and 'professional' in Table 8, at 54.9%.

Tables 9 and 10 further reinforce this view of educated, skilled and professional people making up the majority in the sample group. These tables explore the questions, "With whom are the 'housewife' and 'professional' clients partnered?" respectively. The housewife clients are overwhelmingly partnered by skilled and professional people, as are the professional clients.

Table 11 reports the income levels of the sample group of families. The largest single group is those with incomes exceeding R5 000 per month, and the number, 15, closely correlates with the numbers of 'professional' clients or those married to 'skilled' and 'professional' partners.

Balancing the above perspective, it is important to note that 21 of the 102 father/ mother/partner pairings report occupations such as clerical, worker, semi-skilled and disabled. Discounting the missing values, this group is 23,1%. Table 11 also shows that 52.9% of the families represented in the sample had incomes of less than R2 000 per month

In only two of the seven cases where the mother's education is less than 8 years is the father's education reflected, at standards five and nine. In all seven of the cases the family income is below R2 000 per month. Of the poorest educated mothers in the sample (six), only one is in a partnership, reporting re-marriage. The sample thus reinforces the perception that poorly educated mothers tend to be financially poor, and solitary.

In concluding this section on demographic information, it should thus be noted that the largest groups represented in the client sample were 'professionals' and 'housewives.' Partners were predominantly 'skilled' or 'professional.' This is possibly a further comment on accessibility in terms of office hours and geographic location, as well as of knowledge of the existence of the service.

However, it also perhaps reflects the assertion by many that the whole notion of counselling and psycho-therapy as means of problem-solving, reflect a westernised, individualised and middle-class world-view and do not naturally lend themselves to the needs of collective cultures and low SES families. (Gwyn and Kilpatrick, 1981; d'Ardenne and Mahtani, 1989; Pinderhughes, 1989; Hickson and Christie, 1989).

OUTCOME INFORMATION CENTRAL TO THE STUDY

Central to this research is the issue of whether or not clients of the Parent Centre regard the counselling service to be effective. Several questions were posed to probe this, most particularly towards the end of the interview (Q43 to Q47). Earlier in the interview, at Q15, a question virtually identical with Q44 was asked, and at Q30, one like Q45. These questions are the most explicit with respect to the core of the research:

Q43 Would you agree or disagree with the statement: 'Overall contact with the Parent Centre was helpful?

Q15 Do you feel your expectations were met?

Q44 Would you agree or disagree with the statement: 'My expectations were met?'

Q30 Do you feel that changes occurred in the problem area you were experiencing?

Q45 Would you agree or disagree with the statement: 'I was able to make changes in my situation?'

Q46 Would you refer a family member/friend to the Parent Centre? Would you come again yourself?

Q47 Would you agree or disagree with the statement: 'Counselling at the Parent Centre is effective?'

The purposive duplications (i.e. Q15 with Q44, and Q30 with Q45) allow a check on the consistency of the respondents over the course of the interview, via correlations between these respective pairs. In both cases the correlation coefficient (being 0.78 for Q15 by Q44, and 0.81 for Q30 by Q45) is highly significant (at the 0.001 level), thereby confirming consistency of response over the duration of the interview.

In common with other 'satisfaction studies,' (see Chapter Four) this research finds the distributions of answers to the above virtually direct questions to be highly skewed towards the positive, i.e. the answers reflect high appreciation of the services of the Parent Centre. Since these questions are at the heart of this study, Tables of the responses are included in this chapter, rather than in Appendix C. The ratio of respondents who were 'very much' or 'yes' to those who were 'unsure,' 'no' or 'very much no' is given in brackets at the end of

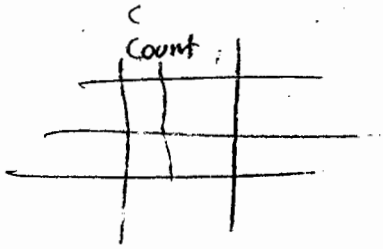
each question. These ratios are then reported in a single table, Table 6.9, in order to show the overall split between 'positive' client ratings, and 'unsure or negative' ratings.

Table 6.1 - Q15 : Do you feel your expectations were met? (71:29)

Category	Count	Cumul. Count	Percent	Cumul. Percent
Very much	20	20	39.2	39.2
Yes	16	36	31.4	70.6
Not sure	6	42	11.8	82.4
No	9	51	17.6	100.0
Not at all	0	0	0.0	
Missing	0	51	0.0	100.0

Table 6.2 - Q44 : Would you agree or disagree with the statement: 'My expectations were met.'? (77:23)

Category	Count	Cumul. Count	Percent	Cumul. Percent
Strongly agree	24	24	47.1	47.1
Agree	15	39	29.4	76.5
Unsure	4	43	7.8	84.3
Disagree	6	49	11.8	96.1
Strongly disagree	2	51	3.9	100.0
Missing	0	51	0.0	100.0



Tables 6.1 and 6.2 indicate high approval ratings for the Parent Centre.

Table 6.3 - Q30 : Do you feel that changes occurred in the problem area you were experiencing? (78:22)

		Cumul.		Cumul.
Category	**Count**	**Count**	**Percent**	**Percent**
Strongly agree	19	19	37.3	37.3
Agree	21	40	41.2	78.4
Unsure	3	43	5.9	84.3
Disagree	6	49	11.8	96.1
Strongly disagree	2	51	3.9	100.0
Missing	0	51	0.0	100.0

Table 6.4 - Q45 : Would you agree or disagree with the statement: 'I was able to make changes in my situation.'? (78:22)

		Cumul.		Cumul.
Category	**Count**	**Count**	**Percent**	**Percent**
Strongly agree	24	24	47.1	47.1
Agree	16	40	31.4	78.4
Unsure	1	41	2.0	80.4
Disagree	8	49	15.7	96.1
Strongly disagree	2	51	3.9	100.0
Missing	0	51	0.0	

Tables 6.3 and 6.4 are consistent with each other in indicating that 78% of clients found they were able to make changes in their situations.

Table 6.5 - Q43 : Would agree or disagree with the statement: 'Overall contact with the Parent Centre was helpful'? (90:10)

		Cumul.		Cumul.
Category	**Count**	**Count**	**Percent**	**Percent**
Strongly agree	36	36	70.6	70.6
Agree	10	46	19.6	90.2
Unsure	3	49	5.9	96.1
Disagree	2	51	3.9	100.0
Strongly disagree	0	0	0.0	
Missing	0	51	0.0	

Table 6.5 indicates very high approval rating (90%) for finding the Parent Centre a helpful place to consult.

Tables 6.6 and 6.7 report the results of a single question which had two parts, as can be seen from the question reflected in the titles of the tables. Of interest in this question was that the schedule provided space for only three categories of response - yes, unsure, no. So many respondents spontaneously responded with emphasis (definitely!), a fourth category was added - definitely. The two tables reflect very high (over 90%) approval ratings for the Parent Centre.

Table 6.6 - Q46 Would you refer *a family member/friend* to the Parent Centre? Would you come again yourself? (96:4)

'Family'		Cumul.		Cumul.
Category	**Count**	**Count**	**Percent**	**Percent**
Definitely	18	51	35.3	35.3
Yes	31	31	60.8	96.1
Unsure	2	33	3.9	100.0
No	0	33	0.0	
Missing	0	51	0.0	

Table 6.7 - Q46 Would you refer a family member/friend to the Parent Centre? Would you *come again yourself*? (92:8)

'Self'		Cumul.		Cumul.
Category	**Count**	**Count**	**Percent**	**Percent**
Definitely	18	51	35.3	35.3
Yes	29	29	56.9	92.2
Unsure	3	32	5.9	98.1
No	1	33	2.0	100.1
Missing	0	51	0.0	

Table 6.8 reports the results of the most direct question, judged relative to the core purpose of the research. Ninety percent of the respondents agree or agree strongly that the counselling at the Parent Centre is effective. The balance are unsure; no one reports that they found the counselling service ineffective.

Table 6.8 - Q47 : Would you agree or disagree with the statement: 'Counselling at the Parent Centre is effective.'? (90:10)

		Cumul.		Cumul.
Category	**Count**	**Count**	**Percent**	**Percent**
Very effective	34	34	66.7	66.7
Effective	12	46	23.5	90.2
Unsure	5	51	9.8	100.0
Ineffective	0	0	0.0	
Very ineffective	0	0	0.0	
Missing	0	51	0.0	

Table 6.9 - Summary of approval ratings in Tables 6.1 to 6.8

	Thrust of	Percentage	
Question number	**question**	**Positive**	**Unsure/ negative**
15	Expectations met	71	29
44	Expectations met	77	23
30	Changes occurred	78	22
45	Changes occurred	78	22
43	PC contact helpful	90	10
46.1	Refer family member	96	4
46.2	Come again oneself	92	8
47	Counselling service is effective	90	10

The picture given by Table 6.9 is emphatically positive. As final confirmation of this, the responses to the follow-on question to Q30 (Do you feel changes occurred in the problem area you were experiencing?) should be noted. Q32 probes as to whether the client feels that the changes occurred as a result of the counselling; results are summarised in Table 6.10. Interestingly, the lowest 'positive:unsure/negative' ratio is seen in this table. Four people seem sure that the changes were not as a result of the counselling. Unfortunately 9 clients failed to submit data for this question, limiting the insight that can be gained by further analysis.

Table 6.10 - Q32 asks 'Do you think these changes were a result of the counselling?' (71:29)

		Cumul.		Cumul.
Response	**Count**	**Count**	**Percent**	**Percent**
Yes	36	36	70.6	70.6
Unsure	2	38	3.9	74.5
No	4	42	7.8	82.4
Missing	9	51	17.6	100.0

Discussion : Apart from noting the positive attitude in the sample respondents relative to the counselling service of the Parent Centre, the above data requires examination for ways in which significantly associated factors can be identified. Being so positively skewed creates difficulties. The questions were largely unable to discriminate sufficiently at the positive ends of the scales, resulting in a lumping of the data there, and very little data at the 'negative' end of the scales; Q47, the direct question on effectiveness is a case in point where 90% of the responses were 'very effective' or 'effective' but only 10% were 'unsure,' i.e. none felt the counselling service to be 'ineffective.' Such skewed responses, whilst highly complimentary of the counselling service of the Parent Centre, are entirely unhelpful in the search for factors which are predominantly associated with 'effective' and those that are predominantly associated with 'ineffective.'

A useful means of seeking relationships among interval data (such as gathered in this research), is to generate cross-tabulations. Cross-tabulation statistics are, strictly interpreted, valid only where expected cell frequencies are 5 or more (Statsoft Inc., 1995). This condition is not met for this data in general, as a result of the relatively small sample (51) compounded by the skewed nature of the data. In some instances cells were 'collapsed' to generate higher cell counts in the pursuit of 'significance.' However this also rarely yielded much that could be attested to with statistical rigour.

In seeking significant associations, the above tabulations also point to the particular question which was best at discriminating amongst the sample group of clients. Q47 with its 90:10 split is clearly non-discriminating despite its being the most direct probing of the research aim of this thesis. The best question, in discrimination (spread) terms, appears to

be Q15, with a 71:29 split. Even though Q44, its 'twin,' gained two 'strongly no' responses, it has only 23% of the responses in the unsure/ negative area.

When Q15 is correlated with Q47, the correlation coefficient of 0.54 is found to be very highly significant, at the 0.001 level. So, because of its better spread of positive to negative responses and its good correlation with Q47, Q15 will be used in cross-tabulations which seek to identify factors significantly associated with perceptions of the effectiveness of the counselling services of the Parent Centre.

