

**ADOLESCENT SUICIDAL BEHAVIOUR IN THE 'LOSTCITY' :
THE EXPERIENCES OF MENTAL HEALTH WORKERS**

MERRAN WELSH

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

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ABSTRACT

This study examines the high levels of anxiety and stress of mental health workers when dealing with cases involving adolescent suicidal behaviour. Mental health workers including nursing sisters, social workers and paraprofessionals were interviewed. Initially an unstructured interview schedule was used to explore the nature of adolescent suicidal behaviour in the course of their work. A semi-structured interview schedule, using focus groups was utilised to elicit the experiences and reactions of mental health workers to adolescent suicidal behaviour. A year after the initial interviews a few respondents were interviewed using a semi-structured interview schedule. The aim was to evaluate the effects of the research intervention. A thematic analysis highlights factors which disorganise the work of mental health professionals and paraprofessionals and contribute to their high levels of anxiety and stress. Results are discussed and recommendations are made regarding processes and structures which could provide containment for mental health workers in their work settings. Particular attention is paid to the role of group psychodynamic consultation as a way of relieving worker stress and anxiety.

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CHAPTER ONE: INTRODUCTION

1.1. INTRODUCTION

This study deals with aspects of the experiences of mental health workers in Atlantis, a dormitory town 43 km from Cape Town. I am particularly interested in the factors that disorganise these workers and contribute to their high levels of stress and anxiety. Adolescent suicidal behaviour is used as an clinical example to explore these issues. I will focus on the nature of this phenomenon and consider the issues it raises for mental health care-givers.

The preliminary findings of the World Health Organisation (WHO) across 39 countries suggest that there is an increase in suicidal behaviour among the adolescent and young adult populations (World Health statistics annual 1987, 1988, 1989). In North America and Europe suicide is the third leading cause of death in the 15-19 year old age group, exceeded only by homicide and accidents (Holinger, 1978; McClure, 1986). Studies show that prevalence rates for adolescent suicidal behaviour are higher than lifetime rates for the general population (Diekstra, 1993). One explanation for this is the earlier age of 'first-time' suicidal behaviour. There is ample evidence to suggest that suicidal behaviour amongst adolescents and young adults is a growing public health problem which needs a comprehensive response. In the absence of accessible and adequate mental health care facilities, mental health professionals cannot handle the case-load alone and rely on assistance from paraprofessionals from all sectors, who are in contact with adolescents.

Durlak (1979) defines 'professionals' in the mental health context as persons who have received academic clinical training in one of the core "psy" disciplines (psychology, psychiatry, psychiatric nursing and social work). Durlak distinguishes 'professionals' from 'paraprofessionals' who work as counsellors but have not received formal clinical training. In Atlantis, this includes teachers, church workers, development workers, school nurses, and police personnel. In many cases, particularly in rural areas where

there are few mental health professionals, paraprofessionals are already involved in the management of psychosocial emergencies like adolescent suicidal behaviour. With varying levels of knowledge and expertise, these mental health workers feel ill-equipped to handle cases which are often complex and stressful. I will discuss the potential of the psychodynamic consultation method as a way of countering the difficulties of mental health workers.

A 'consultative' way of working is essentially about consultants, in this case psychologists, sharing ways of understanding and responding to problems with others i.e. consultees (Orford, 1992). The objective is to increase the effectiveness of the consultees' work with clients without the consultant taking over responsibility for the work (Steinberg, 1989).

Although much has been written about the nature of consultation (Caplan, 1970; Caplan & Caplan, 1993; Gallessich, 1982; Steinberg, 1989; Steinberg & Yule, 1985), it has been criticised for making little progress at a theoretical level (Gallessich, 1982).

This dissertation attempts to move beyond the parameters of defining consultation at the level of 'what it is and what it isn't' (to quote Orford, 1992). It will examine the use of a psychodynamically orientated approach to consultancy work, a relatively new area, to understand and counter the disorganising effects of stress and anxiety which impede the work of mental health workers in Atlantis.

1.2. BACKGROUND TO THE RESEARCH

1.2.1. The Mamre Community Health Project

This research grew out of an internship placement in Mamre. Mamre is a village of approximately 5 000 inhabitants situated along the west coast about 48 km north of Cape Town (see regional map, Appendix A). Originally established as a Moravian mission station in 1808, its rural isolation has diminished as increasing number of its

residents seek work both in Cape Town and the nearby peri-industrial centre Atlantis (Lazarus, 1994). Atlantis is a 20 year old dormitory town, about 5 km from Mamre, with a population of 68064 in 1992 (FCR, 1992). A more detailed description of Atlantis will follow in the next section.

The Mamre Community Health Project (MCHP) is a non-governmental organisation set up by the University of Cape Town (UCT) Medical School and the Medical Research Council (MRC). The aim of the project is to improve the health status of Mamre residents (Klopper & Tibbit, 1988). Staff of the University of Cape Town Psychology Department became involved in the delivery of clinical services at MCHP in 1991. Clinical psychology interns have been placed at MCHP since 1992.

Although the psychologist and interns accept a limited amount of referrals for assessment and counselling, their work mainly involves mediated interventions i.e. providing consultation and training services for community health workers, youth leaders and professionals (e.g. social workers, community nurses, teachers and ministers). Often these requests from health or other care personnel for consultation and training are concerned with aspects of their work (e.g. such as cases of sexual abuse, or regarding emotional and family problems which emerge in their work with patients). Usually training takes the form of a one-day workshop, or series of weekly sessions, where a wide range of potential consultees are invited to participate. Topics requested cover a wide range of areas including sexual abuse, substance abuse, parenting skills, basic counselling skills, and crisis counselling.

Initially the consultancy services of the psychologist and interns were confined only to Mamre because of limited professional capacity and resources. However between the second half of 1993 and the beginning of 1994, social workers and school nurses in Atlantis, on hearing that there was a psychologist in Mamre, wanted to refer clients for assessments and counselling. The initial policy of working only with Mamre organisations was consequently re-evaluated. While it was impossible for the psychologist and intern to become involved in direct service provision with Atlantis clients, consultation on a limited basis was made available to health professionals and

paraprofessionals working in Atlantis (Holdsworth, 1994). Initially social workers and professional nurses took up the offer of case consultation on an ad hoc basis.

At the same time a wide range of potential consultees were invited to attend training workshops in Atlantis, run by the psychologist and interns. The aim of the workshops was partly to educate potential consultees about the consultation method, as well as to share psychological knowledge and skills with personnel in Atlantis.

1.2.2. Motivation for the Research

Initially the motivation for this study was to continue research done by a previous intern. Richardson (1994) conducted a needs assessment amongst youth in Atlantis. One of the problems identified by respondents was that many youth were depressed and had thoughts of suicide. Atlantis offers no formal counselling facility which caters for the community's needs (Richardson, 1994). Once I started working at the MCHP as an intern at the beginning of 1994, the research focus began to shift. This was influenced by my clinical work which involved providing consultation to health workers in Atlantis.

At this stage, one of the professional nurses requested a standing arrangement for regular consultation and training. Consultancy consisted of weekly one hour sessions where the consultee discussed difficult cases. Furthermore we arranged that for a limited period I would participate in joint assessments with the consultee at her high-school-based adolescent clinic. The aim was to model counselling and assessment micro-skills for the consultee. In March 1994, a similar contract was negotiated with a community health worker, who runs an adolescent clinic attached to the local day hospital.

In the course of consultation with the two consultees, and supportive contact with social workers in the area, it became clear that they saw a large number of cases of adolescent depression and suicidal behaviour (Sterling, 1994). Some of the social workers were prepared to see such cases but were overloaded, while others felt

insufficiently trained to deal with youth-related problems. The school nurses and guidance teachers who worked specifically with youth felt that they did not have the time to counsel youths, or felt that they lacked the clinical skills to assess risk when suicidal ideation was mentioned. Up to the present, once a suicide attempt has been made, it is referred to the local day hospital, and treated as a medical emergency. In many cases health workers want to make referrals to me or the psychologist at MCHP, as we are perceived as the natural referral for 'specialist' psychological problems like suicide.

I realised that cases involving talk of suicide were representative of a category of difficult and emotionally draining cases which health workers respond to in the course of their work. Cases in the same category include child sexual and physical abuse, child neglect, rape, and teenage pregnancy. But what is interesting about suicidal behaviour is the issues it raises for the helping relationship. The act or the threat of suicide takes to an extreme rejection of help. It therefore contravenes the core values of the helping profession. As Littlewood & Lipsedge (1987) point out this is bound to raise unease and possibly anger in helpers as it "reflect[s] [a] 'perverse' transformation of the clinical paradigm" (p.302).

The psychoanalytic literature offers an interesting formulation of suicidal behaviour. It reflects the theme of 'lostness' which will be developed in this thesis. Sinason (1992) views suicide as an attempt to gain control of a situation where abandonment is imminent. She argues that by committing suicide the patient is ensuring that they abandon the care-giver before the care-giver abandons the patient.

I began to observe the uneasy reactions of consultees when suicidal behaviour was mentioned. In some instances, consultees became shut off from their feelings and adopted an advice giving style. Others expressed feelings of inadequacy, fear, anger and frustration when dealing with such cases. I felt that rather than addressing the problem of suicidal behaviour in isolation it would be more creative to focus on the issues it raised for community health workers in their role as helpers. The idea is that

gaining a deeper understanding of their experiences is the first step to assisting community health workers become more effective in their work.

The first step in the process was to open up the issue amongst community health workers in Atlantis. An initial discussion was held in Atlantis on 17 March 1994 with a small group. The objective was to identify common areas of difficulty in dealing with adolescent depression and suicidal behaviour and to discuss a plan of action. The group agreed that training was a priority for health workers. We agreed that the psychologist and intern would run a one day workshop on adolescent depression and suicidal behaviour. Invitations (see Appendix B) were extended to all professionals and paraprofessionals in Atlantis and Mamre who were known to have counselling skills and were in contact with youth. A small working group was elected to assist with workshop preparations.

In addition, I approached the local day hospital, Wesfleur, and obtained permission to study the register at the casualty unit. The aim was to gather base-line data on adolescent suicide as no figures for the area are available. The findings will be dealt with in a later study.

At this stage of gathering information, planning for the counselling workshop, and consulting with a wide spectrum of community health workers and other care personnel, I felt it could be useful to document the process. I approached the local transitional structure, the Atlantis Development Forum (ADF) (more details in the next section), with a research proposal.

A consultative meeting was held with the Social Fabric Commission, a subgroup of the ADF, on 18 April 1994 to discuss this research proposal. The committee members responded positively to the proposal seeing it as an extension of the youth study done by the previous intern psychologist. The proposal was accepted which paved the way for this study.

1.3. STRUCTURE OF THE DISSERTATION

Chapter one (the current chapter) outlines the background and motivation of the study. Chapter two comprises a literature review which aims to provide contextual information and to introduce factors which contribute to mental health workers' high stress and anxiety levels. Psychodynamic consultation is put forward as a way to address the anxiety and stress of mental health workers. Chapter three outlines the method of study. Chapter four presents an analysis of the results. Chapter five consists of a discussion of the results, recommendations, and a conclusion to the study.

CHAPTER TWO: LITERATURE REVIEW

2.1. INTRODUCTION

The literature review describes the socio-economic crisis in Atlantis and the consequent psychological impact on families in the community. It argues that this has led to increased demands on social and health services in the area. Furthermore, this need has produced high levels of stress and anxiety for mental health professionals and paraprofessionals. Specific areas of difficulty in clinical practice experienced by professionals and paraprofessionals are discussed. Adolescent suicidal behaviour is used as an example to explore these issues. Finally, psychodynamic consultation is put forward as a way to address the anxiety and stress of health workers.

2.2. THE SOCIAL CONTEXT OF ATLANTIS

One of the best ways to introduce the social context of Atlantis is to divulge its local nickname. Residents commonly refer to Atlantis as 'the lost city'. In part, this nickname refers to the Greek legend about an island in the ocean between the Pillars of Hercules. This island was prosperous and fertile but was overwhelmed by the sea because of the impiety of its inhabitants (New Oxford Illustrated Dictionary, 1976). Residents explain that in the same way that the ancient city was drowned by the sea and later forgotten, so too is Atlantis seen as abandoned by the authorities, overwhelmed by socio-economic threats and forgotten by city-dwellers and planners.

It could be said that the legend speaks about the relationship between the apartheid system and Atlantis. Apartheid policies, developed by the Nationalist ruling party in the 1950s, justified the political, economic, social, cultural, and sexual segregation of South Africans on the basis of a politically constructed race classification system (Sharp, 1988). The legislation could not define a coloured category, other than in the negative i.e. a person who is neither white nor black (West, 1988). However being coloured

under this system meant being politically, economically, socially, and geographically segregated from both the privileged white minority, and also from the oppressed black majority.

Atlantis was established in the 1970s as part of the government's apartheid policy of moving coloured people out of the Cape Town metropole into a dormitory town (Katzenellenbogen *et al.*, 1988). The policy of separate development was ruthlessly applied to many coloured and black neighbourhoods. Many of the coloured people who were forcibly removed to Atlantis originally came from a well-known, vibrant, and ethnically diverse neighbourhood called District Six, which bordered on the Cape Town city centre. The effect of these forced removals was traumatic. Extended family networks disintegrated, social organisations were disconnected, neighbourhoods were disorganised, and the local economy was destroyed (Van der Ross, 1979). Twenty years later, people are still struggling to recover from the economic and emotional aftermath of the forced removal policies and the damaging effects are being felt by the next generation. Pinnock describes the long term effects of forced removal policies as:

like a man with a stick breaking spiderwebs in the forest. The spider may survive the fall, but he can't survive without his web. When he comes to build it again, he finds the anchors are gone, and people are spread all over and the fabric of generations is lost.

(Pinnock, 1984, cited in Thornton & Ramphele, 1988)

The effects of the forced removal policies on the next generation emerge in Richardson's study (1994). Adolescent respondents articulate complex and ambivalent feelings towards the 'lost city' which they feel is forgotten, misunderstood, neglected and in some cases ridiculed. Some youths wanted to leave as soon as possible realising that future opportunities are very limited in Atlantis. Others felt a need to protect Atlantis against the perceptions of outsiders who spoke about Atlantis as dangerous, backward, or boring (Richardson, 1994). It is as if, in the Bulhanian (1979) or Fanonian (1968) sense, residents have internalised the contaminating effects of shame and stigma associated with the apartheid system.

Another major setback for Atlantis was the effect of the mid- 1980s national recession, coupled with the loss of commitment to an industrial decentralisation policy, which had

become politically and economically too costly for the government. Many of the industries withdrew from the area, leaving the Atlantis economy in a precarious position. For example, of the 127 firms in Atlantis in 1990, only 106 remained in 1992. As a result of this, 20 00 jobs were lost in the industrial sector between 1990 and 1992 (FCR, 1992). The rate of unemployment by 1992 was approximately 46% (FCR, 1993b).

By way of response to the economic crisis, key stakeholders in the town formed the Atlantis Development Forum (ADF) in December 1991. This initiative began with ADF commissioning the Foundation of Contemporary Research (FCR) to assess the social consequences of the economic turbulence on Atlantis (1992). Some of the problems identified were wide-spread unemployment, high levels of domestic violence, overcrowded living conditions, gangsterism and substance abuse. There was also a sense of moral decay and community apathy. Youth-related problems included: Lack of recreational facilities, the high school drop-out rate, sexual abuse and a high rate of teenage pregnancy. Other problems identified were a lack of identity and a sense of isolation. In families, there was seen to be a lack of support, communication and guidance from parents (Richardson, 1994).

It is interesting to note that the parents of teenagers represent the generation who experienced the traumatic effects of forced migration twenty years ago. Most of the health workers also belong to this generation. It is this very generation that went without the extended family networks when their children were small and dependent. This may have left them feeling overwhelmed and isolated from support while they were establishing families in Atlantis. For the purpose of this study it is interesting to note that the parental generation has created a number of responses to its experience of forced migration. Some have become involved in trying to deal with troubled adolescents. Perhaps the health workers' involvement with troubled adolescents through counselling is in part a way of compensating for the fact that their own generation was unavailable for these teenagers as young children.

I would argue that the history of forced removals with its damaging effects on the parental generation, coupled with the more recent threats to their social and economic survival, has produced a sense of isolation and anomie amongst residents. This sense of anomie is reflected in the generation of teenagers who are troubled; articulate a diffuse sense of identity, and are asking for help in their plea for a counselling facility (see Background section). Furthermore, the community health workers, under increasing pressure to respond to these needs, are part of the parental generation affected by forced migration. They are also possibly struggling against the same social processes and sense of dislocation and anomie. A closer examination of the concept of anomie and its effects on individuals will follow in the next section.

2.3. DURKHEIM'S CONCEPT OF 'ANOMIE'

The concept of anomie was developed by the sociologist, Emile Durkheim, in the late 1800s. He saw it as a factor in the increase of suicide in Europe. According to Durkheim (1950) social norms are largely responsible for shaping individual motivation, behaviour and action. Giddens (1971) explains how this happens:

[social norms] influence the actual setting of goals, defining what is appropriate and legitimate; but as Durkheim emphasized above all, they limit and restrict aspirations.
(Giddens, 1971, 99)

Furthermore, these social norms are sensitive to social or political upheaval. An economic boom or crisis can destroy or disorient social norms. Two possible scenarios follow from this formulation: One, where there is no ceiling to restrict aspirations. This would most likely be in the context of economic prosperity where opportunities abound. In such circumstances opportunity may be experienced as "both a privilege and a threat" (Rakoff, 1989, p.385) in the sense that opportunities produce pressure to compete, perform, and achieve. The other scenario is when aspirations are restricted by an economic depression. The effect on aspirations is that a gap develops between what individuals aspire to and what is practically attainable.

In both instances, a psychological state of anomie develops (Travis, 1990). Atlantis is a good example of the latter scenario.

The application of the Durkheimian model to the social context of Atlantis raises a number of issues. Firstly the complexities of the apartheid system need to be included into the formulation. Opportunities and aspirations have been available or denied to individuals in South Africa, largely on the basis of race. Secondly, and linked to this point, is the issue of how individuals perceive the contradictions about aspirations in South Africa, and what kind of framework they construct to account for their denied opportunities (see Halbwachs, 1978). For instance, residents in Atlantis may explain their 'lost' opportunities in terms of apartheid. This shows some awareness of their alienation i.e. as victims of an unjust system. In some cases awareness of alienation may lead to social activism which may act as a protective mechanism against the experience of isolation and dislocation. However in a more vulnerable individual, acute awareness of his/her alienation may be overwhelming. This predicament may lead to psychological problems (Rakoff, 1989).

The youth in Atlantis appear particularly vulnerable to the effects of anomie and apartheid. Issues about aspirations, opportunity, and identity are central to their talk about Atlantis as a 'lost city' (see Richardson, 1994). Part of the youth's pre-occupation with aspirations and identity is that these issues are linked to this developmental phase. This link will be made at a theoretical level in the section below.

2.4. ADOLESCENCE AS A CONCEPT

The concept of adolescence refers to a period of transition where a number of developmental tasks are confronted (Coleman & Hendry, 1990; Varenhorst, 1984).

Although the various classic theories have different interpretations of these tasks, there is general agreement that the tasks include the development of a personal identity (Hopkins, 1994). Both the psychoanalytic and psychosocial theories of identity development assume that adolescents experience uncertainty about their sense of self,

as they separate from their parents (Blos, 1967; Erikson, 1968; Kroger, 1989).

However this independence from the family provides opportunity for adolescents to explore interests and experiment with identities. Common examples of adolescent experimentation include the idolization of pop stars and famous characters, or the pre-occupation with religious and political groups (Kroger, 1989).

Implicit in the psychoanalytic texts (Blos, 1967) and the identity-focused texts (Erikson, 1968) is the assumption that the social context plays an instrumental role in supporting the adolescent who is busy negotiating the challenges of identity construction.

According to Blos:

No adolescent ... can develop optimally without societal structures standing by ready to receive him, offering him that authentic credibility with which he can identify or polarize ... the psychic structure of the individual is critically affected, for better or worse, by the structure of society ... the successful course of adolescence depends intrinsically on the degree of intactness and cohesion which societal institutions obtain.
(1971, p. 975, as cited in Kroger, 1989)

Revised theories of adolescence, go much further in analyzing the role of the socio-historical context in identity processes. Peer group membership is very influential in identity formation (Eiser & van der Pligt, 1984). Broader social processes of race, class and gender also contribute to the adolescent's self-concept (Hogg & Abrams, 1988; Tajfel, 1978; Turner, *et al.*, 1987).

Indicators of successful identity formation include: a capacity to bear a degree of anxiety and depression over a period of time (Blos, 1967); the development of a solid core and coherent role from which to engage with the world (Erikson, 1968); and a healthy capacity for adventure, risk taking, creative change and idealism (Rakoff, 1989).

Most writers agree that adolescence is a stressful period which produces uncertainty and anxiety and that some, particularly those who live in an emotionally unsupportive environment, struggle more than others to meet the challenges of the developmental tasks, (Blos, 1967; Erikson, 1968; Kroger, 1989; Rakoff, 1989).

Optimal support for the opportunities or aspirations of adolescents may not be feasible for a community like Atlantis, in the midst of social turbulence. Rakoff (1989) says that restrictions on, or lack of support for, opportunity and aspirations may leave adolescents "fragile, self-doubting, deprived, or in other ways vulnerable individuals, who left to their own resources, feel themselves unequal in opportunity and unable to cope" (p.385). Rakoff (1989) recognises the vulnerable adolescent in a propensity towards despair, depression, impulsivity and risk-taking behaviour (see Flisher *et al.*, 1993; Hopkins, 1994; Lee & Weinlander, 1976; Lester & Gatto, 1989; Williams *et al.*, 1977). In severe cases, this vulnerability may be reflected in what Rakoff (1989, 1994) refers to as "disorders of aspirations" (p.384). He argues that this heterogenous group of problems is bound by the theme of identity diffusion and includes adolescent suicidal behaviour, drug and alcohol abuse, traffic accidents, anorexia nervosa and cult experimentation. One example, adolescent suicidal behaviour, will be discussed below.

2.5. ADOLESCENT SUICIDAL BEHAVIOUR

2.5.1. Terminology

The terms 'suicidal', 'attempted suicide', 'parasuicide', 'suicidal behaviour' and 'deliberate self-injury' are used inconsistently in the literature. For the present study the term 'suicidal behaviour' is used as far as possible to refer to an episode of deliberate self-harm or a non-fatal suicide attempt which may be serious enough to warrant medical care (Diekstra, 1993). However, because national records on suicidal behaviour are not common or consistent, trends are gleaned from suicidal deaths as the latter is more likely to be documented (Diekstra, 1993). In Atlantis, neither rates of adolescent suicidal behaviour nor suicidal deaths have been documented.

2.5.2. Recent South African trends: adolescent suicidal behaviour

Recent work done by Flisher & Parry (1994) assesses the extent of suicide in South Africa between 1984-1986 using mortality rates. The mean annual suicide mortality rates per 100,000 of the population are outlined in table one below:

Table 1: Proportional mortality and mean annual mortality rates per 100,000 for suicide for each population group, gender and age group in South Africa, 1984-1986

Age Group (years)	Whites				Coloureds				Asians				Blacks	
	Men (n = 2184)		Women (n = 577)		Men (n = 2184)		Women (n = 577)		Men (n = 2184)		Women (n = 577)		Men (n = 2184)	Women (n = 2184)
	PM	MR	PM	MR	PM	MR	PM	MR	PM	MR	PM	MR	PM	PM
15-24	11.8	25.75	9.5	6.58	2.4	9.80	2.6	3.72	8.4	19.74	12.8	11.36	2.5	1.5
25-34	16.1	42.04	12.4	12.14	2.6	18.03	1.4	4.13	7.4	24.52	3.1	3.94	2.3	1.1
35-44	11.8	43.57	6.6	11.70	1.5	16.26	0.6	3.48	3.4	20.76	2.8	6.78	1.6	0.5
45-54	5.5	49.95	3.0	13.97	0.7	12.81	0.3	3.42	1.5	21.66	0.4	2.63	0.9	0.3
55-64	2.3	50.30	1.0	11.45	0.3	9.60	0.1	1.50	0.8	26.18	0.4	7.65	0.5	0.2
≥ 65	0.7	41.27	0.2	6.21	0.1	5.70	0.0	0.56	0.3	26.79	0.0	0.13	0.2	0.0
All Ages	3.5	39.93	1.1	10.10	1.0	13.08	0.4	3.38	2.2	21.11	1.1	6.65	1.1	0.3

PM = proportional mortality; MR = mortality rate; * mortality rates not valid for blacks.