As an example, the income data (Table 11) was used to test whether there was any difference in the satisfaction, as measured by the benchmark Q15, by income level. To get more meaningful cell counts, Q15 was recoded to 35 positive responses (P in the table) and 16 unsure or negative (N), whilst income levels were recoded to these groupings (counts shown in brackets): Up to R1 000 per month (16)(L in the table), From R1 001 to R5 000 (18)(M), above R5 000 (13)(H). The following combined table shows the observed and expected frequencies:

Table 6.11 - Cross-tabulation of income groupings with expectations met

Expectations	**Income group (observed frequencies)**			
met?	**L**	**M**	**H**	**Totals**
P	12	10	11	**33**
N	4	8	2	**14**
Totals	**16**	**18**	**13**	47
Expectations	**Income group (expected frequencies)**			
met?	**L**	**M**	**H**	**Totals**
P	11.23404	12.63830	9.12766	**33.0000**
N	4.76596	5.36170	3.87234*	**14.0000**
Total	**16.00000**	**18.00000**	**13.00000**	47.0000

* Expected cell frequency < 5

In just one expected cell is the count significantly below 5. Pearson Chi-square: 3.31367, df=2, p=.190758. The conclusion is that there is no apparent relationship between positive or negative attitudes being particularly associated with certain income groups. This finding is consistent with that of Beck and Jones (1974) who in their vast survey of 3596 cases from 266 family agencies in the USA, found that clients at all socio-economic levels showed a positive response to counselling. As they point out, these findings run counter to the assertion that counselling and family agency services are suitable primarily for middle- and upper-income level clients. Similarly, Wattie (1973), in evaluating short-term casework in a family agency, found that clients' income level assumed no significance relative to client satisfaction.

MANAGEMENT INFORMATION

Introduction

Table 6.12 reports who the client was when seeking help. It is clear that mothers dominate in seeking help; in that fathers were on their own for only 7.8% of the occurrences, it means that mothers were present as the client in 92.2% of the cases. Fathers were present in 21.6% of the cases. In that from Table 4 it can be seen that 46% of the clients reported they were 'married,' fathers are significant by their absence. Emphasising this point it can be pointed out that one client unaccompanied by her husband was the remarried step mother of her husband's son. She had no children. She came because of concern for his children. Brannen and Collard (1982) in their study of marriage counselling services found similarly

that it is women, rather than men, who are likely to contact counselling agencies. The home and family relationships remain largely, in practice, the responsibility of women, despite the demographic changes sweeping the world.

Table 6.12 - Who was the client? (Qa11)

		Cumul.		Cum.
Client	**Count**	**Count**	**%**	**%**
Mother	40	40	78.4	78.4
Father	4	44	7.8	86.3
Both	7	51	13.7	100.0
Missing	0	51		

Referral source and initiative for contact

How do clients arrive at the Parent Centre for help? Are they referred, or have they heard of the service via other means? It is well documented that sources of referral can impact profoundly on a client's benefiting or not from a social work intervention (Mayer and Timms, 1970; Tessler, 1975; Rees, 1978; Burck, 1978; Rees and Wallace, 1987), as can their previous encounters in help-seeking situations (McLeod, 1990). Indeed Weber et al. (1985) include the referring person consciously as a part of their initial contact with a family, sometimes even including them in the first interview. They feel that it is extremely important to clarify what the client has been told about the agency, for this will to some extent determine client expectations and whether or not such expectations are appropriate for the particular agency.

Clients in the sample were asked to recall what the problem or issue was which caused them to make contact with the Parent Centre (Q1). The counsellor's view of the presenting problem was recorded from each file's face sheet (Qa3). The results are shown in Tables 12 and 13 respectively. Table 14 compares the results of the earlier two tables. The client and counsellor views are largely in agreement, but some differences arise in the areas of 'communication and skills' where counsellors say there are 19 instances, and the clients say there are 11. In both 'self-esteem' and 'information' the clients give higher counts than the counsellors: 9 vs. 5 and 7 vs. 2 respectively. In that the Parent Centre's value frameworks stress issues of communication, it could be that the counsellors are more sensitive to these areas than the clients. It is also something of a theme, which will emerge later in this chapter, that clients find the information they receive most helpful.

Of interest in Table 14 is that for all that discipline is the most frequently occurring category for both client and counsellor, it is more frequently cited by clients, whilst counsellors more frequently than clients cite communications and skills. This perhaps highlights the fact that discipline issues can arise as a result of faulty communication (Dinkmeyer and McKay, 1982). This finding also concurs with findings of Llewellyn (1988), who in her study to identify 'helpful and unhelpful events' in therapy hypothesized that clients may have been more interested in solving problems and feeling better on a short-term basis whilst therapists were more concerned with helping clients to understand the genesis of problems so as to prevent their recurrence in the long-term.

For the majority (59%) in the sample, the Parent Centre was the first place approached for help with the problem being experienced. Who referred them to or recommended the Parent Centre to those who had previously sought assistance? Table 15 refers. Of those who had previously sought help, only 2 had approached two other agencies (person of religion, and school). Nearly 40% of those previously contacted were psychologists or psychiatrists. This indicates the agencies through which the Parent Centre seems successfully to publicize its services. It also perhaps highlights others which could be targeted - schools, clinics, general practitioners, and factories.

The research also explored how people in the sample first came to hear of the Parent Centre. Three categories were offered, with subsets : Media, Network, and Formal Referral. The specific responses are shown in Table 16. 'Friends' (under Network), emerge as the single biggest channel by which people come to the Parent Centre, followed by 'Teachers' and 'Social Workers.' However, the medical and paramedical group (psychologist, clinic, doctor, nursing sister at work) constitute the biggest conduit. The Parent Centre thus needs to target schools, social workers, and the medical professions for marketing attention.

What caused the people in the sample finally to seek help from the Parent Centre? (Q4)

Mayer and Timms (1970, p.39) suggest that the norms prevalent in western society which 'enjoin individuals to be self-reliant rather than dependent on others, often make it difficult for people to seek help.' Gurin et al. (1960, p.304) states that 'a person who goes for help with a personal problem is, in a sense, revealing at least two assumptions that he (sic) has made about his situation: first that he is faced with a personal problem that distresses him;

and second, that he cannot solve this problem by himself or by the help and advice of family and friends.'

Table 17 gives the responses of the 51 people in the sample. Apart from the predominant 'build-up of circumstances,' (51%), the three categories implying 'heat' in family relationships or possible crisis (arguments and loss of control) were the most frequent reason for finally seeking help (33%). It is well documented that people in crisis are usually receptive to and motivated to change. A 'minimum' amount of therapeutic intervention during a period of psychosocial disequilibrium can mobilise an individual or family's coping skills to effect a therapeutic change (Parad and Parad, 1968). This could well be one of the reasons that seemingly significant changes (see below) are effected in many parent-child relationships despite the short-term nature of the counselling at the Parent Centre.

Waiting for an appointment

Table 18 reports both the sample clients' desired speed of having an appointment, and the actual wait experienced. Nearly 24% (12) desired an appointment on the day of calling. Of these 12 people, half had to wait more than a week, and 2 of them waited over two weeks. Nevertheless, it may be seen from Table 19 that only 3 of the 12 expressed dissatisfaction with the delay.

Thirty-six people, or 70,6%, hoped for an appointment within a week. Five of these had to wait over a week, and two over two weeks. Four people in this group expressed

dissatisfaction with the wait (Table 19). All three of the people who requested an appointment within two weeks were seen in that period; all were satisfied.

In Table 19 there was statistical significance in the responses as cross-tabulated, the dissatisfied being those required to wait a week or two longer than they had hoped. This was one of the two areas in the whole schedule which had clients rating scores of 5 - that is 'very dissatisfied.' Some people had very strong feelings about the Centre's hours of operation, (see Table 22) and about their having to wait a long time for an appointment. As they pointed out, when one is experiencing a crisis, one needs to speak to someone immediately. Although the receptionist is very sensitive to this reality, and requests that a counsellor make telephonic contact where necessary, occasionally people are too vulnerable to talk to a person unseen. This was the case with one young mother who was losing control and hitting her three year-old. She was unable to communicate this over the phone and was very unhappy about the length of time she had to wait for an appointment. Some thought needs to be given to establishing a formalised policy for crisis situations.

Rees and Wallace (1982) point out that when there are complaints from clients about social work services, they are often about fairly concrete things; the lack of material provision (generally not a factor for the Parent Centre since this is not part of its mandate), and being in queues and on waiting lists for services. In that having to wait for appointments is a 'queue,' this finding concurs with theirs.

First telephone contact with the parent centre

There appears to be no real problem here. Fully 88% of clients had first contact with the receptionist and of these, 93% found this to be helpful or very helpful. (Table 20) Over 82% of the 35 respondents who expressed an opinion on what it was that was helpful said that it was the warmth and containment of the receptionist's response. (Table 21)

The 'unsure' and negative responses are too few to draw any inferences.

Some client comments were (numbers in brackets indicate the random code numbers of the respondents):

(21) " reassurance without being patronising"

(55) "I wasn't sure how it worked; she was very tactful, very helpful, explained the services. I sketched my concerns - I felt very welcome."

Parent centre administration

When observing (Table 22) the satisfaction expressed regarding the operating hours of the Parent Centre, a bi-modal distribution is seen: 69% of the sample were happy with the hours of operation, whilst 29% were not; a negligible number is indifferent. Table 23 searches for the dissatisfied population via a cross-tabulation with marital status. It can be seen that 8 of the 15 dissatisfied respondents are 'married.' Table 24 searches via a cross-tabulation with the client's occupation. Here some one third of each of those whose occupations require 'office hours' express dissatisfaction, remarkably close to the overall

figure of 29% stated above. This result indicates a need to offer 'after hours' counselling services, particularly if a trend to working outside of the home is discerned. Certainly unskilled or hourly-paid workers hesitate before taking time off work (Nell & Seedat, 1989).

The Parent Centre charges fees on a sliding scale according to means, with the intention that the service should be available to everyone wishing to avail themselves of it. Table 25 reflects respondents that are almost unanimously satisfied with the fee required (96%). However, since the time of the survey, fees have had to be increased, particularly for those in the higher income brackets. A current survey might therefore reflect a different situation.

PROCESS INFORMATION

Introduction

Cheetham et al. (1992) and Videka-Sherman (1988) state that, in general, less attention is paid to the actual process (the content and manner) of social work intervention than is given to the measurement of outcomes to determine whether or not an intended objective has been achieved. Given the range of activities and approaches subsumed under such inclusive concepts as 'casework' or 'counselling,' failure on the part of a researcher to specify the nature of the social work input severely limits the utility of the results. Which factors within an intervention explain the obtained outcomes? If research is to have an impact on policy or practice, there is little point in knowing the effects of a service, unless there is knowledge of how that intervention may be repeated, modified or avoided.

There are numerous studies which testify to the fact that the *manner* in which a service is delivered may be regarded by clients as an end in itself (Rees and Wallace, 1982; Sainsbury, 1975, 1987; Goldberg, 1987). In some cases these studies have been able to determine little positive change in clients' difficult situations, although the intervention is still valued for its *process*; sensitive, empathic understanding, reliability, regularity of contact, warmth, genuineness and positive regard (Truax and Carkhuff, 1967; Cheetham, 1992).

Expectations

Burck (1978) notes that client expectations of a service can influence considerably the kind of help offered and how this will be used. Clients whose expectations are at variance with services offered are less likely to return for follow-up sessions and are less likely to feel satisfied by the social work intervention. McKay et al. (1973), in their study of a social services department, found that client satisfaction was related to the fulfillment of expectations, as was the finding in the follow-up study conducted by Glampson and Goldberg (1976).

Clients in the sample were asked to recall the expectations and hopes they had on approaching the Parent Centre originally. In all, 13 respondents gave only one answer, 30 gave two, and 8 gave three. The total is thus 97 responses, spread over the 8 categories shown in Table 26. Ninety percent of the responses fell into the following four categories:

- To change the situation with my child/ren
- To be given support in my role as parent
- To be given advice
- To be given information

The latter two are very similar, yielding the view that there were three pressing expectations, the principle one being to 'change the situation with my child.' Q15 was reported above, indicating the degree to which people felt that their expectations had been met; 71% were positive and the rest unsure or negative. Only nine people registered a clear 'no.' However sixteen gave comments as to what might have been more useful, given that their expectations had not been met (Q16). (This reinforces the view that the 'unsure' category in Q15 should be regarded as negative.) Seven of the sixteen wanted continued or greater depth of counselling (in itself an affirmation of the counselling process they did experience); in that 82% of the sample had fewer than three sessions (Table 27), this is not in itself surprising. Four people said that the situation with the child 'could not be changed,' showing some resignation. But the number (16) is too small for any meaningful analysis.

Forty-one of the clients (80%), declaring that their expectations had been met, responded to the question as to what had helped most (Q17), some offering more than one answer. To facilitate quantification, responses were coded: 26 cited 'support;' 22 cited 'time to be heard/empathy;' 14 cited 'the giving of information.' Lishman (1978) also found the first two categories to impact significantly on client satisfaction outcomes.

The next largest category ('focusing on the needs of the parent') attracted only 6 responses. There is a sense in which 'support' and 'time to be heard/empathy' could be regarded as synonymous. Therefore, in terms of meeting one of the stated goals of the Parent Centre 'to strengthen the effectiveness and self-confidence of parents by providing them with *support* and *information* on child development and child management skills...' it may be concluded that this objective is being met.

Five people responded as if their expectations had both been met *and* not been met, implying a meeting of expectations, but nevertheless, a recognition that 'more' or 'different' might have met expectations still more fully. This demonstrates the veracity of the statement in Chapter Four that client satisfaction with service may co-exist with criticism of that service.

Some actual comments regarding what was found to be helpful:

> (14) "Ek weet hoe moet ek praat met hulle (die kinders). Ek het so vas gevoel, so donker. Toe ek die geselskap uitle, voel ek 'n verbetering. Ek kan weer normaal wees met die kinders en hulle luister mooi." (Translated: I know how I must talk to them (the children). I felt so stuck, so dark. When I implemented the advice I felt an improvement. I can again be normal with the children and they listen nicely.)

> (28) "Talking about it (the problem). The counsellor wasn't judgmental. She got to the underlying reasons causing the problem of hitting my daughter. I gained insight into my behaviour." (Mother who had been physically abusing her 3 year

old and had realised she needed help when her daughter had said: "Mummy I love you, please don't hit me.")

(35) "Genuine, unhurried interest, and the counsellor's ability to give a feeling of hope." (A mother struggling with post-natal depression).

(48) "Support and concern and caring advice - not wishy-washy. I could put it to use."

Reaction to counsellor

All clients reported being 'comfortable' or 'very comfortable' with the age of their counsellor. (See Table 28) A similar pattern exists for questions regarding 'sex' and 'population group and language,' of the counsellor.

A series of questions (Q21 to Q25) was asked regarding what might be regarded as 'counsellor characteristics': warmth, interest in client's difficulty, competence, respecting of confidentiality, and being non-judgmental. Table 6.13 reflects the responses.

Table 6.13 - Q21 to Q25 : Response to counsellor characteristics

	Counsellor characteristic				
Response category	**Warm**	**Interested in difficulty**	**Competent**	**Respected confident-iality**	**Non-judgmen-tal**
Strongly agr.	34	43	33	35	36
Agree	12	8	16	12	11
Unsure	3*	0	2*	3	2
Disagree	1*	0	0	0	1*
Strongly dis.	0	0	0	0	1*
Totals	**50**	**51**	**51**	**50**	**51**

* Denotes those who responded 'no' or 'unsure' to Q15 (Do you feel your expectations were met?).

Overall, counsellors are very positively regarded. However, for those for whom the counselling experience was generally not positively regarded, feeling judged by and lack of warmth from the counsellor were significant factors (as indicated by the asterisked items in the above table). Perceptions of competence also appear to colour the experience.

> (23) Said one client, "I was glad when the session was over because I felt blamed. I wanted to remove myself from the situation." And: "I felt labelled, when what I needed was support."

Feeling judged appeared to colour the entire counselling process for such clients and accords with findings by Woodward et al. and Lishman (both 1978), that for those who were dissatisfied, worker-client interaction was the aspect of greatest dissatisfaction.

The current research also found (see Table 29) that the just 2 out of 51 respondents who felt less than 'secure' with the counsellor and at the Parent Centre, were people whose expectations were not met. In view of these significant signals, it is a pity that the small number of less than happy respondents precludes any statistical rigour from an exploration of this phenomenon in the current research.

The vast majority of respondents were positive about the safety feelings around the Parent Centre and counsellor, as attested to by these comments:

> (55) "It was good to come into that environment; I enjoyed watching people; it was very homely and warm." (Mother with a physically disabled child).

> (26) "Everyone was *so* nice, and they greeted you; you feel they're saying 'we're here to help you.'"

Only 8% felt some uncertainty about their comfort in sharing their problem fully with their counsellor. (See Table 30) They did not include 'expectations unmet' people.

It would seem obvious that feeling that one's problem has been understood by the counsellor is positively correlated with having one's expectations met and feeling that the counselling service is effective; 89% of the respondents felt satisfied or very satisfied about being understood. (See Table 31) Epperson et al. (1983) stress the need, especially in the initial session for the counsellor to understand the client's definition of the problem as well as the changes desired. Amongst the 6 people (12%) who were unsure or dissatisfied, were

only 2 of the 9 who felt their expectations were not met, and 3 of the 6 who were unsure as to whether their expectations had been met. (See Table 32)

Put differently, in Table 32, 7 of the 9 people who felt that their expectations were not met were 'satisfied' or 'very satisfied' that the counsellor understood their problems; this raises a question about whether there is in fact a correlation between feelings of expectations having been met and feeling understood. Here again the issue of levels of satisfaction as opposed to expectations being met as discussed in Chapter Four arises. In a cross-tabulation, as reflected in Table 6.14, of observed and expected frequencies, a Pearson Chi-square of 9.52315, df=1, p=.002031 results, indicating that there is indeed evidence of very significant association. (However, the expected cell frequencies below 5 should be noted, placing doubt over the significance of the finding.)

Table 6.14 - Cross-tabulation of expectations met with whether client felt their problem had been understood

Observed frequencies			
	Problem understood?		
Expectations met?	**Yes**	**Unsure/No**	**Totals**
Yes	35 *	1	**36**
Unsure/No	10	5	**15**
Totals	**45**	**6**	51
Expected frequencies			
	Problems understood?		
Expectations met?	**Yes**	**Unsure/No**	**Totals**
Yes	31.8	4.2*	**36.0**
Unsure/No	13.2	1.8*	**15.0**
Totals	**45.0**	**6.0**	51.0

*Expected frequency cell numbers < 5

To the question probing whether or not the counsellor had shared any of her own parenting experiences (Q29), 27 clients replied affirmatively, 6 were unsure, and 18 indicated she had not. The significance of this will be explored after reviewing some previous studies and revealing some of the actual comments made in the interviews undertaken in this research.

This response, as to whether the counsellor had shared or not, was then further explored in an attempt to clarify *what* about the intervention had been helpful (just 2 of the 27 said the sharing was unhelpful). Of the 27 in the first category, 22 gave as their reason that it facilitated a feeling of identification with the counsellor, 1 said it normalised her situation for her, whilst 2 valued the suggestions offered since they were 'based on experience.'

In this regard, Mayer and Timms (1970) found that clients typically preferred workers of approximately the same age, marital status and sex as themselves, since being similar, they would 'understand what the clients were going through.' Similarly, Tessler (1975) who did research on client satisfaction attempting to establish determinants of relationship-centred and problem-centred satisfaction, found greater relationship-centred satisfaction when his subjects expected to have much in common with their counsellor.

In a comparison of consumers of social work services undertaken by the National Institute for Social Work in Britain in 1972 and again in 1975 where satisfaction levels were 71% and 73% respectively, Glampson and Goldberg (1976) found that where there *were* complaints, they were raised particularly by clients with family or child care problems. Comments made often referred to the youth and inexperience of social workers dealing with complex child or family related issues when they themselves were single and without

children. Magura and Moses (1984) evaluating child protective services question whether counselling be a caseworker 'who usually has no training in parenting education and may well have less practical experience with children than the parents themselves' can be really effective. Given the 'life crisis' that becoming a parent is acknowledged to be, the Parent Centre requires that all counsellors be parents so as to facilitate greater mutual identification.

Of the 25 who found the sharing of parenting experience helpful, the following are some of the comments given from among their number:

"that helped ***so*** much"

"she knew how a mother feels - it is a very wonderful place"

"she has her own children - it made me feel as though I am not the only one with a problem"

"she knew what she was talking about"

Two respondents, however, found the sharing of parenting experience unhelpful:

(23) When asked if her counsellor had shared any of her own parenting experiences, this client replied: "Yes, all the time! I didn't need to hear about her success - I needed to work my way out of *my* situation." This respondent was also one of the two who had felt 'judged' or 'blamed' by her counsellor (Q25) and who had felt that the counsellor had not understood her problems (Q28).

(42) The other client for whom it was unhelpful was a single mother of a rebellious 16 year old. Although overall her experience was that the counselling facilitated communication between mother and daughter in new ways, the counsellor's sharing of parenting experiences was not helpful. "The church doesn't allow contraception. I felt she was encouraging the child to ignore the church - I was very dissatisfied with this." This perhaps emphasises the enduring social work maxim 'start where the client is.'

To explore whether sharing was significantly associated with a feeling that expectations had been met (the surrogate in this research for 'effectiveness'), a cross-tabulation of 'expectations met' feelings with whether the counsellor shared feelings was carried out. Table 33 reports the results. The statistics are : Pearson Chi-square: 6.50841, df=1, p=.010741. In this case the expected cell frequencies are all above 5. There is thus evidence that sharing is significantly associated with expectations being met. Incidentally, of the two people saying that the sharing was unhelpful, one said that expectations had been met 'very much' whilst the other said 'no.'

Discussion of Counsellor or Nonspecific Factors

The literature abounds with the assertion that it is the *relationship* in counselling and psychotherapeutic endeavours which 'heals' or is the single most critical factor. In this regard, Yalom (1980, p.401) writes:

> If any single fact has been established by psychotherapy research, it is that a positive relationship between patient and therapist is positively related to therapy outcome. Effective therapists respond to their patients in a genuine manner; they establish a relationship that a patient perceives as safe and accepting; they display a nonpossessive warmth and a high degree of accurate empathy and are able to 'be with' or 'grasp the meaning' of a patient. Several reviews that summarize hundreds of research studies concur in this conclusion.

Whilst research also has demonstrated that the knowledge and skills acquired through professional training are necessary components of the interpersonal helping process (Frank, 1971; Goldberg, 1978), it is the clinician's 'use of self' (England, 1986) and the resulting therapeutic alliance (Strupp, 1978; Cooley & Lajoy, 1980; Orlinsky and Howard, 1986; Marziali and Alexander, 1991; Coady, 1993) which is the primary medium through which change or 'social care' (Goldberg, 1987) can be effected. Speaking of this relationship, Biestek (1994) writes: 'it is the *soul* of casework, (counselling, psychotherapy) while the processes of study, diagnosis, and treatment may be considered the body. As the life-giving principle, it vivifies every part of casework and makes the whole a warmly human helping experience.'

Frank (1973) identified human qualities intrinsic to the client-clinician relationship for which he coined the term 'non-specific factors.' Much like the 'core conditions' identified by Rogers (1965), these include understanding, respect, interest, encouragement, acceptance and forgiveness. Hunt (1985) quotes Ryle (1980) for whom non-specific factors are : the instillation of hope, the provision of support, clarification, giving permission, communication, promoting learning and the encouragement of different behaviours. It may be seen from the responses to the questions Q21 to Q32 that non-specific factors were of central significance to the experience of counselling.

OUTCOME INFORMATION

Therapeutic changes

The key questions in this area (Q30 : Do you feel that changes occurred in the problem area you were experiencing?; and Q32 : Do you think these changes were a result of the counselling?) have already been reported on above in the discussion on outcome information central to the study. In this section, expressed helpful and unhelpful aspects of the counselling are explored.

Q30 found that 78% (40) of clients experienced a change in their problem situation; 22% (11) were unsure or did not experience a change:

(40) A father who stated that his reasons for approaching the Parent Centre were "severe discipline problems at school and at home" and that things had built up to a pitch where he feared becoming aggressive, stated that he 'strongly agreed' that changes had occurred in the problem area. Changes effected were improved communication and all family members "pulling their weight in making things work." Asked what had been most helpful, he responded: "the counsellor initiated a process of change in the family. She was able to draw us out and enabled us to verbalize to each other the problems we were experiencing."