Between 1984 and 1986, the suicide rate for coloured adolescents, aged 15-24 years was 9.80 per 1 00 000 for males, and 3.72 per 1 00 000 for females. This accounts for 1% of deaths amongst coloured males and 0.4% of deaths amongst coloured females in this age group. This is low in comparison with other population groups in South Africa, particularly whites where 10.7% of adolescent deaths in this population group are accounted for by suicide (Flisher, Joubert & Yach, 1992). This is in keeping with adolescent suicide rate in the United States and United Kingdom where 13% and 14% of all deaths, respectively were accounted for by suicide (Shaffer & Piacentini, 1985).

One explanation for the relatively low suicide trend amongst coloureds is the high rate of homicide as a cause of death for members of this population group (Flisher & Parry, 1994). This is consistent with previous findings (Lester, 1989). Writers explain the high rates of homicide in the context of a politically oppressive society where the oppressed individual displaces hostility to family and friends because the oppressor cannot be directly challenged (Bulhan, 1979; Fanon, 1968). Flisher & Parry (1994)

argue that aspects of this analysis would be relevant to South Africa and could explain the relatively high homicide rates for coloured South Africans.

Another aspect identified which could account for the relatively low suicide rates among coloured communities is religion. The argument is that belonging to a religion such as Islam or Christianity in which suicide is vehemently forbidden reduces the likelihood of engaging in suicidal behaviour. In terms of Atlantis, there is only one mosque with a membership of 200 (FCR,1992). However a large part of the community identifies itself with Christian churches (FCR, 1992). This will be discussed in a later section.

A striking finding in both the Flisher & Parry (1994) and Schlebush (1986) studies are the high rates, for Asian females in the 15-24 age group. Suicide accounts for more than 10% of all deaths in this age group. Restrictive parenting styles and lack of communication between parents and adolescents are discussed as contributory factors. Causal factors will be discussed in more detail in the section below.

Another recent study investigates suicidal behaviour amongst high school students in the local Cape Peninsula area (Flisher, Ziervogel, Chalton, Leger & Robertson, 1993). Findings suggest that 7.8% had made a suicide attempt during the past 12 months. Comparison is limited by the lack of similar local studies. However the researchers suggest that their findings are in keeping with international trends (Smith & Crawford, 1986). More females made an attempt than males, which the researchers argue is inconsistent with previous findings. This is attributed to the view that females are more reflective and less likely than males to direct aggression outwards.

In the next section I will discuss studies which stress the importance of socio economic, gender and cultural factors in the aetiology of adolescent suicidal behaviour.

2.5.3. Socio-economic change, stress, and suicidal behaviour

A number of studies in the international literature have investigated the relationship between changes in social, economic and community life, and the kind of stress, social upheaval, and sense of dislocation this produces for families and communities. Many of the international studies identify socio-economic upheaval as a factor in increases in suicidal behaviour (Blanchard, Blanchard & Roll, 1976; Catedra, 1992; Dizmang *et al.*, 1974; Grove & Lynge, 1979; McAnarney, 1979; Rao, 1975). I will highlight a few examples which are relevant to the context of Atlantis.

Blum *et al.* (1992) focus on American Indian-Alaskan youth living in a rural, isolated reservation in Alaska. Findings suggest that 17% of respondents had tried to put an end to their lives, which suggests that rates for American Indian youth are higher than all other race groups in the United States (US). This is consistent with previous findings that mortality amongst American Indian youth is twice the rate of that of teens from other US race groups (Indian Health Services, 1990). High rates of suicidal behaviour were attributed to a legacy of forced migration, economic crisis, poverty, social isolation and hopelessness.

Grove and Lynge (1979) investigated the marked increase in suicidal behaviour amongst the Eskimo youth in the township Nuuk in Greenland. Nuuks' original rural isolation has diminished with increasing urbanisation. This includes the rapid development of administrative and educational institutions producing an influx migrants into the area. The suicide rates are explained in the context of socio-economic changes taking place in the Nuuk community. Unlike the previous example which highlights economic crisis as the basis of distress, the Nuuk scenario highlights an economic boom, yet in Durkheimian terms the affects of dislocation and anomie are the same. Increased social opportunities and migration patterns have produced a sense of dislocation and anomie in individuals which manifests in disrupted family units, conflict between generations, and a rapid shift away from traditional values (i.e. hunting culture, extended family networks, Eskimo values). These factors are said to

explain the high rates of emotional distress, substance abuse, and suicidal behaviour amongst Eskimo youth.

There are many parallels between the social disruption that Grove & Lyng (1979) have described amongst the youth in the Nuuk community, and the Shoshonean youth in Idaho, as described by Dizmang *et al.* (1974).

The Shoshonean community has been subjected to forced migration over the past 75 years which has led to the break up of the extended family group. Ten completed suicides of young adults under the age of 25 are compared with a matched control group from the same community. The results suggest that the suicide group experienced more losses (loss of parent by desertion or divorce) during their early years than the control group. What is significant for the purpose of this study is the focus on the trauma experienced by the parental generation. Dizmang *et al.* (1974) describe parents' loss of family networks through forced migration and its consequences in terms of lack of support with child-rearing which had previously been available. They also highlight the effects of a changing economic structure on roles in the family; males felt frustrated and powerless. This leads to marital conflict, substance abuse, criminality, and domestic violence.

These formulations of dislocated communities resonate with the experiences of many oppressed South African families living under the apartheid system. A striking theme which emerges in the examples is the transfer of traumatic effects from one generation to another. What does not emerge clearly in the examples, is the role consciousness plays in motivating someone to commit suicide. For instance Blum *et al.* (1992) fail to make clear the Indian-Alaskan youths' awareness of their alienation, and how they construct their experience. In analysing the South African experience Swartz (1987) warns against portraying all oppressed South Africans as vulnerable or as 'at risk' to some form of mental disorder. One of the ways around falling into this trap follows from Swartz's (1987) suggestion that one considers how individuals, families, youths construct their experience of oppression, and to what extent the individual links his/her alienation to the social system.

In the next section I will discuss South African texts which demonstrate a relationship between social upheaval, increased stress in families and communities, leading to high rates of suicidal behaviour in some groups. All the research studies were conducted in Durban, the major city of Natal and examine the experience of the Indian population under a changing social and political system. Researchers highlight the context of apartheid to account for the suicide rate, to varying degrees (Cheetham *et al.*, 1983; Edwards *et al.*, 1981; Meer, 1976; Pillay & Schlebush, 1987).

Work done by South African sociologist, Fatima Meer (1976), has to a large extent provided a framework for the understanding of suicidal behaviour and its relationship with social conditions in South Africa. She argues in Durkheimian terms that deprived persons are likely to be under-integrated in the [now legacy of the] "racist organisation of South African society" (p. 227).

Her understanding of deprivation refers to both economic and emotional deprivation which provide an access point for her formulation of the relationship between poverty, powerlessness, dispossession, anomie, and high suicide rates.

More recent texts on Indian South Africans have attributed apparently high suicide rates among youth, to stress as a result of a shift from traditional Indian to western values. This process is referred to as 'acculturation' in the literature (Amod & Shmukler, 1986; Cheetham *et al.*, 1983; Edwards *et al.*, 1981; Wood & Wassenaar, 1989). Indicators of traditional Indian values in the sample were "their fathers were born in India, the fathers had fewer than eight years of education, grandparents played an important role in the family and either most or all of the religious laws and traditions were obeyed in the home" (Amod & Shmukler, 1986, p. 16).

In research conducted among a sample of Indian adolescents referred to one of the Durban hospitals after a suicide attempt, Pillay & Schlebush (1987) show how the cross-generational conflict manifests. They point out that Indian adolescents, especially females, are subject to strict discipline by parents; parents limit social activities with peers where there is no adult supervision and interfere with choices around

heterosexual relationships. Their adolescent sample reported feeling victimized and unfairly treated after a dispute, and resorted to suicidal behaviour as a means of communicating their distress. Similarly Schlebush's (1986) sample of suicidal adolescents reported that they struggled to resolve conflicts constructively with their parents, which left them feeling alienated and unsupported.

The application of an 'acculturation' model to the context of Atlantis is problematic because it ignores the impact of broader social processes in South Africa. The legacy of apartheid is not integrated into the analysis. Unlike Meer's (1976) text, the later work does not formulate the striking issue of powerlessness which emerges in the studies on Indian youths. In terms of Durkheim's formulation of aspirations, not only are the Indian youths' aspirations restricted by the expectations of their parents and traditional culture, but also restricted by the social system of apartheid. While the local studies provide useful information with regards to the rate of suicidal behaviour among South African adolescents, there is a need to begin to theorise contextual factors in order to deepen our understanding of the social and personal meaning of the behaviour.

In summary, there is ample evidence from international research to suggest that adolescent suicidal behaviour is a public health problem which needs a comprehensive response. Furthermore, adolescent suicidal behaviour must be understood in the context of living under the apartheid system. In the next section I will argue that the current health care services in Atlantis are strained, and struggling to cope with the increased demand for psychosocial interventions. Reasons for this will be examined in more detail in the section below.

2.6. FACTORS INFLUENCING THE CURRENT HEALTH CARE RESPONSE TO MENTAL HEALTH PROBLEMS

2.6.1. Lack of Primary Health Care Facilities in Community

South African mental health services are inadequate for the majority of its residents (Freeman, 1992; Seedat & Nell, 1992). Historically, there has been an unequal distribution of resources weighted towards a privileged minority. For example, 80% of the population is unable to afford private mental health care and is dependent on the public sector. However very few psychologists, psychiatrists and mental health professionals are employed by the state (Freeman, 1992). This means that "in the public sector there is approximately one psychologist per 304 000 of the population", as compared with the first world ratio of "one psychologist per 4 000" (Lin, 1983; Visser, 1989). This imbalance has implications for the kind of services made available. State services, used predominantly by the black population, focus narrowly on care for psychotic and mentally ill patients, with medication as the treatment of choice (Freeman, 1992). Psychotherapy is thus limited to those who can afford private care, largely those in urban areas (Freeman, 1991). There is only one psychologist in private practice in Atlantis (FCR, 1992).

There are also inequalities between the distribution of mental health care personnel and services in urban and rural areas, leaving the latter sorely neglected (Freeman, 1991). In many instances rural services have been further undermined by the tricameral¹ and homeland² systems, contributing to increased fragmentation between departments. Most mental health care in rural areas is provided by medical officers who have little training in this area (Gangat, 1989). These situations encourage a focus on physical symptoms and a de-focus away from psychological distress (Rumble, 1994). Until mid-1994, Atlantis was visited by a psychologist twice a month,

¹the state's attempt to introduce limited representation of Coloureds, Asians, and Indians to Parliament in 1983

²refers to the state's attempt to classify black people according to groups and place each within a geographic unit under apartheid separate development legislation from the 1960's (West, 1988).

and a psychiatrist once every three months, leaving community psychiatric nurses to cope with an overwhelming number of patients. In order to get through an out-patient clinic, nurses may have to allocate as little as five minutes per consultation (Holdsworth, 1994).

Recent findings estimate the prevalence of mental disorder in adults in the Mamre area at 27.1% which gives some idea of high levels of distress, and the need for psychiatric services (Rumble, 1994). This prevalence figure is similar to previous findings (Miller *et al.*, 1991).

In cases where psychiatric problems are identified, persons have to be referred to a psychiatric hospital 45 km away in Cape Town (FCR, 1992). Transport systems are also inadequate. There are two ambulances for the broader Atlantis area which is insufficient (FCR, 1993a). Patients are often referred to a secondary or tertiary hospital unnecessarily because practitioners at the local level are not equipped to assess psychiatric disorders (Freeman, 1992).

The situation is even more complex for those suffering from diffuse psychological problems like anxiety or depression, where facilities for assessment and intervention are very limited, and in some areas simply do not exist. In the case of adolescent facilities, there are only three specialist units in the whole province, namely William Slater Adolescent Unit, Sonstraal and Tygerberg, all in the greater Cape Town area.