(2) A single mother (income R600 p.m.) with an acting out 14 year old boy disagreed in terms of changes occurring in the problem area. However, despite this, she *felt* more contained, since communication with her son improved and she had a better understanding of the reasons underlying his behaviour. This would tie in with the assertion that even though *circumstances* might not change significantly, the *process* of the counselling intervention was in itself beneficial. (See Chapter 3).

People who felt that there had been changes in the problem area (i.e. 78% of the sample), were asked to identify what the changes had been. This was an open-ended question allowing for multiple responses. The answers were coded, yielding Table 34. Nearly 30% (25) of the responses are coded as 'empowerment of the parent,' indicating that the parent felt more contained and in control again. Some 19% (17) dealt with more insight into the child's situation, and nearly 15% (13) with the view that the child's behaviour or attitude had changed.

Some actual client comments follow; they hopefully provide depth and texture to the statistical counts of changes seen to have occurred. Once again they attest to the appreciation expressed for the counselling service experienced.

(8) "My daughter and I became so much closer - if I look at my daughter I can't believe the difference - I feel I'm a better parent." This was a divorced mother. When asked what had brought her to the Parent Centre, she had responded: "I had been through a traumatic divorce; I felt I was losing it, that I was losing my daughter since the divorce."

(13) "I can communicate with people; I can understand my daughter's feelings; I listen - the skills are working tremendously; I don't hit." This was a widowed mother with a monthly income of R600 who had felt isolated and unable to 'handle' her 9 year old daughter. One of the recommendations that had emerged from counselling was that she attend a **Positive Parenting** programme. This enhanced her self-esteem, her relationship with her daughter and opened up opportunities for social interaction.

(12) "He (18 year old son) is more co-operative. He tells me where he's going, comes home earlier. He has an easier relationship with my boyfriend." This was a never married mother who was encouraged to listen to feelings, to spend quality time with her teenage son.

(14) "Sy gaan skool (truanting 19 year old). Ek voel gewoon, nie lelik nie. Ek kan sien wat is haar probleem." (Translated: She goes to school. I feel fine, not bad. I can see what her problem is.) This was a single mother with an income of R400 per month who, in desperation had been hitting her children with a wooden spoon, causing them to abscond and truant.

As indicated before, when asked in Q32 whether these changes were a result of the counselling, the responses were:

yes	36	85.7%
unsure	2	4.8%
no	4	9.5%

Those responding 'yes' were asked to identify the most helpful aspect of the counselling; the coded multiple responses are shown in Table 6.15.

Table 6.15 - Q32 : What was the most helpful aspect of the counselling?

Most helpful aspect of counselling	Count	%	Cum %
Support of self as parent	26	28.6	28.6
Insight	26	28.6	57.1
Gaining information	18	19.8	76.9
A place to be heard	7	7.7	84.6
Acceptance/non-judgment of counsellor	6	6.6	91.2
Other	9	9.9	101.1
Total	**91**	**101.1**	

It can be seen that the two largest categories are 'support' and 'insight', the latter being a kind of gaining of information, and that therefore, together with the third category, once

again the Parent Centre's objective of offering support and information to parents is being realised. The fourth and fifth categories testify to the centrality and significance of the nature of the interpersonal encounter as discussed above. These latter two categories can also be seen as support, and so the above could be summarised as in Table 6.16.

Table 6.16 - Summary of most helpful aspects of counselling

Most helpful aspects of counselling	**%**
Information/insight	48.4%
Support/acceptance	42.9%
Other	9.9%

In that most respondents gave more than one answer, it is likely that both of the main categories were cited by most people. Some actual comments were:

(26) "Support of both of us (husband and wife) - facilitation of insight without judgment. She wasn't on anyone's side - she was equal to both of us. She spoke to my husband in a way that made him feel good - in a very soft way. He realised he needed to change." (A blended family where there was rivalry between husband and his 18 year old step-son. When asked what she had hoped/expected would happen (Q14) this mother responded: "I didn't know *what* to expect. But I left a different person. My whole house was different after that. When I thanked her I said 'you've saved a marriage'."

(24) "A wise ear."

(8) "There must be a place like that to talk about problems." (A mother with an income of less than R600 per month which is therefore in conflict with the assertion that low SES clients are unable to benefit from counselling.)

(52) "She cared; I could feel that; it made me feel better about myself; I had been feeling down, not knowing what more to do. The burden lifted by speaking about it." (A single mother with depressed 7 year old).

(15) "Good to talk to someone (who is) not a neighbour pointing at my child; as a single parent, I like to talk to someone like you." (A Xhosa-speaking parent with an income of less than R800 per month.) She also stated in response to Q20 regarding population group and language: "it pleased me - I could talk deeply."

For those who felt that the changes were not due to the counselling, the causes of the changes were probed; answers were open-ended and coded to form Table 35. Ten people responded to this although only 4 answered no to the first part of the question. With the ten responses spread over more than four coded categories, the counts are too low for any meaningful commentary. However, this question enters the sphere which in a rigorously controlled experiment would control for variables other than the dependent one (the intervention) impacting on outcome. The response to this question is subjective, but is an attempt to link the intervention with outcome.

At Q33 the sample was asked what might have been more helpful, if they feel the problem had not been adequately addressed; 21 people responded, each giving one suggestion.

Their coded responses are shown in Table 36. One third (7) wanted more counselling sessions, whilst another 4 felt that the counsellor had done all she could. Thus over 50% are indirectly affirming the counsellor.

Clients 53 and 54 both of whom felt their expectations had been only partially met, would have valued more sessions. Although in one case further sessions were suggested and agreed to, a date was not set and the parent did not initiate further contact despite the fact that she felt she would have benefited.

Q34, the last in this section on therapeutic changes, asked 'Do you feel that the problem continues?' The following table reflects the responses:

Table 6.17 - Q34 : Do you feel the problem continues?

Problem continues?	Count	%	Cum %
Yes	17	33.3	33.3
Yes, but improved	13	25.5	58.8
No	21	41.2	100.0
Totals	**51**	**100.0**	

Thirty (59%) of the sample of 51 feel that the problem continues, whilst 34 (68%) feel that it has ceased or has improved (the 'Yes, but improved' category overlaps with the 'Yes' category to create this rather confusing set of figures). How does one then explain the very high levels of satisfaction expressed by the sample? Selecting from the actual client responses is illuminating:

(44) This client responded: "Yes (the problem continues) but our attitude is completely different. We handle the children as a team, handle them totally differently. It's now father and me with *our* children. Before it was him and his against me and mine. Now the conflict is more humourous than a problem." This was a blended family with teenage sons from father's first marriage; mother had only a small child and had had no experience of teenagers. She had actually left home for two weeks when she came to the Parent Centre, saying that "everything was chaos" and she thought she was "going mad." In response to the question regarding what had helped most in meeting her expectations (Q17) she responded: (The counsellor) "was a mother who also had teenagers. She opened my brain for me and made me feel 'this is not a problem family and this is what you can expect from teenagers'." Asked what had been the most helpful aspect of the counselling (Q32): "She gave information, support, normalised things. Our communication needed work so we came together. And I learnt I don't have to be superwoman!"

(49) Client said that whilst the problem does continue "it's no longer a big problem - there has been a shift in coping skills, a shift in the way the problem is seen." She felt both she and her 18 year old unmotivated daughter had been 're-empowered.'

This question of whether the problem continues was cross-tabulated with Q15 regarding expectations being met; Table 37 reflects the output. The statistics are: Pearson Chi-square:15.5146, df=2, p=.000428; one expected frequency cell of 3.5. This is unsurprisingly very highly significant; people for whom the problems continue are also those whose expectations were not met.

Interview content

Over 88% (45) of the respondents felt that they had been in agreement with the counsellor as to what the problem areas were. (See Table 38) The ratio of positive agreement to unsure or negative, is thus 88:12, indicating a high level of agreement.

Discussion: Although the lack of variation in response to this question and the small sample size do not permit any definitive conclusions, it is perhaps relevant to note that client and worker having a shared perspective on a problem has been found to be a significant factor having a direct impact on outcome. Mayer and Timms (1970) coined the phrase 'a clash in perspective,' where in their study of 61 clients of the Family Welfare Association, they found that those clients who were dissatisfied with agency service had been those who had come with an anticipation of practical and concrete help, instead of which, interventions were insight oriented. Similarly, Burck (1978), Lishman (1978), Corney (1981) and Wilson (1985) confirm this finding. Burck defines a shared perspective as client and worker being in agreement regarding the nature of the problem(s) and agreeing over the proposed plan of action.

At the Parent Centre there is often a clash in perspective regarding the notion that the clients' children should be seen. It is as though parents approach the agency with the idea that the 'difficult child' is the problem and needs 'sorting out.' While it may be true that the child may need to be referred for treatment, it is always true that the child's parent(s) need to be engaged in treatment, even if only initially. In her work in a child guidance

clinic, Burck found that parents who came not expecting to be a focus for intervention, generally were dissatisfied with the service. An example in point from the present study illustrates this:

> (43) This client felt blamed and judged in the counselling session and stated that she had come hoping her *children* would be seen, not only herself. She had left the session feeling "very mixed up" and had "walked away feeling I was battering my children when in fact I don't."

Despite the point made in the discussion above, in this study there does not appear to have been a correlation between 'agreement' regarding the problem and 'expectations' being met as Table 6.18 indicates:

Table 6.18 - Cross tabulation of agreement between client and counsellor as to problem areas, and client's expectations being met

	Agreement regarding problem areas?				
Expectations met?	**Complete**	**Yes**	**Unsure**	**No**	**Total**
V. much/ yes	20	12	4	0	**36**
Unsure/ no	7	6	1	1	**15**
Total	**27**	**18**	**5**	**1**	51

A formal cross-tabulation with the collapsing of the positives regarding agreement into one (positive) column, and the unsures and no's into one (negative) column, yielded these statistics: Pearson Chi-square: .050370, df=1, p=.822421. One of the four expected frequency cells had a count of only 1.76 which reduces the statistical credibility, but the

indication is clear: this data shows no significant association between agreement between counsellor and client regarding the nature of the problem(s) and the client's expectations being met.

Task-centred counselling. Counselling at the Parent Centre is not specifically articulated as 'task-centred' in the sense that task-centred work has been developed by Reid and Epstein (1972). However, in the course of the counselling intervention tasks are frequently mutually articulated. Regretfully, the issue of contracting and task setting was not more carefully examined in the survey. Were it to be done over, these issues would be clearly specified and measured, given the literature's clear indication of the effectiveness of such variables (Cheetham, 1992; Sheldon, 1986; Reid and Hanrahan, 1981).

Nearly 68% of the client sample (38 people) agreed with the counsellor to work on specific tasks; therefore 32% did not. No one was 'unsure' on this question. Thirty five people then gave the following as the tasks:

Communication (incl. listening)	15
Setting limits	13
Quality time	7
Affirmation of child (positive talk)	9
Consequences, not smacks	4
Reading material	4

A cross-tabulation of agreement to work on tasks with expectations being met yielded these statistics: Pearson Chi-square: .222779, df=1, p=.636934; one expected frequency cell of only 3.36. There is thus no evidence that agreeing to work on tasks, or not, is associated with expectations being met, or not met.

Time for counselling. Table 39 reflects the feelings regarding how the counselling session(s) were ended, e.g. in terms of timing. Eighty eight percent feel this was done appropriately or very appropriately. A cross-tabulation of this with whether expectations were met yielded these statistics: Pearson Chi-square: 1.38833, df=1, p=.238696; one expected cell frequency was 1.76. The way the session(s) ended does not appear to be associated with feelings of expectations being met.

Regarding whether the sample clients felt there was enough time to feel that they had fully communicated their difficulty, there was more spread of answers than for most questions; 2 people even stated 'definitely not.' (See Table 40) Some 22% (11) felt that they were unsure, or had not had sufficient time. Cross-tabulated with whether expectations were met yielded: Pearson Chi-square: .030909, df=1, p=.860444; one expected frequency cell count was 3.24. It would thus appear that feelings regarding having enough time to fully communicate the difficulties are not associated with feelings as to whether expectations were met.