Rumble (1994) raises questions about the impact of the lack of psychological services on how community residents understand psychological problems. She argues that cultural belief systems are very influential in communities. Strange behaviour or bad experiences may be attributed to bewitchment or "getoor" (Miller *et al.*, 1991). Religious beliefs also need to be considered, as a large percentage of residents in the Atlantis area identify themselves with the church. Bizarre behaviour is also explained as spirit possession. An interesting issue is how community health workers think about psychological problems, given that as members of the Atlantis community they have been socialised by cultural models of understanding health, illness, and distress. The

extent of the influence of such belief systems on community mental health workers is an interesting area for further investigation.

The limited medical services available in Atlantis are conceptualised in terms of the biomedical model. This means that community health workers are exposed to the biomedical definition and management of psychological problems. Exposure to a more psychologically orientated approach to problems is a very recent development in Atlantis. This has occurred mainly through contact with the psychologists attached to the MCHP who provide consultancy services to Atlantis community health workers on a limited basis. In the next section I will briefly discuss the differences between the biomedical and progressive psychological approach to psychosocial problems.

2.6.2. Biomedicine vs progressive psychology

The biomedical model assumes that disease is a biological entity, isolated from the lives, experiences, and contexts of patients (Mishler *et al.*, 1981). This view of disease is perpetuated by the kind of instruments such as blood tests, X-rays and MRI used by doctors to define, diagnose and treat problems. As Engel (1977) notes, if these scientific instruments do not pick up "objective" biological signs of disease, then patients are viewed as having no "pathology", and in some cases may be viewed by doctors as:

a nuisance, extraneous to the real concerns of medicine and less deserving of medical care than patients with physical illnesses.

(Hawton, Marsack and Fagg, 1981, as cited in Littlewood & Lipsedge, 1987)

Sophisticated technology also facilitates the rapid turnover of patients through the system, and allows for minimal contact between doctor and patient. Talk between doctor and patient becomes limited to responses to the prescribed questions (Levenstein, 1988) and psychological distress goes unacknowledged, as a result of the inability, unwillingness, or time constraints of the practitioner. Management strategies may reflect the same trend of "getting rid of patients" (Mizrahi, 1987, as cited by Swartz, 1991), and consequently neglect the psychosocial aspects of the patient's distress.

An attempt to correct the one-sided biomedical approach to health and illness is provided by the more recent systemic tradition. Systemic thinking assumes an "interaction of the individual, ... the family, the community and the society-level systems" (Levenstein, 1988. p. 112). It takes biological, psychological, and social factors into account to explain illness. The systemic tradition in psychology, which has been reviewed elsewhere (Heller *et al.*, 1984), has come to be associated with the attempt to theorise issues of power, control, and inequality in mental health care (Orford, 1992).

In South Africa (like elsewhere) this tradition is associated with "progressive" or community orientated clinical psychology (Freeman, 1991). The clinical practice of this "progressive" psychology has taken interventions out of the office into the relevant context (be it a factory, a ghetto, a high school) with the parameters of practice extending to working with paraprofessionals, encouraging self-help groups, working with organisations, doing social action orientated research, and advocacy around policy issues at a political level (Orford, 1992).

The systemically orientated approach incorporates the following: It allows for more flexible, creative interventions for complaints that cannot fit into neat conventional diagnostic categories (Levenstein, 1988); takes cognizance of issues of class and culture (Rappaport, 1977); is more holistic, addressing psychological wellness as opposed to pathology (Orford, 1992).

It is criticised for not having begun to penetrate medical practice in hospital settings (Arney and Bergen, 1984); and the shift from reactive mode to proactive mode has been seen not to have gone far enough (Rappaport, 1977).

The above criticisms appear to be true for Atlantis. The services at the day hospital are conceptualised in terms of the biomedical model. To a limited degree, health workers are exposed to a more systemically orientated approach through contact with MCHP. In the absence of services which are sensitive to psychosocial problems, health workers have been forced to adopt a more proactive way of dealing with these

problems. This has led to the emergence of a category of paraprofessionals (police, teachers, ministers, youth leaders, development workers) who assist professionals responding to the psychosocial needs of Atlantis residents. I use the term 'category' with caution as paraprofessionals are not a coherent, or formally constituted group. In fact, many are unaware of other workers playing a similar role. By 'category' I wish to denote another level in the hierarchy of care which is not formally recognised within health structures. In the next section I will discuss specific difficulties which confront professionals and paraprofessionals in the course of their work.

2.7. SPECIFIC AREAS OF DIFFICULTY IN CLINICAL WORK EXPERIENCED BY PROFESSIONALS AND PARAPROFESSIONALS

2.7.1. Lack of theoretical knowledge

Many writers point out that consultees are prone to feeling insecure about their knowledge of the psychological aspects of client problems (Caplan & Caplan, 1993; Carkhuff, 1969; Danish & D'Augelli, 1976; Ivey, 1971; Karafat & Boroto, 1977). Often the consultee's inability to handle the case is due to lack of theoretical knowledge necessary to identify and define the nature of the problem (Meyers, 1984). This raises issues about exposure to theoretical models underlying the assessment process. Consultees may have limited exposure to psychology, psychopathology, or mental health theories (Caplan & Caplan, 1993). In Atlantis previous training in psychology or psychiatry is the exception rather than the rule amongst consultees and potential consultees. Secondly, consultees may recognise that their difficulties are due to a lack of knowledge about mental health issues, but then confront the difficulty of accessing information when libraries and resource centres are up to 45 km away in Cape Town. Furthermore, some of the most common problems which consultees face in their day to day work, are neglected in the curriculum of clinical training i.e. alcoholism, suicide, and mental retardation (Caplan & Caplan, 1993).

The absence of a theoretical model for consultees also has implications for how one formulates management plans (Meyers, 1984). It could be argued that theory assists consultees to generate multi-faceted intervention plans. In Atlantis there are pressing material needs which consultees are unable to provide. Clients are stressed because of lack of employment, finances and housing. Because consultees lack theoretical models to disaggregate the conditions under which they work, consultees often become overwhelmed by the needs of their clients and then lose sight of the supportive interventions which they are able to provide.

2.7.2. Lack of clinical skills

Closely linked to the issue of theoretical knowledge is skills training. Meyers' (1984) view of skills training encompasses both an individual as well as organisational focus. In terms of a training focus on organisational factors, he argues that "organisational factors can have a profound effect on individual consultation [either consultee or client], and the organisation can also be the target of change" (p.237). This notion is supported by Orford (1992) who remarks on a trend in more recent texts on consultation, that emphasise the need for knowledge and skills regarding the appropriate assessment and intervention strategies to deal with inter-professional relationships between consultees and the agencies, or systems in which they work.

In terms of an individual-focus, Meyers (1984) emphasises the need for the consultee to be equipped with assessment and diagnostic skills. These include exposure to assessment techniques such as "interview, questionnaire, rating scales, sociometric devices, behaviour observation, and psychodiagnostic techniques" (p.234). Caplan & Caplan (1993) argue that the more consultees participate in the assessment process, the easier it becomes for the consultant to avoid offering direct solutions or advice.

Another way of increasing the participation of the consultee in the learning process is through constant evaluation of the efficacy of interventions. Meyers (1984) emphasises the need for consultees to develop evaluation skills. He argues that evaluation facilitates the transfer of the positive effects in one case, to other clients in the future.

Caplan & Caplan (1993) argue that the supervisors of agencies and institutions need to take primary responsibility for skills training. In many instances in Atlantis, consultees have no regular supervision to supplement consultation. In one case, a professional nurse sees her supervisor once a month, and focus is on administration procedures rather than skills development (Holdsworth, 1994).

There is general agreement in the literature that skills training should be an ongoing process. One of the difficulties for many rural mental health workers is that they feel left out of continuing education opportunities because of difficulties with distance, time, and budgeting constraints which make it impossible to get to workshops and conferences in metropole areas (D'Augelli, 1982). Clayton (1977) points out that many rural mental health workers feel penalized by continuing education requirements which they are unable to meet.

2.7.3. Lack of confidence

Caplan's (1970) view is that lack of confidence is related to lack of knowledge and skills about psychological distress and difficulty. A different perspective on lack of confidence is offered by Bibring's (1953) psychodynamic approach which Edward Hanna (1993) uses in consultancy as a social worker. According to Bibring (1953) confidence is closely related to living up to goals and aspirations. When unable to live up to aspirations in one's work performance, self-esteem collapses, and the self responds with anxiety, and possibly depression.

Reed *et al.* (1990) make the point that very often people who work in human agencies have personal needs to fulfil through their work. Consequently, competent work is experienced as a great boost to the worker's self-esteem, while work difficulties are experienced as deep failures. Menzies (1970) points out that such personal investments in coping at work only increase worker stress and anxiety.

2.7.4. Anxiety

The Tavistock Clinic's Consulting to Institutions Workshop in Britain uses a psychodynamically orientated consultation method in its work with staff in service organisations.

Coming from a psychoanalytic background, its point of departure is that stress in the helping professions is symptomatic of conscious and unconscious anxieties which get stirred up in the course of such work (Obholzer & Zagier Roberts, 1994). Obholzer (1994) identifies three layers of anxiety which may interfere with work in organisations. They have been separated for conceptual clarity but in practice overlap and co-exist.

2.7.4.1. Primitive anxiety

Our knowledge about primitive anxieties is informed by the psychoanalytic work done by Melanie Klein with children in the 1920's (see Klein, 1952a, 1952b, 1959). This type of unconscious anxiety is distinguished by its paranoid, persecutory flavour which consciously manifests as feelings of being attacked, blamed, or punished (1952a). Obholzer (1994) extends the Kleinian idea of primitive anxieties to institutions. A common example of primitive anxiety in institutions is the 'experience of inadequacy' among workers. This usually manifests in talk or expressed fears of being ridiculed, devalued, or attacked (Mawson, 1994).

2.7.4.2. Personal anxiety

Personal anxiety manifests where aspects of a work situation evoke unresolved personal issues in staff members (Obholzer, 1994). Menzies (1970) argues in her evaluation of nursing services in Britain that often personal anxieties are not dealt with sensitively. Either managers lack confidence in their ability to handle personal distress, and rely on platitudes or advice, or in some cases, dealing with it may run counter to the staff hierarchy with its traditional roles and relationships. Menzies (1970) found that often it was the most empathetic nurses who were most likely to leave nursing because personal anxieties were not addressed.

2.7.4.3. *Work-related anxiety*

Obholzer (1994) wrote about work-related anxiety to describe how the "particular nature of work elicits work-specific anxieties" (p.207). Anxieties may be related to a special client group who are at risk; an excessive workload in a particular department; or high risk work where making a mistake would have serious consequences. An example which illustrates how anxieties develop particular to settings and specific to the moment in the life of an organisation, is outlined as follows:

Reed *et al.* (1990) set up a consultation group at a school for the mentally handicapped. The aim was to assist a multidisciplinary team (teachers, assistant nurses, and auxiliary workers) deal with stress caused largely by their adolescent clients' behaviour problems. It is important to note that due to de-institutionalization processes in Britain at the time, only the most handicapped and difficult clients were staying in institutions. Linked to this, support services were being cut-back which meant that staff no longer had a school nurse, a janitor and a resident school doctor.

Reed *et al.* (1990) report the following presenting complaints from staff in a consultancy group: Teachers reported feeling guilty about being paid more than assistants; staff reported that the school was being used as a 'dumping ground' for the most marginalised adolescents by the education department and some were angry with their union for dismissing their application for membership.

Reed *et al.* (1990) use these issues to understand the hidden anxieties amongst the staff which may have been contributing to their stress levels. He also interprets the feelings of abandonment experienced by the staff towards the department of education (expressed in their anger towards their union), their sense of powerless to protect themselves in the accepted manner of limiting their numbers (because of the de-institutionalization process), thus leaving them overwhelmed by the increased numbers of children.

Work-related anxiety often resonates with both primitive and personal anxiety (Obholzer, 1994). Obholzer argues that if organisations do not structure ways of

dealing with anxieties into the work setting, these anxieties emerge through "illness, absenteeism, high staff turnover, low morale, and poor time-keeping", which are counterproductive to the work of the organisation. (Obholzer, 1994, p.170).

Besides dealing with their own anxieties, service providers also have to deal with the anxieties of their clients. Moylan (1994) points out that often patients cannot verbalise anxious or distressed feelings. As a result, clients use other communication methods to convey their experience to counsellors. Two common examples of unconscious communication processes will be discussed below.