One mother (7) said: "There was no-one waiting; I had a nice time; I was alone in the office" (with the counsellor) - possible commentary on previous interactions with social services. This links with the comments by Gutek (1978) and Rees and Wallace (1982) regarding clients previous encounters with human service agencies resulting possibly in low expectations. (See Chapter Four).

However, one of those who had not been satisfied said she had 'felt rushed' and that there was 'definitely not enough time - something was missing.' Yet another said that the counsellor had 'opened up stuff and I could have gone on a lot longer - I could have talked for hours.'

One person who responded that she was 'unsure,' had nevertheless experienced that she 'never felt rushed,' nor had there been any 'looking at the clock.' However, despite this, she would have preferred more time.

Another (47) whose teenage step-sons were acting out by stealing and fighting and she felt were 'out of control,' said she had not had enough time to communicate her difficulty. She had felt rushed and that she 'had to talk fast.' She also had not had time to 'say everything I needed to.' For her personally, the counselling had been helpful and 'very effective,' but in terms of the 'overall situation,' her expectations had not been met.

Ten people recalled being asked to agree to a certain number of sessions, 3 were unsure, and 38 had not been asked to agree to a certain number of sessions. The number of sessions agreed to varied between 1 and 3 sessions.

A comparison of actual sessions taken from the file face sheet and the client's recollection of the number of sessions reveals:

Recollection was more than actual number	7
Accurate recollection	35
Recollection was less than actual number	9
Total	51

Whilst it may be understood how blurring of such details could easily occur with the passing of time, this is an example of one of the limitations of a retrospective self-report survey as discussed in Chapter Five.

Follow-up sessions

Twenty-five people said that they had agreed to having follow-up sessions, but only 13 actually attended them. Questioning the 12 who failed to attend the follow-up sessions agreed as to why, proved inconclusive. A wide variety of reasons were given: 10 different reasons for the 12 people who said 'no', including multiple reasons per person. (See Table 41)

Referral out

Fifteen people in the sample reported that on termination of counselling they were referred elsewhere, to the sources shown in Table 42. The 15 are spread over 10 referral areas. No meaningful observation can be made of such a spread. Fourteen indicated that they regarded the referral as appropriate (one missing response); 13 felt the timing of the referral to be correct, 1 felt the timing not to be appropriate, and 1 was a-missing response (making up the 15 people referred elsewhere).

Therefore, referrals, where made, appear to have been perceived as appropriate. However, a mother who responded 'unsure' to Q47 regarding overall effectiveness, felt that her needs regarding her depressed 6 year old son had not been met. She felt she should have had

follow-up sessions (she had only 1) and said: "I felt strange, as though I had come to the wrong place, as though I had made the wrong choice." This parent ultimately found appropriate help with a psychologist, but was not referred to same by her counsellor.

One client whose 14 year old daughter was acting out by stealing and smoking dagga soon after the birth of step-siblings, was referred, appropriately, to the Drug Counselling Centre. However, the client felt that there were parenting issues which impacted on the acting out, and she would have valued further work at the Parent Centre. She said: "More should have been done at the Parent Centre in terms of the communication gap. I would have liked to continue at the Parent Centre. At the DCC they work only with the teenager."

An area for the Parent Centre to consider incorporating in the counselling routine presents itself from the above. When concluding any session, it would possibly be helpful to offer further opportunities for follow-up work, even if the counsellor feels the situation has been adequately dealt with.

CONCLUDING QUESTIONS

Twenty of the sample responded on being asked if there were any changes they felt would enhance the effectiveness of the service? (See Table 43) Fourteen (23%) of the 'suggestions,' the biggest single category, in fact said the service was already helpful! 'Hours of operation' constitute 13% of the suggestions, reinforcing the views expressed in response to Q12 where 15 of the 51 clients in the sample, or 29%, expressed dissatisfaction with the Parent Centre's hours of operation.

It was felt necessary to ask the sample clients 'How has it been for you to participate in this survey?' This was to explore the appropriateness, in the eyes of the clients of doing such research. They clearly regarded the survey as pleasant, and approved of it. These were the responses:

Table 6.19 - Feelings about participating in the survey

Reaction	Count	%	Cum %
Comfortable	27	37.0	37.0
Nice/enjoyed it	21	28.8	65.8
Glad to help	7	9.6	75.3
Good for accountability	5	6.8	82.2
OK/alright	4	5.5	87.7
Other (7 categories)	9	12.3	100.0
Totals	**73**	**100.0**	

One of the five clients who felt the survey was good in terms of accountability stated: "Good; necessary. You might have someone who is not working properly. I had an experience of marriage counselling in another country with inappropriate questions asked, and I had no-one I could report this to."

One client said spontaneously: "I felt so at home. I want to tell her (counsellor) how I am. After my holiday I am going to come in and tell her." This mother had come in with divorce issues: the children - boys aged 10 and 7 - were constantly fighting and were especially difficult on returning from visits to their father. In terms of changes she felt she had made (Q31) she stated that she was more at ease with herself, the children "are fine" and communication generally was better.

However for another who had been struggling with post-natal depression, she found that it had been 'difficult' because emotions were stirred up. This mother did ultimately return for further counselling.

CONCLUSION

A considerable amount of data has been presented in this chapter, and in Appendix C. The central findings are summarised at the beginning of the following chapter, which is also the last chapter. The conclusions and recommendations are then presented.

CHAPTER 7

SUMMARY OF RESULTS, CONCLUSIONS AND RECOMMENDATIONS

INTRODUCTION

This final chapter provides a summary of the findings of the study as they relate to the research questions. Conclusions which may be drawn provide an overall indication of the effectiveness of the counselling service at the Parent Centre, whilst simultaneously highlighting some areas which may be examined by agency decision-makers with a view to modifying and improving the service. Topics for future research are suggested.

As in Chapter 6, table references will be : if in Appendix C, Table 1, Table 2, etc.; in Chapter 6, Table 6.1, Table 6.2, etc.

SUMMARY OF FINDINGS

Effectiveness of the counselling

The overall purpose of this study was to evaluate how effectively the Parent Centre is meeting its goal of providing parents with support and information on child development and child management skills through counselling. Ninety per cent of the client sample population came to the Centre with one or more of the following expectations: to change the situation with their child or children, to be given support

in their role as parent, to be given advice or to be given information. Interventions then occurred within the context of these expectations. Whilst cognizance must be taken of the limitations articulated in Chapter Five, and in this instance, most particularly of the 'halo effect,' it can be seen from Table 6.9 which summarises the responses to the pivotal questions, that clients in the sample responded overwhelmingly positively to the counselling intervention. Ninety percent felt, on the basis of their experience that the counselling service is effective, and that overall contact had been helpful. Ninety-two percent would return again themselves if the need arose, and 96% would refer a family member or friend. Seventy-eight percent felt they had been able to make changes in their situations of difficulty.

It is necessary to consider these findings within the previously stated context (see Chapter Four) of universally high levels of satisfaction in other client studies. However, this study did attempt to do more than provide global satisfaction ratings.

Demographic information

The client profile: The predominant client profile may be seen to be white women, aged between 31 and 45, married (including remarried) with 2 children. Sixty-one percent have Std. 10 or are educated at the tertiary level, are skilled or professional and/or are partnered by such a person. A quarter have incomes of more than R5000 per month. This concurs with the well documented findings in relevant literature (as previously indicated) to the effect that this method of problem-solving and support (counselling) is favoured primarily by middle-class, well-educated whites. However,

and although no generalizations can be made due to the small numbers of disadvantaged clients in the sample, this survey found (Table 6.11) that clients from lower socio-economic groups were as likely to find the counselling intervention as supportive and effective as their more privileged counterparts. Moreover, as noted in Chapter Six, the Khayelitsha office is beginning to be deluged with requests for help as, increasingly, the accessibility and existence of the service become known. It needs also to be noted that counselling is but one of the services offered by the Parent Centre.

Management information

Hours of Operation: The predominance of mothers in the client population is also part of a universal trend indicating that for all the rhetoric regarding egalitarianism, the primary responsibility of child rearing in general terms, remains that of the mother (see Table 6.12). It may, however also be a reflection on hours of operation.

'Hours of operation' was one of the few areas in which strong dissatisfaction was expressed (Table 22). This, too, has been a factor of which management has been aware and to this end, counsellors are increasingly available in the afternoons. However, hours of operation remain a primary concern relative to the most needy and marginalised groups in the population - the poor, some single parents with multi-problem situations. Dissatisfaction with hours seems spread across all groups, as measured by marital status and client occupation (Tables 23 and 24).

Presenting problem: For both clients and counsellors the largest category of problems articulated concerned discipline issues of some sort. However, as stated in Table 14, the frequency was greater for clients than counsellors. Although, for the most part, clients and counsellors seem to share a perspective regarding the presenting problem, this is an area which deserves more focus from counsellors. As will be emphasised below, a feeling of being understood is a key issue which significantly impact on outcome as attested to in the literature, and in this study. (See Table 6.14)

Referral Source: Clients most frequently come to the Parent Centre via word of mouth (friends). However, medical and paramedical professionals are also significant sources of referral. Much networking and workshopping is done with groups of professionals and it would seem that this is energy well spent.

Waiting for an Appointment: Of the sample of 51, 12 people had hoped for an appointment on that day. This indicates a feeling of having been in a crisis situation. Whilst some crises can be contained merely by the knowledge that an appointment has been made and steps have been set in motion to address the crisis, others are more pressing - in this sample the parents who were out of control are obvious examples. The issue of screening for urgency of appointment is one which needs attention.

First Telephone Contact: An overwhelming 93% found this to be helpful or very helpful. Therefore, for all that there may be frustration regarding the wait for an appointment, clients find the reception they get very positive.

Fees: At the time of the survey, fees were found to be acceptable to most.

Process information

Helpful Factors in Meeting Expectations: In attempting to understand *what* in the counselling intervention had been helpful, clients were asked to name helpful or unhelpful events. The open-ended responses, coded, yielded 'support' and 'time to be heard/empathy' as the most significantly helpful factors. These findings underline the fundamental centrality of the 'relationship,' which is at the heart of social work, as well as of parenting.

These were followed by 'information.' It may therefore be seen that the objective of strengthening the effectiveness and self-confidence of parents by providing them with support and information on child development and child management skills is being met for many clients.

Reaction to Counsellor: All clients were comfortable with the age, sex and population and language group of their counsellor. (See Table 28) However, not all found their counsellors warm or non-judgmental and these factors appear to have profoundly affected the counselling experience as well as the outcome. Similarly, those who were unsure about the competence of their counsellors felt that their expectations had not been met. Nevertheless, the vast majority of clients experienced their counsellors as warm, non-judgmental, competent, and found them to be interested in their difficulty and respectful of confidentiality. (See Table 6.13)

Similarly, 49 of the 51 clients experienced the general atmosphere at the Parent Centre and with their counsellor as 'safe.' (Table 29)

Sharing of Parenting Experiences by the Counsellor : This is an intervention that yielded a significant association with expectations being met; p = .011 (Table 33). However, as can be seen from the comments made by individual clients, it may be experienced as extremely unhelpful, and the counsellor needs to be acutely sensitive before sharing. Moreover, the client's values frame of reference must always be respected. The counsellor needs to be sensitive to the maxim 'start where the client is.'

Something which proved very significant was that the client should feel that their problem was understood by the counsellor. Table 6.14, and Tables 31 and 32 refer : it is quite clear that this is far more significantly related to feelings that expectations were met, than is agreement with the counsellor as to the nature of the problem. There was no significance on the latter (see Table 6.18).

Outcome information

Therapeutic Changes: Seventy-eight percent of the client sample felt that they had been able to make changes in their problem situations. Of these, 71% felt the changes were a result of the counselling. For these people the most helpful aspects of counselling were : information and insight, and support and acceptance. (Table 6.16)

Even people who felt the problem had been inadequately addressed actually expressed affirmation for the counselling service. (Table 36)

Sixty-eight percent of the sample felt their problem had ceased or at least improved. The 59% who felt their problem continued in the same or lesser form, were very highly significantly associated with those who felt their expectations had not been met ($p = .00043$).

Interestingly, there was no association found between 'having enough time to fully communicate difficulties' and having expectations being met. Similarly there was no significance found between agreeing with the counsellor to work on tasks and feeling that expectations were met.

RECOMMENDATIONS AND CONCLUDING STATEMENTS

This study was located within a limited overview of research literature pertaining to effectiveness studies. It highlighted, moreover, the significance of client studies in contributing to research into outcomes of social work intervention. The study, itself, falls within the pragmatic/eclectic paradigm and is context-specific.

Given that the succinct answer to the question 'what does it mean to be effective in social work?' has to do with whether or not programme goals have been achieved, it may overwhelmingly be concluded that, within the limitations of the methodology, the counselling service at the Parent Centre can be seen to be effective. This survey

has indicated that the majority of clients coming to the agency feel empowered, supported, heard, understood, and have gained insight and information, thereby strengthening their effectiveness and self-confidence as parents.

Although one of the limitations is that, being retrospective, the survey may have included distortions, an advantage of its being retrospective is that in asking if the problem continued, it is possible to assess that changes had been able to be sustained - for 4 months at least (July-October) or longer. Therefore, whilst this was not formally a 'follow-up' study, sustained change can be seen to have occurred.

Areas which have been highlighted by the findings for attention by agency decision-makers include the following:

1. The demographic profile which does not reflect that of South Africa as a whole. As previously stated, this profile is changing significantly, but nevertheless is an area requiring careful consideration and planning to make services more available to the most needy.

2. Operating hours which discriminate against parents working 'office hours.'

3. Procedures for screening and identifying those in crisis, and establishing protocols to accommodate such. It might be possible to suggest that clients telephoning the Parent Centre are asked to rate themselves, for example on a ten-point scale, where 1 = 'needing help but contained,' and 10 = 'in crisis.'

4. Where formal referrals occur, e.g. via school teachers, it would perhaps be helpful at initial contact to elicit a picture of what the potential client hopes to gain from contact with the Parent Centre.

5. The issue of children not being seen needs to be clarified to avoid a 'clash in perspectives.' This point should also be seen in the light of 4.

6. The literature has repeatedly highlighted the well researched evidence of the value of short-term, task-centred and focused intervention which includes contracting and mutual articulation of goals, as well as a focus on the client's understanding of the problem. Whilst this is broadly the *modus operandum* of the Parent Centre, clear policy in this regard has not been articulated.

7. Similarly, whilst it is generally accepted that clients should be encouraged to return for follow-up appointments, a few clients in the survey felt that they were not encouraged to return, some because they had been referred, appropriately, elsewhere. Nevertheless they felt they would have benefited from further counselling at the Parent Centre. Again, clear policy should be articulated in this regard.

8. Possibly precisely because they were so few in number, the clients who were dissatisfied stood out in the survey. Their unhappiness underlines the centrality of the social worker's use of self in providing empathy and understanding and in respecting the client's values frame of reference, of which we all need to be reminded.

9. The question 'Were your expectations met?' was found to be the most discriminating of the 'direct' questions as to effectiveness. It is commended for further testing in effectiveness studies.

10. The challenge in South Africa is to indigenise and contextualise services. This study assists in illuminating contextual demographic factors with a view to highlighting groups in the community needing to be targeted who are not being reached.

11. The study has served to move toward an integration of the researcher/practitioner divide. Further evaluative studies need not repeat the literature search and it can be seen that at relatively little cost in terms of time and money, relevant client feedback may be obtained. Other ways might perhaps be to ask clients to fill in a form on arrival regarding issues bringing them in and hopes and expectations of the session. This could be followed up with a telephone call at termination of counselling.

RECOMMENDATIONS FOR FUTURE RESEARCH

Inevitably, ongoing reading provides ongoing awareness of how the study could be differently done. Areas to focus on might be : contracting; articulation of problem; and, articulation of goals.

CONCLUSION

This research set out to evaluate the effectiveness of the counselling service at the Parent Centre. In terms of the challenge to arrive at working definitions of effectiveness in specific contexts, this study has demonstrated that, using self-report data, parents believe they are receiving effective support and information when approaching the Parent Centre through the medium of counselling.

APPENDIX A

THE TELEPHONIC INTERVIEW SCHEDULE

Instructions:

1. Complete section A of schedule (demographic information).

2. Commence telephonic contact by ascertaining that you are speaking to the client.

3. Read `Introduction' and arrange a suitable time to phone for the interview, if the client is willing to participate.

Introduction:

Hello, may I speak to X, please?

My name is Caroll Faull. I am a social worker involved in counselling at the Parent Centre. The Parent Centre is undertaking a survey of randomly selected clients in an attempt to improve the counselling service offered. Your name was randomly selected from the appointment diary of clients seen in the first 6 months of this year. It would help us a great deal to gain a clearer picture of how our clients view our service, if you would be willing to participate in this survey by allowing me to ask you some questions over the phone. Your responses will be entirely confidential and will be identified by a number only. I am purposely unaware of who your particular counsellor was. She, too, will be identified by number only.

The interview will last approximately ..... If this is not a convenient time to speak, we could arrange a time more suitable for you.

Thank you very much for agreeing to participate....

Section A:

Client's name: (To be filled in pencil and erased as soon as interview and notes are complete).

Client's telephone numbers: (h) (w)

1. Client's random number:

2. Client's geographic area:

3. Counsellor's view of presenting problem:

4. Age of client:

5. Marital status:

6. Number and ages of children:

7. Occupation of client: Occupation of spouse/partner:
8. Income bracket:

9. Educational level of father:
of mother:

10. Number of sessions:

11. Who was the client?

Mother
Father
Mother and Father

Section B INTERVIEW SCHEDULE

Referral Source and Initiative for Contact:

1. Could you tell me briefly what the problem or issue was which caused you to make contact with the Parent Centre? (Open-ended - categories for recording only).

adjustment to parenthood
discipline issues
communication - with child(ren)
- with partner re children
post-natal depression
self-esteem - in child
- in parent(s)
information
divorce issues
single parent issues
parenting skills
support
other

2. Had you previously approached anyone else for help - any other resource/service in the community?

yes/no

If yes, which one(s)?

- doctor
- psychologist/psychiatrist
- hospital
- person of religion
- school
- other

3. How did you hear of the Parent Centre?

- media
  - newspaper
  - radio
  - magazine
  - other
- network
  - family member
  - friends
- formal referral
  - doctor
  - social worker
  - person of religion
  - teacher
  - other

4. Frequently there is something that is the `last straw' which causes one to contact an organisation like the Parent Centre. Do you recall such an event? If yes, what was that?
(Open ended)

- argument with child
- argument with partner
- losing control
- other

Need for Urgent Appointment:

5. When you phoned the Parent Centre, how soon did you want an appointment?

- same day
- same week
- within 2 weeks
- more than 2 weeks

6. How long did you have to wait for an appointment?

one week
two weeks
more than two weeks

7. Did you request a particular counsellor?

yes/no

8. How did you feel about the length of time you had to wait for your appointment? (Ask open ended)

scale: very satisfied
satisfied
indifferent
dissatisfied
very dissatisfied

Reaction to First Telephone Contact with the Parent Centre:

9. Who was the first person you spoke to at the Parent Centre?

receptionist
counsellor
group leader

10. Would you agree or disagree with the statement:
'The first telephone contact with the Parent Centre was helpful.'
scale: strongly agree
agree
unsure
disagree
strongly disagree

11. In what way was it helpful/unhelpful?

12. Were you satisfied with the Parent Centre's hours of operation?
scale: very satisfied
satisfied
indifferent
dissatisfied
very dissatisfied

13. Were you satisfied/dissatisfied with the fee required?
scale: very satisfied
satisfied
indifferent
dissatisfied
very dissatisfied

Expectations:

14. What did you hope/ expect would happen as a result of coming to the Parent Centre? (Open ended)

be given advice
be given information
be given support in my role as parent
to change the situation with my child(ren)
to gain parenting skills
other

15. Do you feel your expectations were met?
scale: very much so
yes
not sure
no
not at all

16. (If no), what might have been more helpful in having them met?

17. (If yes), can you identify what helped most in meeting your expectations?

Reaction to Counsellor: Introduce with a linking sentence like:` I'm now going to ask you some questions about your experience of your counsellor.'

18. Were you comfortable with the age of your counsellor?
scale: very comfortable
comfortable
indifferent
uncomfortable
very uncomfortable

19. Were you comfortable with the sex of your counsellor?
scale: very comfortable
comfortable
indifferent
uncomfortable
very uncomfortable

20. Were you comfortable with the population group and the language of your counsellor?
scale: very comfortable
comfortable
indifferent
uncomfortable
very uncomfortable

21. Would you agree or disagree with the statement: 'My counsellor was a warm person.'
scale: strongly agree
agree
unsure
disagree
strongly disagree

22. Would you agree or disagree that your counsellor was interested in you and in your difficulty?
scale: strongly agree
agree
unsure
disagree
strongly disagree

23. Would you agree or disagree that your counsellor was competent?
scale: strongly agree
agree
unsure
disagree
strongly disagree

24. Would you agree or disagree that your counsellor respected confidentiality?
scale: strongly agree
agree
unsure
disagree
strongly disagree

25. Would you agree/disagree that your counsellor was non-judgmental?
scale: strongly agree
agree
unsure
disagree
strongly disagree

26. Would you agree or disagree that the general atmosphere at the Parent Centre and with your counsellor felt safe?

scale: strongly agree
agree
unsure
disagree
strongly disagree

27. Were you comfortable enough with your counsellor to share fully what was troubling you?

scale: very comfortable
comfortable
unsure
uncomfortable
very uncomfortable

28. How satisfied were you that your counsellor really understood your problems?

scale: very satisfied
satisfied
unsure
dissatisfied
very dissatisfied

29. Did your counsellor share any of her own parenting experiences?

scale: yes
unsure
no

If yes, was this helpful?

Therapeutic Changes:

30. Do you feel that changes occurred in the problem area you were experiencing?

scale: strongly agree
agree
unsure
disagree
strongly disagree

31. If agree, what were these changes?

32. Do you think these changes were a result of the counselling?

scale: yes
unsure
no

If yes, can you name what was the most helpful aspect of the counselling? (Open ended).

information
insight
support of self as parent
acceptance/non-judgement of counsellor
other

If no, to what do you attribute the changes that have occurred?

children's development
more support from others
other

33. If the problem was not addressed adequately, what might have been more helpful?

34. Do you feel that the problem continues?

Interview Content:

35. Did you and your counsellor agree regarding what the problem areas were?
scale: agreed completely
agreed
unsure
disagreed
completely disagreed

36. Did you agree to work on specific tasks or issues?
scale: yes
unsure
no

If yes, what were they?

37. Was the ending of the session(s) sensitively/appropriately handled e.g. in terms of timing? (Did the counsellor cut you short?)
scale: very appropriate
appropriate
unsure
inappropriate
very inappropriate

38. Was there enough time for you to feel that you had fully communicated your difficulty?

scale: definitely enough
enough
unsure
not enough
definitely not enough

39. Was it agreed that you would attend a certain number of sessions? If yes, how many?

scale: yes
unsure
no

40. How many sessions did you attend?

Follow-up Sessions: (If applicable)

41. If follow-up sessions were agreed to, were you able to attend these.

scale: yes
unsure
no

42. If no, what were the difficulties which prevented your attending? (Open ended)

time constraints
financial constraints
problem resolved
counselling a waste of time/unhelpful
counsellor too intrusive
spouse not in favour
Parent Centre's hours of operation
transport difficulties

Referral Out:

41. If on termination of counselling you were referred elsewhere, to whom was this referral made?

psychologist
psychiatrist
Child and Family Unit
family therapy
adolescent unit
school clinic
a group
other

42. Was this an appropriate referral?

- in terms of to whom referred
- in terms of timing?