2.7.5. Anxiety and communication processes

2.7.5.1. Countertransference as communication

A classical definition of countertransference reaction is that "which arises in the physician as a result of the patient's influence on his [or her] unconscious feelings, ..." (Freud, 1910, p. 144). Implicit in this classical definition is the assumption that the client has tapped an unresolved conflict in the therapist. As a result the therapist may feel uncomfortable, threatened or defensive (Horner, 1991). Essentially such reactions are seen as negative processes (Langs, 1981). Another view of countertransference is that it can be used as a way of connecting with a client in a deep and empathic way (Horner, 1991). Kernberg (1965) explains the difference in emphasis as follows:

here countertransference is viewed as the total emotional reaction of the psychoanalyst to the patient ... that the analyst's conscious and unconscious reactions to the patient ... are reactions to the patient's **reality** [my emphasis] as well as to his transference ... this implies that these emotional reactions of the analyst are intimately fused, and that although countertransference should ... be resolved, it is useful in gaining more understanding of the patient.
(p. 38)

There is some debate about the term and how it is used in the literature. It is not my intention to enter into the debate. For the purpose of this study, I will use the term in its broader sense. In Atlantis consultees see clients who have undergone traumatic experiences (rape, incest, neglect, physical abuse). Moylan (1994) points out that the more distressed the client group, the more likely unconscious communication will be

activated. In terms of Atlantis, it is important that the clients' reality is taken seriously by the counsellor.

The literature on counselling torture survivors raises important issues for work with countertransference. The assumption is that clients who have had traumatic experiences evoke powerful feelings in counsellors (Bustos, 1990; Danieli, 1980). Common reactions include feeling overwhelmed, incompetent, or uncomfortable. If these reactions are denied they may communicate to the client an inability to bear certain aspects of the experience, or a curiosity which may put pressure on the person to give graphic details (Pope & Garcia-Peltoniemi, 1991). This may result in the client terminating therapy. If countertransference material goes unprocessed in either supervision or personal psychotherapy, such reactions may produce anxiety, depression or burnout in the counsellor and result in her leaving the profession (Pope & Garcia-Peltoniemi, 1991).

There is considerable debate over whether or not countertransferences should be acknowledged in consultation. Although Caplan & Caplan (1993) do not use the term 'countertransference' they take a clear stance on personal experiences and reactions to case material. Caplan & Caplan (1993) suggest that any attempt to process or explore reactions to case material is inappropriate, and should be avoided at all costs:

If the consultee spontaneously begins to talk about his feelings, the consultant should as soon as possible interrupt and divert the discussion to some aspect of the client, usually by asking a question to elicit further facts or making a comment about the case. The consultant should not talk about the consultee's feelings, even supportively ...

(p. 80)

Caplan's (1970, 1993) formulation has largely set the trend of consultative theory and techniques. Steinberg (1989) and Heller *et al.* (1984) take up a similar stance on reactions material. Reasons for this are attributed to the understanding of countertransference reactions as largely reflecting personal dynamics of the consultee rather than client projective processes. This is in keeping with the narrow, classical definition of countertransference.

A major text which provides a theoretical space for issues of countertransference in consultation is by Obholzer and Zagier Roberts (1994). Their understanding of countertransference is typically Winnicottian (1947) in that they encourage mental health practitioners to tolerate and accept these feelings:

Indeed, to become conscious of such feelings has become a fundamental part of ... training. Such permission – from within ourselves and from the environment – to acknowledge and own uncaring elements in ourselves and our ‘caring’ institutions is crucial, both for individual well-being, and for the provision of effective services.

(Zagier Roberts, p. 83, 1994)

It is their view that countertransferences anxieties often reflect important information about organisational dynamics which need attention. As a result, a self-reflexive stance towards both personal reactions and organisational dynamics is encouraged. The rationale is that such a view helps mental health workers understand clients’ feelings more effectively.

Part of the controversy in the literature relates not to whether or not countertransference reactions need processing, but where the appropriate space is for this to happen. As Steinberg (1989) points out there is a general lack of clarity about whether people in the caring professions attend private psychotherapy for the sake of their work, or whether it is undertaken for personal reasons. For mental health workers in Atlantis this point is purely academic, given the limited opportunities for private psychotherapy.

2.7.5.2. Projective identification as communication

Closely linked to countertransference is another communication process called projective identification. This concept is also drawn from the psychoanalytic literature (see Bion, 1967; Klein, 1959). It refers to a form of communication where one person puts feelings into another person making the recipient have the feelings rather than the projector (Casement, 1991 p.71). Usually the kind of feelings that get projected are unmanageable, uncomfortable feelings like inadequacy, helplessness or anxiety (Casement, 1991).

Moylan (1994) extends the use of projective identification to understanding processes in institutions. Reflecting on experiences of consultation with staff at the Daniel Finch Drug Dependency Clinic, she points out that often resistance towards the consultant is a hint that projective processes may be active. If the resistance is explored, in many cases the anxiety which underlies the projection is a sense of inadequacy.

An image which is helpful in understanding the impact of these projective identification processes is of the processes as 'toxins' to which "workers get exposed, and support groups (when they are successful) as providing a kind of 'dialysis' to remove these toxins so that workers can continue to function without undue harm" (Bolton & Zagier Roberts, 1994, p.165). They warn that consultants are not immune to these same 'toxins' and point out that they also need support systems to deal with the effects of projective processes. One positive aspect of projective identification processes which Mawson (1994) highlights is that they represent hope:

Partly, we unconsciously try to rid ourselves of them, but there is also the hope that the recipient of the projected distress might be able to bear what we cannot, and, by articulating thoughts that we have found unthinkable, contribute to developing in us a capacity to think and hold on to anxiety ourselves.
(1994, p.70)

Menzies' (1970) study on student nurses investigates how nurses tolerate such high levels of anxiety, distress and tension. Her findings suggest that nurses were not coping. Instead nursing staff developed collective defences to circumvent awareness of anxiety which gradually become part of their work (Menzies, 1970; Obholzer & Zagier Roberts, 1994). A few common examples of these collective defence mechanisms will be outlined below.

2.7.6. Common defence mechanisms used by mental health workers

2.7.6.1. Projection and splitting

Relief from anxiety is achieved by projective processes whereby the anxiety is split off and projected outwards (Casement, 1991). Criticisms often indicate that projective processes are active. For example, a manager or a consultant may be seen as "bad",

"disruptive", "persecutory" (Obholzer, 1994). Halton (1994) points out that projective processes provide fertile ground for stereotypes, prejudices, negative images and competition amongst people and groups to emerge.

2.7.6.2. Labelling

Labelling refers to a tendency to categorise clients. For example mental health practitioners talk about patients not by name but by label; "that borderline" (Rhodes, 1991), or "that liver in bed 10" (Menzies, 1970). Littlewood & Lipsedge (1987) found that medical practitioners unconsciously categorise patients as a way of dealing with their discomfort and anger towards certain patients. Their findings suggest that adolescent patients, referred following an overdose, were categorised into the "manipulative" category and the "serious want to die" category.

2.7.6.3. Detachment or denial of feelings

This defence mechanism reflects the contradiction in the culture of the caring professions. Menzies (1970) remarks that nurses are taught to be empathetic, yet any sign or display of emotion is seen as a sign of weakness and is often met with a disapproval by other staff members of the "pull yourself together" or "stiff upper lip" variety (Menzies, 1970). Detachment is facilitated by the pre-occupation with administrative work, lists of tasks, and set routine which reduces staff contact with patients (Menzies, 1974).

2.7.6.4. Delaying decision-making

According to Menzies (1974) decision-making, particularly when not all the information is available, can evoke anxiety for mental health practitioners. Menzies (1970) says nursing staff can attempt to minimise the number of decisions they have to make by focusing on administrative tasks and postponing intervention for as long as possible.

In summary, writers argue that service providers working in the caring professions run the risk of being overwhelmed by anxiety and stress. While defence mechanisms keep some aspects of this anxiety out of conscious awareness, they fail to reduce or relieve workers of the anxiety. In some cases this leads to stress spilling over into inter-staff

relations and undermining the work of an organisation (Mawson, 1994). Obholzer and Zagier Roberts (1994) suggest that the only way to address this anxiety is to build structures into the work day to act as 'containers' for staff anxiety and stress. The concept of containment will be discussed in more detail below.

2.8. THE CONCEPT OF CONTAINMENT

Halton (1994) borrows the concept of 'a container' from the psychoanalytic work of Bion (1967) and extends it to institutional settings. The original concept of a 'container' refers to the role of the mother, who by temporarily holding painful feelings, relieves the child. The nature of the 'container' in institutions is not prescribed. Obholzer & Zagier Roberts (1994) suggest the following structures; individual consultation, peer support groups, supervision, case conference. For the purpose of this study I will focus on individual and group consultation as 'containers'.

The literature warns, however, that any attempt to introduce 'containers' into work settings needs to be carefully facilitated (Obholzer, 1994; Menzies, 1974). This is because any change in an organisation, even if supportive, automatically tampers with the collective defences and is bound to increase anxiety levels amongst workers. If supportive structures are introduced without attending to the above, Obholzer (1994) warns that it will be met with resistance.

A local example of resistance to the introduction of a potential container is illustrated in Holdsworth's (1994) thesis. She describes the resistance she initially encountered by mental health workers in Atlantis when she setting up psychological consultation services two years ago. It is possible that at a conscious level workers welcomed support, but at another level, they may have felt threatened, as the intervention may mean giving up the known ways of coping, and being confronted with their high levels of anxiety and stress. In summary, the literature suggests that gaps in theoretical knowledge and clinical skills hamper the work of consultees and potential consultees and undermine their confidence as helpers. In the case of Atlantis, geographic

isolation makes access to information and resources difficult. Health workers miss out on training opportunities because of distance, transport, time and budgeting constraints. The nature of the clientele, often affected by traumatic experiences, coupled with the overwhelming number of case-loads leave professionals and paraprofessionals stressed and stretched. It is interesting to note that this is the case both for professional consultees, as well as paraprofessional consultees in Atlantis. The literature fails to differentiate between the experiences of professionals and paraprofessionals which is an interesting area for further investigation. 'Containers' for stressed professionals and paraprofessionals are extremely limited in Atlantis. In many cases potentially supportive structures like supervision or case conferences become forums for administration rather than containers for staff stress.

These dynamics need to be kept in mind when exploring the difficulties experienced by professionals and paraprofessionals in their work with suicidal adolescent clients.

CHAPTER THREE: METHODOLOGY SECTION

3.1. RESEARCH METHOD

3.1.1. Research approach

This study adheres to the principles of the action research approach as defined by Rapoport:

Action research aims to contribute both to the practical concerns of people in an immediate problematic situation and to the goals of social science by joint collaboration within a mutually acceptable ethical framework.
(1970, p. 499)

The research meets the criteria of being both action orientated, as well as a collaborative effort between the researcher and the community participants. These dimensions are illustrated in the way in which the research process unfolded. (described below).

3.1.2. Research objectives

- A. Mental health workers in Atlantis, are the object of study in this research. The aim is to explore their high levels of stress, anxiety and lack of confidence when dealing with cases involving adolescent suicidal behaviour. This objective is in keeping with the brief of action research, which is to work with community members exploring, and offering solutions to real world problems.
- B. The second objective involves furthering the project of theory development by reflecting on the psychodynamic consultation method, as a potential solution to the difficulties experienced by mental health workers in Atlantis.
- C. The third objective is in keeping with the 'action orientated' characteristic of action research. 'Action' takes the form of a training workshop for mental

health workers; the institution of a monitoring mechanism for episodes of adolescent suicidal behaviour in Atlantis and the establishment of a consultancy group for mental health workers.

3.1.3. Research process

Mental health workers were involved in each step of the process; the initial discussion group with key players from the helping agencies of the training workshop on Depression and Suicidal Behaviour in Atlantis; the consultation procedure with the Social Fabric Commission of the Atteridgeville Forum; the establishment of the register at the Wesfleur day hospital; and the co-ordination of the consultancy group.

3.2. DATA COLLECTION

Unstructured interviews (Appendix C) were conducted with ten service providers in Atlantis, and one from Mamre. These mental health workers included social workers, clergy and development workers. These initial interviews were purposefully unstructured to facilitate exploration. Informants were selected because they constituted key players in the delivery of mental health services in Atlantis because of their experience of the Atlantis and Mamre communities. The objectives of the interviews were to find out from respondents: "What is your experience of adolescent suicidal behaviour amongst adolescents in Atlantis?" Some respondents shared their experiences of suicidal adolescents and the interviews were thus structured. If interviewees had experience of suicidal adolescents they were asked to describe their first contact they had with a suicidal adolescent, the most recent suicidal adolescent to describe any difficulties they had experienced in the course of such

As well as unstructured interviews with service providers, two focus group interviews (Appendix D) were facilitated by the present consultant psychologist, myself, during my internship placement in Mamre. An attempt was

way to 'sound out' a cross section of service providers. Orford (1992) affirms the use of unstructured interviews in the initial stages of research:

In the early stages of the research the enquiry should be made in as open-ended a fashion as possible. This is not only to obtain the widest possible range of answers to the original questions, but also to allow for the raising of new questions that had not originally been thought of ... It is ... an essential ingredient if the theoretical account that is produced is to be firmly based or grounded in the actual data collected ...
(p. 129)

The next layer of data collection included the use of focus groups in the context of a training workshop on the Assessment of Suicidal Behaviour and Depression amongst Adolescents. An invitation was extended to all service providers who had previous counselling experience and through their work had contact with adolescents.

By this stage I was most interested in how adolescent suicidal behaviour affected service providers; their subjective feelings and reactions, and how they saw these feelings, as either useful or detrimental in their counselling work. The stance of the focus group is that attitudes and perceptions are developed partly by interacting with other people (Krueger, 1988). The focus group provides a space for a large amount of interaction, debate and discussion on a given topic in a limited period of time (Lankshear, 1993).

Besides providing service providers with an opportunity for in-service training, the focus group method encouraged the cross-pollination of ideas. The groups also gave service providers a chance to network among their peers. A proposal to set up an interdisciplinary consultation group was one of the recommendations which emerged out of the workshop.

The follow-up interviews with five of the respondents happened a year after the initial interviews and focus groups. They were designed to evaluate the effects of the research intervention, through feedback from respondents. These evaluative interviews co-incided with the reportback of my findings to mental health workers, organised through the consultancy group.

3.4. DATA ANALYSIS

3.4.1. Introduction

Data analysis is defined in the qualitative research tradition as "the process of bringing order, structure, and meaning to the mass of collected data" (Marshall and Rossman, 1989, p.112). The literature suggests that this process is eclectic (Cresswell, 1994) and that there is no "right way" (Tesch, 1990). Furthermore, the qualitative tradition allows for data analysis to be conducted concurrently with data collection (see Marshall and Rossman, 1989). The rationale for this simultaneous process is that it "binds" data collection (Miles and Huberman, 1984). It also encourages the researcher to maintain a research focus, by making early decisions about specific interesting areas which are then explored to the exclusion of others. Bogdan and Biklen (1992) warn however, that a split focus may be difficult for the inexperienced researcher. The plan which guided the development of my data analysis incorporates this method of simultaneous data collection and data analysis activities according to the schema which (Marshall and Rossman, 1989, p.114) call data "reduction" and "interpretation" which is outlined below. The data was then subjected to a process of verification to determine issues such as validity and reliability.

3.4.2. Data "Reduction"

Data "reduction" involves breaking the information down into manageable chunks (Tesch, 1990), developing "coding categories" (Bogdan and Biklen, 1992), and then generating "themes" (Marshall and Rossman, 1989). In the course of the initial consultative discussion with a small group of community health workers, three problem areas which health workers face were already identified, documented, and used to form the framework of the research focus. These included:

1. Myths about suicidal behaviour held by community members

Myths

Suicidal behaviour runs in families

Suicidal behaviour triggers a chain reaction amongst peers

Suicidal behaviour is attention seeking behaviour

Speaking about suicide promotes thoughts

People who say they will kill themselves, generally don't

Only mad people kill themselves

Suicide is associated with sin or bewitchment

2. Feelings experienced by health workers which they associated with suicidal behaviour

Feelings

Inadequacy

Helplessness

Fear

Anger

Powerlessness

Uncertainty

Judgement

Impotence

Anxiety

Guilt

3. Obstacles experienced by health workers in service delivery when a suicidal adolescent was involved

Obstacles

Inadequate counselling skills

Lack of information about suicide and depression

Absence of a youth clinic

Inadequate referral agencies

Lack of trained, experienced clinicians or personnel

Attitudes of parents, teachers, principals and ministers towards adolescent suicidal behaviour

Further validation of these areas was then obtained by a larger more representative sample through the focus groups and semi-structured interviews. The focus group questions were designed to provide, explore and extend already identified problem areas. The content of the focus group discussions was then coded into two main categories, namely: obstacles facing community health workers in their work with suicidal adolescents, and solutions to these identified problems. The two main categories were then divided into sub-categories according to segments that related to one another or shared similar dimensions. A further two sub-categories emerged in the semi-structured interviews and my clinical experiences (noted by**). These were then incorporated under the two above-mentioned main categories. The coded categories and sub-categories are outlined below:

CATEGORY ONE: Obstacles facing health workers responding to adolescent suicidal behaviour.

LACK OF RESOURCES

Youth counselling centre

Inadequate psychiatric emergency services

Lack of trained personnel in Atlantis

Time constraints

Inadequate backup from senior managers or supervisors

Inadequate transport to referral sources

Money

Insurance

INADEQUATE COUNSELLING SKILLS

Basic counselling skills

Crisis intervention techniques

Microskills used to assess depression and suicidal behaviour

INADEQUATE THEORETICAL KNOWLEDGE

Developmental phase of adolescents

Mental illness

Risk factors which precipitate adolescent suicidal behaviour

Recognition of the signs of adolescent depression and suicidal behaviour

Access to information about suicidal behaviour

Legal definition of suicide

COUNTERTRANSFERENCE

Personal experiences

Memories

Reactions to

Fantasies

(Lack of) discourse around feelings

Feelings as weakness

Gendered response to feelings

Intensity of

Containment of

DEFENCE MECHANISMS (**)

Advice-giving

Story-telling

Detachment

Depersonalization

Categorisation

CULTURE

Suicide as a taboo

Stigma

Familial pride

'Ubuntu' values

Church attitude towards

Bewitchment

Myths about suicidal behaviour

Material vs "psy" reality

AREAS OF CONFLICT (**)

Attitude of authority (health authorities, managers, supervisors, parents)

Health worker hierarchy

Medical response vs counselling

Lack of interdisciplinary collaboration and contact

Diffuse work identity

Lack of work boundaries

Interstitial position of paraprofessionals

CATEGORY TWO: Needs identified by health workers to address obstacles

TRAINING OPPORTUNITIES

Basic counselling skills

Microskills

Grief work

Crisis intervention techniques

INTERDISCIPLINARY

Joint work around cases

Communication

Networking

Consultation and training group

SUPPORT

Interdisciplinary support group

Increased support from supervisors and managers

RESOURCES

24 hour crisis intervention service

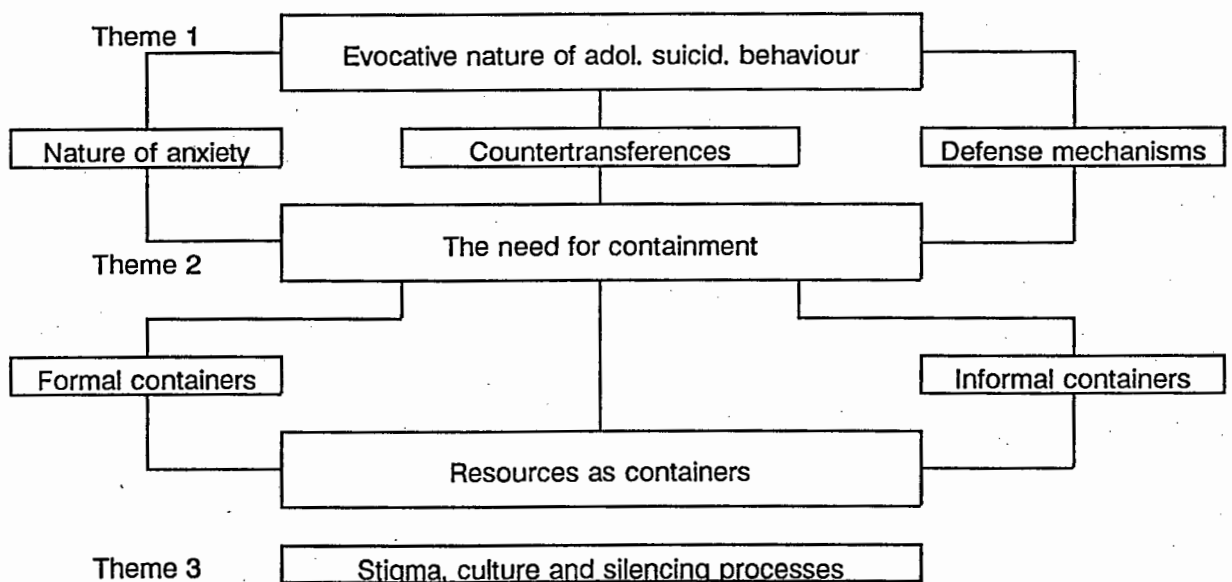
Youth counselling facility

Access to information around adolescent suicidal behaviour

3.4.3. Data "Interpretation"

A further step in the process of data analysis involves interpretation whereby "meaning and insight is given to the words and actions of participants in the study" (Marshall and Rossman, 1989, p.114). The literature suggests that this results in a "higher level" analysis (Cresswell, 1994, p.154) and helps to move towards "... the emergence of a larger, consolidated picture" (Tesch, 1990, p.97). This is achieved by subjecting the results of the data analysis to concepts in the literature (see Marshall and Rossman, 1989). Obholzer's (1994) psychodynamically orientated theory of consultation was then applied to the above mentioned broad categories. Issues pertaining to worker's feelings, conflicts, and needs were then interpreted according to Obholzer's key concepts of 'anxiety', 'countertransferences', 'defences', and need for 'containment'. (See diagram outlined in table below).

Table 2:



of time confirmed my view that countertransference is critical and needs to be confronted in order to increase support, education and training in the consultative relationship. However, although these biases have shaped the way I view the data I collected, and the way I interpreted experiences, every opportunity was made to ensure objectivity.

Besides my personal assumptions and biases, another factor which may confound the issue of internal validity, is the dual nature of the roles I played in the community as researcher and consultant. As I mentioned above, I was linked to the MCHP clinical team and thus closely associated with the model of consultation as a method of providing support, training and supervision to health workers in the area. Health workers who were participants in the research, came with varying experiences of this way of working. Some participants had wanted to make referrals to MCHP in the past, only to be told about the consultative way of working with health workers. This group may well have brought ambivalent feelings about consultation and even the clinical team, to the focus group discussions. A few participants received consultation on a regular basis, and may have felt obliged to express positive sentiments about consultation, as well as the consultants.

Evidence to suggest that the dual nature of my roles was a problem, lies in the fact that negative comments about consultation were not articulated, and that no other possible solutions to the issue of worker stress were raised for discussion. In other words, the fact that I was both researcher and consultant, at the same time, may detract from the accuracy of the data.

The following strategies were used to promote internal validity in the light of the problems of researcher bias, and the duality of roles: Data was collected through various sources (semi-structured interviews, focus groups and clinical experiences). The rationale behind triangulation is that accuracy is increased by the constant comparing and contrasting of one data collecting method with another (Cresswell, 1994). Hence data from the semi-structured interviews were compared against the data from the focus groups. Also the information from my clinical experiences was

checked against information from the semi-structured interviews. A general consistency of data was found. The follow-up interviews a year after the initial interviews were aimed at discussing findings and receiving feedback from informants as a way of checking the accuracy of categories and interpretations.

A third factor which could undermine the authenticity of the data relates to broader differences in societal position between researcher and participants. The fact that I am a white, middle-class woman who has attained a post-graduate level of training, inevitably sets up a power relation weighted against the participants who are coloured, working class, and who for the most part, have not attained a tertiary level of education. These differences in life experience have consequences for perspectives on suicide, understandings of the development stage of adolescents, and frameworks for counselling, which need to be made explicit. Strategies built into the research to address issues of power and differences in life experience include; firstly, a thorough process of consultation with community leaders. This provided an opportunity for community members to be involved in the shaping of the research. Secondly, an attempt was made to involve community members at most stages of the research process. The aim was to ensure that it was an inclusive and open process. Thirdly, a detailed account of the context and history of the Atlantis community was included in the research document. This aims to convey a sensitivity to the complexities of South African society.