Concluding Questions:

43. Would you agree or disagree with the statement: `Overall contact with the Parent Centre was helpful.'
scale: strongly agree
agree
unsure
disagree
strongly disagree

44. Would you agree or disagree with the statement: `My expectations were met.'
scale: strongly agree
agree
unsure
disagree
strongly disagree

45. Would you agree or disagree with the statement: `I was able to make changes in my situation.'
scale: strongly agree
agree
unsure
disagree
strongly disagree

46. Would you refer a family member/friend to the Parent Centre? Would you come again yourself?

scale: yes
unsure
no

47. Would you agree or disagree with the following statement: `Counselling at the Parent Centre is effective.'?

scale: very effective
effective
unsure
ineffective
very ineffective

48. Are there any changes which could be implemented which would enhance the effectiveness of the service?

49. How has it been for you to participate in this survey?

opportunity to give something back
opportunity to express satisfaction/
dissatisfaction
other

APPENDIX B

THE DATA CAPTURE SCHEDULE

SECTION A:

a1 client's random number

a2 geographic area

a3.1 Counsellor's view of presenting problem:
3.2
3.3

1. parent/s out of control i.t.o. discipline
2. adolescent acting out
3. discipline
4. adjustment to parenthood
5. communication 1. with child/ren
   2. with spouse
6. PND
7. self-esteem - 1. in child
   2. in parent
8. information
9. divorce issues
10. single parent issues
11. parenting skills
12. support
13. truanting
14. parent out of control i.t.o. potential abuse
15. adjustment to loss
16. difficulties at school
17. social isolation
18. financial problems
19. child left home
20. step-parenting issues
21. stress - 1. in parent
    2. in child
22. physical disability

a4.1 Age of client
a4.2 of partner

a5 Marital status m = married
s = single
d = divorced
w = widowed
rem = remarried
coh = cohabiting

a6 Number and ages of children:
a6.1 = 0 - 4
a6.2 = 5 - 12
a6.3 = 13 - 18
a6.4 = 19 - 21
a6.5 = 22+

a7.1 Occupation of client
a7.2 of partner
1 = skilled
2 = clerical
3 = worker
4 = professional
5 = semiskilled
6 = housewife
7 = disabled

a8 Income bracket 1 < R600
2 = R600 - R1000
3 = R1001 - R2000
4 = R2001 - R3000
5 = R3001 - R5000
6 > R5000

a9.1 Educational level of father
a9.2 of mother

a10 Number of sessions

a11 1 = mother
2 = father
3 = both parents

SECTION B:

b1.1}
1.2} same categories as a3
1.3}
1.4}

b2.1 yes/no
2.2
1 = doctor
2 = psychologist/psychiatrist
3 = hospital
4 = person of religion
5 = school
6 = social worker
7 = Famsa
8 = Lifeline

b3.1 media
1 = newspaper
2 = radio
3 = magazine

b3.2 network
1 = family member
2 = friend
3 = employer

b3.3 formal referral
1 = doctor
2 = social worker
3 = person of religion
4 = teacher
5 = psychologist
6 = nursing sister at work
7 = clinic
8 = Red Cross Child Information Service
9 = Lifeline
10 = attorney

b4
1 = argument with child
2 = argument with spouse
3 = losing control
4 = a build up of circumstances
5 = needing information
6 = teacher's recommendation
7 = clinic's recommendation

b5 1 - 4

b6 1 - 3

b7 yes/no

b8 1 - 5

b9 1 - 3

b10 1 - 5

b11
1 = warm
2 = immediately recommended counselling
3 = listened helpfully
4 = linked with appropriate counsellor
5 = containing
6 = didn't tune in to stress
7 = unhelpful because not experienced with teenagers
8 = unhelpful because wanted information on courses

b12 1 - 5

b13 1 - 5

b14.1
14.2
14.3
1 = be given advice
2 = be given information
3 = be given support in my role as parent
4 = to change the situation with my child/ren
5 = to gain parenting skills
6 = to change self
7 = therapy - more depth
8 = get rid of anxiety

b15 1 - 5

b16
1 = couldn't change situation with child
2 = she tried everything
3 = continued counselling/ greater depth
4 = listened
5 = skills
6 = seen the child/ren
7 = facts
8 = spouse to have come

b17.1
17.2
17.3
1 = support
2 = focused on needs of parent
3 = time to be heard/empathy
4 = spoke to child
5 = skills
6 = gave information
7 = own experience of PND
8 = reading material
9 = got to underlying problem - insight
10 = appropriate referral
11 = facilitated communication between parents
12 = hope

b18 1 - 5

b19 1 - 5

b20 1 - 5

b21 1 - 5

b22 1 - 5

b23 1 - 5

b24 1 - 5

b25 1 - 5

b26 1 - 5

b27 1 - 5

b28 1 - 5

b29.1 1 - 3

29.2 1 = identification
2 = normalised the situation
3 = suggestions given, based on experience
4 = unhelpful

b30 1 - 5

b31.1 1 = try to communicate better
31.2 2 = more insight re the child's situation
31.3 3 = empowerment of parent/skills
4 = changed relationship with child
5 = child has changed behaviour/attitude
6 = anti-depressants
7 = changed self-perception
8 = gained hope
9 = changed my attitude
10 = referred to group
11 = referred to doctor

b32.1 1 - 3

b32.2.1 1 = information
32.2.2 2 = insight
32.2.3 3 = support of self as parent
4 = acceptance/non-judgement of counsellor
5 = place to be heard
6 = skills
7 = supportive - joint interview
8 = reading material
9 = normalised the situation
10 = they cared

b32.3 1 = children's development
2 = more support from others
3 = no. 3
4 = therapy
5 = teacher helpful
6 = self empowered to change
7 = referral
8 = minister

b33
1 = I don't know
2 = she did all she could
3 = continued counselling
4 = therapy/going deeper
5 = session with child
6 = better follow-up
7 = referral to psychologist
8 = against values
9 = session with spouse

b34 y/n/c c = yes problem continues but has improved

b35 1 - 5

b36.1 1 - 3

b36.2.1
1 = affirmation of child
2 = expression of love
3 = consequences not smacks
4 = contact child (away from home)
5 = reading material
6 = communication (listening)
7 = quality time
8 = setting limits
9 = giving choices
10 = eye contact
11 = respect struggle
12 = consult specialists
13 = medication
14 = respect self
15 = father to have access
16 = back off
17 = rewards

b37 1 - 5

b38 1 - 5

b39.1 1 - 3

39.2 no. of sessions

b40.1 0 = ongoing
m = many
40.2 session with child
40.3 session with ex-spouse

b41.a 1 - 3

b42.a.1 1 = time constraints
2 = financial constraints
3 = problem resolved
4 = counselling a waste of time/unhelpful
5 = counsellor too intrusive
6 = spouse not in favour
7 = Parent Centre's hours of operation
8 = transport difficulties
9 = family member ill
10 = dates confusion
11 = did courses
12 = no child cure
13 = no follow-up appointment made

b41.b 1 = psychologist
2 = psychiatrist
3 = Child and Family Unit
4 = family therapy
5 = adolescent unit
6 = school clinic
7 = a group
8 = a course
9 = Famsa
10 = specialist doctor
11 = drug counselling centre
12 = legal aid

b42b.1 y/n
b42b.2 y/n

b43 1 - 5

b44 1 - 5

b45 1 - 5

b46.1 y/n
b46.2 y/n

b47 1 - 5

b48.1 1 = home visits
b48.2 2 = hours of operation
b48.3 3 = child care facilities
4 = support groups late afternoon or evening
5 = classes or lectures
6 = service already helpful
7 = continued counselling
8 = follow-up phone call
9 = greater depth
10 = don't blame
11 = needed immediate appointment/crisis facility
12 = financial information embarrassing
13 = see the child/ren
14 = Centres to have greater contact and co-ordination
15 = appropriate referrals or containment
16 = foyer imposing
17 = facts/ statistics
18 = longer sessions
19 = more co-ordination with other organisations to avoid duplication
20 = screening of clients (e.g. for crisis)

49.1 1 = nice/enjoyed
49.2 2 = comfortable
49.3 3 = glad to help
4 = would like to get involved at the Parent Centre
5 = didn't understand purpose initially
6 = exciting
7 = reconnected with intention to return for counselling
8 = important - good for accountability
9 = o.k./alright
10 = opportunity to express dissatisfaction
11 = difficult because stirred up feelings
12 = opportunity to express satisfaction

APPENDIX C

TABLES OF RESULTS

Questions in Section A of the interview schedule (Appendix A) are referred to as Qa1, Qa2, etc. Questions in Section B of the interview schedule are referred to as Q1, Q2, etc.

Table 1 - Qa2 : Client's Geographic Area

Area	Frequency	%
Southern Suburbs	21	41
Cape Flats	12	23
City Bowl	8	16
Southern Seaboard	5	10
Northern Seaboard	1	2
Northern Suburbs	1	2
Total	51	

Table 2 - Racial Classification - based on assumptions regarding geographic area

Classification	Frequency	%
White area	32	63
Coloured area	14	27
Black African area	5	10
Total	**51**	**100**

Table 3 - Qa6 : Age of Client

Category	Frequency	%
21-25	2	3.9
26-30	8	15.7
31-35	10	19.6
36-40	12	23.5
41-45	10	19.6
46-50	2	3.9
51-55	6	11.8
Missing	1	2.0
Total	**51**	**100.0**

Table 4 -Qa5 : Client's Marital Status

Marital Status	Frequency	%
Married	23	46
Separated	2	4
Widowed	3	6
Divorced	10	20
Single	6	12
Remarried	5	10
Cohabiting	1	2
Divorced/cohabiting	1	2
Total	**51**	**100**

Table 5 - Qa8 : Ages of Children

Age Group in Years	Number of Children	%	Index Child	%
0-4	29	29	13	25.5
5-12	34	34	22	43.1
13-18	20	20	11	21.6
19-21	8	8	3	5.9
>22	9	9	2	3.9
Total	**100**	**100**	**51**	**100.0**

Table 6 - Qa8 : Number of Children per Family

Number per Family	Frequency	%
1	17	33.3
2	23	45.1
3	9	17.6
4	1	2.0
5	1	2.0
Total	**51**	**100.0**

Table 7 - Qa9 : Educational levels of parents

Schooling	Father	Mother	Total	%
< std 8	1	8	9	9
stds 8/9	3	4	7	7
std 10	9	10	19	19
> std 10	19	23	42	42
Missing	17	6	23	23
Total	**49**	**51**	**100**	**100**

Table 8 - Qa7 : Occupational groupings

Occupation	Client	Partner	Total	%
Skilled	6	19	25	24.5
Clerical	8	2	10	9.8
Worker	6	1	7	6.9
Professional	15	16	31	30.4
Semi-skilled	2	1	3	2.9
Housewife	14	0	14	13.7
Disabled	0	1	1	1.0
Missing	0	11*	11	10.8
Total	**51**	**51**	**102**	**100.0**

* It is assumed that divorced, widowed, etc. clients gave information regarding their previous marital status, resulting in this low number of missing values

Table 9 - Qa7 : Partners of "Housewife" Clients

Occupation	Partners
Skilled	6
Clerical	0
Worker	0
Professional	6
Semi-skilled	1
Housewife	0
Disabled	0
Missing	1
Total	**14**

Table 10 - Qa7 : Partners of "Professional" Clients

Occupation	Partners
Skilled	4
Clerical	0
Worker	0
Professional	9
Semi-skilled	0
Housewife	0
Disabled	0
Missing	2
Total	**15**

Table 11 - Qa8 : Income distribution

Income in Rands per Month	Frequency	%	Cum %
<600	6	11.8	11.8
600-1000	10	19.6	31.4
1001-2000	7	13.7	45.1
2001-3000	5	9.8	54.9
3001-5000	6	11.8	66.7
>5000	13	25.5	92.2
Missing	4	7.8	100.0
Total	**51**	**100.0**	

Table 12 - Q1: Client-expressed problem or issue bringing them to Parent Centre

Presenting Problem	Frequ-ency	%	Cum %
Discipline issues	33	33.7	33.7
Divorce or step-parenting issues	13	13.3	46.9
Single parent issues	12	12.2	59.2
Communication and skills	11	11.2	70.4
Self-esteem issues	9	9.2	79.6
Information	7	7.1	86.7
Parent stress or possible loss of control	5	5.1	91.8
Support	4	4.1	95.9
Post-natal depression	3	3.1	99.0
Financial problems	1	1.0	100.0
Totals	**98**	**100.0**	