3.4.4.2. External Validity

It is accepted in the literature that the intention of qualitative research is not primarily to generalise findings but to present and respond to a real problem which affects a specific community (Merriam, 1988). The challenges which face mental health workers in Atlantis are in some ways unique, yet findings emerge which may well be relevant to other socio-economically disadvantaged communities in the throws of transition. To increase the chances of replicating the study in a different context, the following strategies have been employed: A detailed account of the research process is provided, together with a description of the categories, sub-categories, and themes which emerge from data collecting and analyzing procedures. Explicit statements of

my biases and the dual nature of my roles in Atlantis also aim to enhance the chances of the study being replicated.

The use of clinical experiences in data collection and analysis, which is inherently difficult to reproduce, could be considered a methodological limitation which mitigates against replicating the study exactly in another context. However, this needs to be weighed up against the useful and positive contribution of thick, rich descriptive material which is accessed through clinical experience.

CHAPTER FOUR: THEMATIC ANALYSIS OF RESULTS

4.1. INTRODUCTION

This section comprises a thematic analysis of the results from the interviews, focus groups, and my clinical experiences. Discussion of the results is presented in chapter five.

4.2. ADOLESCENT SUICIDAL BEHAVIOUR IS EVOCATIVE

4.2.1. Adolescent suicidal behaviour is anxiety-provoking

Attention was repeatedly drawn to the high levels of tension, stress, and anxiety amongst the mental health workers, even very capable respondents with many years experience. Some of the dimensions of the anxiety will be illustrated below although primitive, personal and work-related anxiety as defined by Obholzer (1994) will be dealt with together since in practice they are difficult to extricate.

4.2.2. Anxiety about damage

Anxieties about not being able to make a difference in adolescents' lives was frequently expressed by respondents, and in some cases workers expressed fears of actually doing more harm than good as counsellors. Referring to a case involving a young boy who showed sexual identity diffusion and who had made two suicide attempts, one of the interviewees reported:

I was prepared to see him as it was an interesting case but I felt it was outside of my field ...in a way I was scared that I wouldn't handle it right, possibly do something judgemental or say something the wrong way and do damage. For me it was something too delicate.

It may be that the anxiety about 'damage' expressed by respondents relates to an underlying anxiety about being ineffectual as counsellors. Because this is so painful to put into words, expressed fears about doing harm may be an unconscious communication to me about how ineffectual some respondents feel; and secondly an extension of their trying to refer the clients to me as the 'expert', in this way protecting themselves from painful feelings, as well as offering protection to their clients from their perceived inefficacy as counsellors.

Another hypothesis is that projective processes are active. It may be that the experience of feeling like perpetrators rather than helpers, may stem from working closely with damaged adolescents, many of whom are social casualties as a result of experiences of abuse and neglect by adults. In turn it may be that the counsellor is made to mirror how the adolescents feel about parents or other authority figures.

The perception of oneself as a damaging figure was raised by one of the respondents who said:

Ja, discussing suicide is very difficult because you really don't know whether your involvement in such discussions could result in the actual killing.

4.2.3. Anxiety about fatality

Five interviewees mentioned the fact that the nature of the case material generated particular fears about injury and death. A respondent who runs a teenage counselling group said:

I definitely sat with the fear that she might try. Because I am not used to dealing with suicide I had no idea how to prevent it happening.

A theme underlying the expressed anxieties about death or injury which emerged when there was talk of suicidal ideation or behaviour, is a sense of impotence and helplessness on the part of the interviewee having to respond to such evocative case material.

4.2.4. Anxiety about lack of theoretical knowledge

Only three of the respondents in the individual interviews felt reasonably adequately equipped in terms of knowledge and skills to assess and manage a suicidal adolescent on their own. Of the remaining interviewees, most sought out other services. Half felt the need to refer such cases directly to a doctor, psychologist, psychiatric nurse without delay and not to get involved in case management.

Attempts to explore reasons for this elicited the following: Talk of suicide constituted a psychiatric emergency which fell within the parameters of the work of a doctor or psychologist; suicidal behaviour may suggest a mental disorder and warrant a referral to a secondary or tertiary institution which could best be facilitated by a professional; fears about failing to pick up mental disorder or symptomatology. A social worker attached to a church-based social welfare agency expressed insecurity about her knowledge of clinical syndromes, particularly when trying to identify depressive symptomatology in adolescents:

When a teenager presents with aggressive behaviour, staying out late, drinking, or trying drugs and that sort of thing, I don't know whether those are seen as symptoms of depression or not.

The remaining half of respondents ideally wanted to work collaboratively with professionals and made themselves available for collateral, follow-up or family work. They envisaged their role as a supportive one after a period of in-patient treatment, or at least an assessment by a professional, like a doctor, psychologist or psychiatric nurse.

In the focus groups, however, considerable debate and discussion emerged about the construction of distress in a psychological framework. Interviewees (3) felt that suicide was attention-seeking behaviour which was best left to mothers to deal with. As one of the ministers reported:

In our community if a teenager says 'I feel like committing suicide' the response from the mother would be 'Okay, here is the wire. Go ahead and do it'. The threat is seen as manipulative or self-pitying and it would be seen as an effective way of dealing with the threat.

This discussion about interpretations of the aetiology of suicide, gave way to a more general debate about the use of "psy" language. A few interviewees (3) from one of the focus groups questioned its validity in a coloured, working class context. One of the interviewees expressed his reservation in this way:

Stress is not a word in my vocabulary. I have not got time for it. It's something I have noticed ... there is a vast difference between white and coloured societies ... Terms like 'depression' and 'stress' are not used in coloured society ... our people take the abnormal for normal ... if a breadwinner is unemployed and the family lose their house ... the community absorbs the disaster ... it's part of ubuntu³ ... I feel very cautious to use words like stress and depression ... people begin to talk too easily about 'having stress'.

One hypothesis is that "psy" talk using terms like 'stress' and 'depression' highlights non-coping styles in a community that is very invested in coping. In keeping with Swartz's (1987) formulation about collective coping mechanisms against apartheid, Atlantis has developed its own coping mechanisms. A good example is the Atlantis Development Forum which was formed in response to the social crisis in Atlantis in 1993. It runs along ubuntu principles of 'community participation', 'activism' and 'empowerment'. It is possible that the criticisms raised by interviewees are directed at a "psy" intervention to psychosocial problems which may be perceived as undermining the ADF's collective response to psychosocial problems. Whereas the ADF formulates the root of problems as apartheid and the national recession, a "psy" framework may be perceived to de-politicise suffering, strip the collective of its potential power, and disconnect it from its root causes i.e. the harsh realities of poverty, migration, and suffering as a result of the apartheid system.

The perception of a "psy" framework as an imposed, and possibly irrelevant one has serious implications for the work of psychologists in Atlantis. It is crucial that psychologists work with the ADF, and thus affirm the resilience and the coping mechanisms of the community. It is important not only to focus on the pathology in the community. This is in keeping with the principles of community psychology which is prevention orientated rather than curative orientated. Secondly it raises crucial

³ubuntu describes the traditional African experience of humanness (Nolan,1988).

issues about language for psychologists. Terms like 'stress' and 'depression' tend to be bandied about in an insensitive way. Psychologists need to use the vernacular, which in Atlantis is Afrikaans. They also need to find acceptable way of translating psychological concepts and integrating understanding of aetiologies in such a way that indicate a sensitivity to social realities. In doing so an empathy and a consciousness of the history of residents (both clients and service providers) in Atlantis will be conveyed.

4.2.5. Anxiety about lack of skills

All interviewees expressed anxiety about their lack of skills. None of the respondents in the individual interviews felt they had received adequate clinical practice in their training, current in-service training, or supervision. One of the social workers who works for an alcohol and substance abuse prevention and rehabilitation organisation said:

In our training suicide is not focused on ... during our consultation with other social workers where we bring difficult cases we never speak about suicide ... we have a peer supervision group in which we discuss different topics like the motivational interview but suicide has never been a topic for discussion ...

Lack of micro-skills were identified as an area of weakness by the interviewees (6) and affirmed by the focus groups. As one of the social workers put it:

I didn't know how to ask the questions sensitively enough ... not to upset him ... because I have never learned what questions to ask, how to ask them ... I don't have fixed questions that I ask ...

Much of the anxiety around micro-skills was linked the wide- spread myth that talk of suicide might precipitate the act.

This notion was shared by many of the respondents (8) in the individual interviewees. As one of the social workers reported:

It is as if one draws back from the issue. It is so serious that I felt scared to dwell too much on it because maybe it promotes thoughts.

Consequently none of the respondents in the individual interviews asked routinely about suicidal behaviour when assessing a teenage client. This seemed to be largely related to inadequate micro-skills, but also partly because of the way in which mental health workers framed teenage problems, in terms of social realities as opposed to a "psy" framework. The suggestion of a training workshop, particularly focusing on micro-skills and assessing suicide risk, was welcomed enthusiastically by the focus groups.

4.2.6. Anxiety about inadequacy

A theme underlying all the varying degrees of anxiety was the experience of inadequacy. According to Obholzer (1994) inadequacy is a primitive anxiety. In most cases it was not consciously articulated. However, a few of the respondents in the individual interviews came close to articulating their sense of inadequacy as counsellors. A social worker, working with mentally and physically handicapped adolescents, spoke about the pain that is evoked when she feels at a loss in an interview:

There is the sense that if I don't get the person to open up, it can evoke feelings in me of being a failure so one has to deal with your own feelings as well as the clients.

One of the ministers spoke about feelings of guilt and anxiety he experienced as a result of feeling inadequate. Reflecting on a counselling session with a young teenager who was in his confirmation class, he says:

I am afraid that the discussion I had with the young woman may fail because of my poor skills ... and that the person may go for it [commit suicide]. Then I would feel guilty forever.

The literature suggests that awareness of a sense of inadequacy is very threatening and painful for consultees. Ideally, a safe environment is needed if anxieties about inadequacy are going to be recognised and explored.

4.2.7. Ambivalence about countertransference reactions

All the interviewees (11) described intense feelings they experienced in the course of their work with clients in dire need. Using the broad definition of countertransference reactions (Kernberg, 1965) these refer both to projective processes where other people's feelings are experienced as their own, and as well as their own responses to material. A sense of being overwhelmed by the need of clients emerged clearly in the countertransference material. A respondent involved in running teenage counselling groups said:

One thing I have felt and seen is that you as a counsellor working with an adolescent case-load can become depressed as well ... because it is hard not to become emotional ...

There was also a sense of anxiety expressed about the possibility of being overwhelmed by need. It may be that the following respondent is expressing some unconscious fear of possibly identifying with the projected feelings, and consequently acting them out. He says:

I have heard of a policeman who became very suicidal because of dealing with such situations and not knowing how to respond.

The consultation method which draws on a psychodynamic approach to counselling, and encourages counsellors to be mindful of their feelings, and to even use their feelings as a tool instead of seeing their feelings as "getting in the way" was a novel idea for many of the interviewees. From the way in which respondents framed their responses there seemed to be an implicit assumption that emotional reactions to counselling material, for various reasons, were unacceptable. In many instances emotional reactions were seen as a sign of 'weakness' and that counsellors were supposed to remain detached and objective. One minister said:

I try not to be empathic because should I, I would definitely be involved in their problems, and it would be difficult for me to judge so I try to be objective. It kills me inside.

Another minister spoke about using his feelings, and drawing on past experiences, triggered by the material, when he was stuck in a counselling session. This was however seen as a 'last resort' rather than a therapeutic tool:

I don't like to bring my own memories or feelings into the session when I am counselling but I might try to do it when I am stuck in the session.

The issue of countertransference was raised in the focus groups for discussion in order to gain a deeper understanding of the ambivalence expressed by respondents. Respondents spoke about cultural processes that surround the expression of emotion.

A female respondent explained that:

We are not taught to speak about our feelings ... and we in turn convey this to our children who then also don't learn to speak about their feelings ... if you ask how a teenager feels he will just say "Ek voel vrot" ... it's either good or bad ... but he cannot differentiate fear, frustration, etc ...

Another issue which emerged was discomfort with crying, particularly when a member of the opposite sex was crying in front of the other. For example, a male respondent spoke about his discomfort about a woman crying in front of him:

There is one thing that I cannot take from a young woman is tears. You see in my culture a woman is said to be an egg and when you have got an egg in your hand you cannot just let it fall down otherwise it breaks. That might sound discriminatory but it isn't really.