Table 13 - Qa3 : Counsellor's view of presenting problem

Presenting Problem	Frequ-ency	%	Cum %
Discipline issues	27	27.3	27.3
Communication and skills	19	19.2	46.5
Single parent issues	16	16.2	62.6
Divorce or step-parenting issues	16	16.2	78.8
Support	6	6.1	84.8
Self-esteem issues	5	5.1	89.9
Parent stress or possible loss of control	4	4.0	93.9
Post-natal depression	3	3.0	96.9
Information	2	2.0	99.0
Financial problems	1	1.0	100.0
Totals	**99**	**100.0**	

Table 14 - Comparison of client and counsellor views of the presenting problem

Presenting Problem	Client	Coun-sellor
Discipline issues	33	27
Divorce or step-parenting issues	13	16
Single parent issues	12	16
Communication and skills	11	19
Self-esteem issues	9	5
Information	7	2
Parent stress or possible loss of control	5	4
Support	4	6
Post-natal depression	3	3
Financial problems	1	1
Totals	**98**	**99**

Table 15 - Q2 : Sources from which help had previously been sought

Persons/agencies contacted	Frequency	%
Psychologist/psychiatrist	9	38
School	4	17
Other	3	13
Doctor	2	8
Person of religion	2	8
Famsa	2	8
Lifeline	1	4
Hospital	1	4
Total	**24**	**100**

Table 16 - Q3 : Sources of information about the Parent Centre

Media	Newspaper	3
	Radio	3
	Total	**6**
Network	Family member	5
	Friend	11
	Employer	4
	Total	**20**
Formal Referral	Teacher	7
	Social Worker	6
	Psychologist	4
	Clinic	4
	Doctor	2
	Nursing sister at work	2
	Other	3
	Total	**28**
Grand Total		**54**

Table 17 - Q4 : Circumstances Leading to Seeking Help

Circumstance	**Frequency**	**%**
A build-up of circumstances	26	51.0
Argument with child	7	13.7
Argument with spouse	5	9.8
Losing control	5	9.8
Teacher's recommendation	4	7.8
Other	2	3.9
No response to this question	2	3.9
Total	51	100.0

Table 18 - Q5 & Q6 : Cross-tabulation of desired and actual appointment time

	Weeks actually waited for appointment			
Desired appointment	One	Two	> Two	**Totals**
Same day	6	4	2	**12**
Same week	29	5	2	**36**
Within 2 weeks	1	2	0	**3**
Totals	**36**	**11**	**4**	51

Table 19 - Q5 & Q8 : Cross-tabulation satisfaction with appointment delay and desired wait

	Satisfaction with length of wait for actual appointment					
Desired wait	Very satisfied	Satisfied	Indifferent	Dissatisfied	Very dissatisfied	**Totals**
Same day	5	4	0	1	2	**12**
Same week	24	8	0	4	0	**36**
< Three weeks	3	0	0	0	0	**3**
Totals	**32**	**12**	**0**	**5**	**2**	51

Table 20 - Q9 & Q10 : Cross-tabulation of first contact person and satisfaction with contact

	Was first telephone contact helpful?					
First contact	**Strongly yes**	**Yes**	**Unsure**	**No**	**Strongly no**	**Totals**
Receptionist	30	12	2	1	0	45
Counsellor	3	0	1	1	0	5
Missing						1
Totals	33	12	3	2		51

Table 21 - Q11 : What was helpful in the first telephone contact?

Characteristic	Frequency	%
Warm	18	51.4
Containing	11	31.4
Listened helpfully	2	5.7
Other (unhelpful)	4	11.4
Total	35	100.0

Table 22 - Q12 : Satisfaction with hours of operation

Satisfaction rating	Frequency	%
Very satisfied	25	49
Satisfied	10	20
Indifferent	1	2
Dissatisfied	13	25
Very dissatisfied	2	4
Total	**51**	**100**

Table 23 - Q12 & Qa5 : Cross-tabulation of hours satisfaction with marital status

	Satisfaction with operating hours					
Marital status	Very satisfied	Satisfied	Indifferent	Dissatis-fied	Very dis-satisfied	**Totals**
Married	10	4	1	7	1	**23**
Separated	0	1	0	1	0	**2**
Widowed	1	0	0	2	0	**3**
Divorced	7	1	0	2	0	**10**
Single	3	2	0	0	1	**6**
Divorced-cohabit	0	1	0	0	0	**1**
Remarried	3	1	0	1	0	**5**
Cohabit	1	0	0	0	0	**1**
Totals	**25**	**10**	**1**	**13**	**2**	51

Table 24 - Q12 & Qa7 : Cross-tabulation of hours satisfaction with client occupation

	Satisfaction with operating hours					
Client occupation	Very satisfied	Satisfied	Indifferent	Dissatis-fied	Very dis-satisfied	**Totals**
Skilled	2	2	0	1	1	**6**
Clerical	3	0	1	4	0	**8**
Worker	3	1	0	2	0	**6**
Professional	6	4	0	4	1	**15**
Semi-skilled	1	1	0	0	0	**2**
Housewife	10	2	0	2	0	**14**
Total	**25**	**10**	**1**	**13**	**2**	51

Table 25 - Q13 : Satisfaction/dissatisfaction with the fee required

Satisfaction/dissatis-faction with fee	**Frequency**
Very satisfied	35
Satisfied	14
Indifferent	1
Dissatisfied	1
Very dissatisfied	0
Total	**51**

Table 26 - Q14 : Expectations on coming to the Parent Centre

Category	**Count**	**%**	**Cum. %**
To change the situation with my child/ren	32	33.0	33.0
To be given support in my role as parent	26	26.8	59.8
To be given advice	21	21.6	81.4
To be given information	9	9.3	90.7
To change self	3	3.1	93.8
Therapy, more depth	3	3.1	96.9
To gain parenting skills	2	2.1	99.0
To get rid of anxiety	1	1.0	100.0
Totals	**97**	**100.0**	

Table 27 - Qa10 : The number of counselling sessions

Number of sessions	Count	Cumul. Count	Percent	Cumul. Percent
1	29	29	56.9	56.9
2	13	42	25.5	82.4
3	5	47	9.8	92.2
4	1	48	2.0	94.1
5	1	49	2.0	96.1
7	1	50	2.0	98.0
13	1	51	2.0	100.0
Missing	0	51	0.0	100.0

Table 28 - Q18, 19 & 20 : Acceptability of counsellor 'demographics'

Rating	Age	Sex	Race/ Language
Very comfortable	42	44	45
Comfortable	9	4	4
Indifferent	0	2	2
Uncomfortable	0	1	0
Very uncomfortable	0	0	0
Totals	**51**	**51**	**51**

Table 29 - Q26 : Feelings of safety with respect to the general atmosphere of the Parent Centre and with the counsellor

Level of safety	Frequency	%
Strongly agree	38	75
Agree	11	22
Unsure	1*	2
Disagree	1*	2
Strongly disagree	0	0
Total	**51**	**100**

* Respondents who answered 'no' to their expectations being met.

Table 30 - Q27 : Comfort in sharing with counsellor

Rating	Frequency	%
Very comfortable	39	76
Comfortable	8	16
Unsure	4	8
Uncomfortable	0	0
Very uncomfortable	0	0
Total	**51**	**100**

Table 31 - Q28 : Satisfaction that counsellor understood problem

Rating	Frequency	%
Very satisfied	34	67
Satisfied	11	22
Unsure	4	8
Dissatisfied	2*	4
Very dissatisfied	0	0
Total	**51**	**100**

* Both said 'no' to expectations being met.

Table 32 - Q15 & Q28 : Cross-tabulation of feeling understood with expectations met

Expecta-	Did you feel your problem was understood?				
tions met?	Very much	Yes	Unsure	No	**Totals**
Very much	17	3	0	0	**20**
Yes	10	5	1	0	**16**
Unsure	1	2	3	0	**6**
No	6	1	0	2	**9**
Totals	**34**	**11**	**4**	**2**	51

Table 33 - Q15 & Q29 : Cross-tabulations of counsellor sharing and expectations being met

Observed frequencies			
	Counsellor shared?		
Expectations met?	Yes	No	**Totals**
Yes	23	9	**32**
Unsure/No	4	9	**13**
Totals	**27**	**18**	45
Expected frequencies			
	Counsellor shared?		
Expectations met?	Yes	No	**Totals**
Yes	19.20000	12.80000	32.00000
Unsure/No	7.80000	5.20000	13.00000
Totals	27.00000	18.00000	45.00000

Table 34 - Q31 : Changes experienced in the problem areas

Nature of change	**Count**	**%**	**Cum %**
Empowerment of parent	25	28.1	28.1
More insight re the child's situation	17	19.1	47.2
Child has changed behaviour/attitude	13	14.6	61.8
Communicate better	10	11.2	73.0
Changed relationship with child	8	9.0	82.0
Changed my attitude	8	9.0	91.0
Other	8	9.0	100.0
Total	**89**	**100.0**	

Table 35 - Q 32 : Attributed reasons for change where change was not seen to result from counselling

Attributed cause of change	**Count**
Self-empowered to change	4
More support from others	2
Therapy	2
Other	2
Total	**10**

Table 36 - Q33 : What might have been more helpful, given the feeling that the problem was inadequately addressed?

Suggestion	Count	%	Cum %
Continued counselling	7	33.3	33.3
Counsellor did all she could	4	19.0	52.4
Session with the child	3	14.3	66.7
Therapy/going deeper	2	9.5	76.2
Other	5	23.8	100.0
Totals	**21**	**100.0**	

Table 37 - Q15 & Q34 : Cross-tabulation of whether problem continues with whether expectations were met

Observed frequencies				
	Problem continues?			
Expectations met?	No	Yes but improved	Yes	**Totals**
Yes	20	10	6	36
Unsure/No	2	2	11	15
Totals	22	12	17	51
Expected frequencies				
	Problem continues?			
Expectations met?	No	Yes, but improved	Yes	**Totals**
Yes	15.52941	8.47059	12.00000	**36.0**
Unsure/No	6.47059	3.52941	5.00000	**15.0**
Totals	**22.00000**	**12.00000**	**17.00000**	51.0

Table 38 - Q35 : Agreement between client and counsellor as to problem

		Cumul.		Cumul.
Agreed?	**Count**	**Count**	**Percent**	**Percent**
Completely	27	27	52.9	52.9
Yes	18	45	35.3	88.2
Unsure	5	50	9.8	98.0
No	1	51	2.0	100.0
Completely no	0	51	0.0	100.0

Table 39 - Q37 : Was the ending of the session(s) appropriate?

Ending appropriate or not	Frequency	%	Cum %
Very appropriate	36	70.6	70.6
Appropriate	9	17.6	88.2
Unsure	4	7.8	96.1
Inappropriate	2	3.9	100.0
Very inappropriate	0	0	
Totals	**51**	**100.0**	

Table 40 - Q38 : Enough time to communicate difficulty?

Enough time	Frequency	%
Definitely enough	28	55
Enough	12	24
Unsure	4	8
Not enough	5	10
Definitely not enough	2	4
Totals	**51**	**100**

Table 41 - Q42 : Reasons for failing to attend agreed follow-up sessions

Problem resolved	3
Family member ill	3
PC's hours of operation	2
Counselling unhelpful	2
Financial constraints	1
Transport difficulties	1
Dates confusion	1
Did parent course	1
No child care	1
No follow-up time made	1
Total	**16**

Table 42 - Q41 : People and places to which clients were referred

Referred to	Count
Specialist doctor	4
Psychologist	3
Psychiatrist	1
Child and Family Unit	1
Adolescent unit	1
A group	1
A course	1
Famsa	1
Drug Counselling Centre	1
Legal Aid	1
Total	**15**

Table 43 - Q48 : Suggestions to improve the effectiveness of the counselling service

Suggestion	Count
Service already helpful	14
Hours of operation	8
Crisis facility	6
Follow-up phone call	5
Continued counselling	4
To have seen the child(ren)	4
Other*	20
Total	**61**

*Fourteen categories none of which had more than 2 counts

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