What was clearly very stressful for respondents (5) was the fact that these anxieties lingered long after the session in the form of fantasies expressed in statements like "when the adolescent walks out the door I worry about him and when I see him again I'm relieved". There was overwhelming support for the idea of a peer support and supervision group where these anxieties could be contained and shared, and thus hopefully relieved.

A year after the initial interviews, one of the mental health workers who worked in consultation with the psychologist from MCHP, reflected on how she had come to understand her countertransference feelings through the process of consultation:

I could never understand why I got so upset and emotional about cases ... I looked at other counsellors who spoke about cases in workshops and they seemed to speak in an uninvolved way about cases ... I thought I was

different..odd ... that there was something wrong with me ... but through working with the interns I have begun to feel more 'okay' about my feelings ...

4.3. DEFENSIVE STRATEGIES USED BY MENTAL HEALTH WORKERS

There was evidence to suggest that respondents struggled to tolerate the high levels of anxiety, tension and stress they experienced. While it seemed unreasonable to expect interviewees to reflect on their individual defence mechanisms used in the course of their work, indications were that they could not tolerate the emotions, and found ways of defending against feelings which emerged. One respondent spoke about a conscious strategy used to defend against the sensitive contents of an interview.

4.3.1. Story-telling as a distancing technique

An interviewee described how he used the traditional Xhosa method of story-telling as a way of creating distance from taboo subjects, like suicide or sex, in counselling, which are difficult to broach or discuss openly amongst people in a rural community.

From my background, when you are dealing with people, you must use stories ... so I told her [adolescent suicidal client] that what she is experiencing I once heard about such an experience ... but this was not true because I realised that it might help to make it a story and throw it far from me.

What was interesting is that it emerged later on in the interview that in fact the interviewee was the protagonist in the story. He spoke about his own experience of being depressed and suicidal in his youth during a time of political turbulence and school boycotts. He acknowledged that the use of the story also helped him contain painful memories which the session evoked.

4.3.2. Advice as a defense against feeling

In the course of doing joint assessments with one of the interviewees, who runs a school-based adolescent clinic, I observed an example of an abrupt switch from exploring feelings to the safer terrain of advice-giving, as a defense, when painful feelings were elicited. I will describe the session with the nurse; the client who was a standard 9 pupil, who had been receiving in-patient treatment in an adolescent unit in Cape Town, after an overdose; and myself.

The nurse called the teenager out of class because she worried about her ... the girl was tall, well spoken, earnest, and polite. She greeted the nurse warmly, and assured her that she was 'fine'. Her initial cheerfulness dissipated as she began to talk and we to listen. She was unhappy at home, afraid of her strict father, her sister had run away from home, she thought of falling pregnant to escape her home ... Still she tried to tell us that she was 'fine'. The nurse wanted to believe her. The atmosphere was heavy, helpless ... the teenager became tearful, crumpled, her eyes downcast. In the silence I asked if things were so bad that she could not see a future for herself. She nodded. The nurse became fidgety, uncomfortable and brought the interviewee to an abrupt end with advice; 'work hard', 'get your matric', 'eat more', and come to the family planning clinic'. The nurse's assessment, after the young girl left, was that she 'was fine'.

According to Menzies (1974) advice giving is often a defence against powerlessness. In this example the defence could be viewed as a projective identification process. It may be in response to an empathic experience of the teenager's own impotence or it may be a response to the impotence as a result of limited resources. Interviewees showed varying levels of awareness of defence mechanisms. Some expressed guilt, while others, not aware of what motivated them, would make suggestions like having the client move into their homes, or physically take the client to a facility in Cape Town as a way of dealing with the overwhelming sense of powerlessness.

4.3.3. Detachment/depersonalization and categorisation

A striking example of how staff members in a facility have shaped their working practices so as to shut out feelings which may be evoked due to the nature of the work, was highlighted by interviewees (4) in individual interviews in relation to the day

hospital. All examples refer to the way in which nursing staff (and doctors) related to patients.

One interviewee spoke about a standard 10 boy who took an overdose late one night. She took him to the day hospital where he had to wait one and a half hours for a doctor who was sleeping and did not want to be disturbed. When the interviewee demanded that the nurse wake the doctor his comment was: "Why did you wake me? If he wants to kill himself it's his problem". The interviewee said that without examining the boy, the doctor muttered something about 'liver damage' and wrote a referral to the psychiatric emergency unit at Groote Schuur. Because of the unsympathetic treatment by staff, the boy felt distrustful and refused counselling later offered by an intern psychologist attached to Groote Schuur.

Similar instances were described by another interviewee concerning the detached manner of nurses at the day hospital. As one interviewee said:

Nurses at the day hospital don't care. They will first have their cup of tea ... before they assist a teenager in crisis ...

Interviewees who had contact with day hospital agreed that the matrons were aware of this detached way of relating to patients, but colluded in these interactions, at least by their silence.

4.4. THE NEED FOR CONTAINMENT

All interviewees in the focus groups articulated a need to 'unload' and process feelings which emerged in the course of counselling. As one teacher summed up:

I feel that for you as a counsellor to cope, you also need an outlet ... need to speak to someone else just to release some of the pressure which builds up inside you like a pressure cooker ... because it builds up and builds up and eventually I break ... I would say that in dealing with suicidal feelings that are evoked ... then the counsellor is left feeling and this needs to be relieved.

4.4.1. Containers at work

Interviewees spoke about their participation in formal support structures that could potentially accommodate this unloading activity. Interviewees (2) receiving consultation experienced it positively, saying that it provided a forum to process emotional responses to case material. As one interviewee put it after receiving consultation for a year:

Counselling without consultation is impossible ... it is an absolute necessity ... I discuss all my feelings ... at first it was strange ... but I began to see that it is necessary and it brings relief ...

One social worker was in a supervision group, and five ministers met on a monthly basis for a peer support group. The degree of containment experienced varied with the ministers saying that they used to the group to share experiences and feelings, while the social worker reported that the main aim of the group was the presentation and discussion of difficult cases, which did not incorporate any exploration of personal responses to cases. In the absence of formal containers at work, one interviewee spoke about how he and his professional partner (both policemen) created a container for themselves. He spoke about a morning ritual where they met to discuss personal responses to case-work.

4.4.2. Friends and colleagues as containers

In the absence of formal containers structured into the daily routine, a number of interviewees in the focus groups, especially the teachers, spoke about looking for containment in colleagues and close friends .

In my lewe het ek vier mense, vir wie ek redelik vertroulike informasie betref met wie ek stoom opblaas en weer met my stoom opblaas ...

A problem with this source of support for respondents was the difficulty ensuring client confidentiality in a small community. However, all respondents expressed a reliance on these informal networks of support to help process counselling material. There was

evidence to suggest that the interaction happened at some depth. As one teacher put it:

It's important to say how you feel and perhaps for your colleagues to interpret it and try to work with you just as you work with a client.

This comment seems to suggest that interviewees intuitively recognise that their emotional reactions to clients can be both conscious and unconscious and thus need clarification and feedback.

In summary, all interviewees felt that the containment they received, either formal or informal, was insufficient and responded positively to the idea of an interdisciplinary peer support and supervision group. It was felt that such a forum could play a dual role of providing support, building cross disciplinary networks and facilitating the handling of difficult cases like teenage suicide.

4.5. THE LACK OF RESOURCES

There was overwhelming consensus among the interviewees that lack of local resources in Atlantis, and isolation from existing provincial resources, paralysed efforts to respond to crises like suicide. As one interviewee put it:

I feel angry with the system ... angry with parents ... angry with adolescents and angry with myself ... because I just don't have the resources to respond and deal with the problem.

This anger directed at authority, in many cases parents, resonates with the formulation of Atlantis as the 'lost' city. One interpretation is that underlying this anger is a sense of abandonment by, neglect and lack of support from health authorities. Evidence of abandonment is the de-industrialisation process, withdrawal of state psychologists who worked in Atlantis on a sessional basis, the freeze on posts, and the lack of support from managers based in Cape Town.

Another interviewee (policeman) expressed his frustration at the lack of counselling facilities and described his creative attempts to make alterations in his office to provide a suitable counselling space:

Often I get called to homes ... when I get there I am asked to speak with the teenager ... but I can't counsel the teenager in that environment ... what is needed is space or room to one side which is conducive for counselling ... he must feel relaxed ... comfortable in the space ... it must be a nice room with a 'soft' atmosphere ...

Lack of local resources meant relying on more expensive interventions which raised a series of dilemmas for interviewees. One of the guidance teachers reported:

One of the most frustrating aspects is that most times there is a financial problem at home ... one can be sure that the person does not have a medical aid to go to a local GP ... before you even start thinking about referral elsewhere you have to deal with that problem.

Atlantis is isolated from potential referral sources in Cape Town. The distance and the cost of public transport makes contact with existing resources difficult, particularly after hours. The school nurse raises some of the dilemmas she faces when confronted with a possible long distance referral to the nearest adolescent unit, Sonstraal. This is near the coloured township of Mitchell's Plain, in Cape Town, which is approximately 45 km from Atlantis:

Sonstraal has a unit for teenagers but it is so far away ... often I don't feel equipped enough to assess just how seriously depressed the teenager is, whether he is in danger and whether he needs to go all that way ...

4.5.1. The need for crisis intervention services

Interviewees (5) expressed a great deal of reticence about making referrals to the day hospital because of the way in which the staff handled psychosocial emergencies. It was evident that in many cases, expensive referrals were made directly to Groote Schuur in Cape Town rather than the day hospital. There was a unanimous agreement in the focus groups discussion that Atlantis needed a crisis intervention service for psychosocial emergencies like suicidal behaviour, domestic violence, rape, and child abuse. One idea was that the youth counselling facility which had been mooted in

previous workshops, could include a 24 hour crisis intervention service. Interviewees expressed their willingness to assist in a voluntary capacity:

I would like to see a counselling centre where I would be willing to work a few hours or have night duty so that adolescents can come after hours ... I think that if counselling happens at the school it isn't easy to see someone ...

4.6. THE NEED FOR INTERSECTORAL NETWORKING

All interviewees expressed the need for greater collaboration and networking amongst paraprofessionals and professionals working with adolescents in Atlantis. This was confirmed in the evaluation forms from the adolescent workshop on teenage suicidal behaviour (where the focus groups happened) which reported that the opportunity to network with other local service providers, was the most helpful aspect of the workshop.

4.6.1. The lack of collaboration on case-work

There were few examples of joint work across the disciplines by those who were interviewed. Interviewees felt this was because of time-constraints, lack of inter-disciplinary communication, and in some cases because of the position of paraprofessionals in the 'pecking order' of service providers. For example, one interviewee involved in health education, who runs a very successful teenage club attached to the day hospital, offered to follow-up teenagers referred to casualty. She described hurtful comments made by the nursing staff:

It's about rungs in the ladder ... They say 'I am a Sister and you are a nothing' ... that I'm unqualified' ... yet they have no time for counselling ... or that there is no reason for counselling ... they don't seem to see people's suffering and they refer very few of the teenagers to Sonstraal ...

Another interviewee (policeman) said he initially started counselling teenagers because he was so dissatisfied with the follow-up to his referrals by the social welfare services

and the local hospital. However, incorporating counselling into his job description has met with resistance from his seniors:

A hell of a lot of people think I shouldn't be counselling ... but I see it as part of my community work ... it's because other agencies don't help ... don't give the personal touch ... teenagers come to me and I just listen while they talk ... that is what they want ... and no-one else is prepared to just listen ...

The policeman remarked that having a professional identity has facilitated acceptance by other professionals of his work as a counsellor and referral agent. Describing his referrals to the psychiatric emergency unit at Tygerberg, approximately 45 km from Atlantis, he says:

My position helped me ... people who don't have status will have a problem ...

Other interviewees (3) with no formal psychiatric training or professional identity in another field confirmed that their attempts to make referrals were met with suspicion or resistance. However a year after the initial interviews one of the same interviewees reported a welcoming shift in attitude:

I refer to Sonstraal ... it was difficult in the beginning to phone ... I was frightened ... I was so used to people saying 'you're not qualified' ... and I would anticipate people saying 'you're not a sister ... how dare you refer' ... now when they ask I say 'ja, I am the counsellor ... I am the therapist' ...

She went on to say that she now receives formal written summaries from Sonstraal, Cape Town, which has affirmed her identity as a recognised counsellor. She felt that the consultation process has played an instrumental role in assisting her to develop a work identity which in turn has boosted her confidence and helped her become more assertive.

In summary, it emerged that those interviewees with a professional identity felt they had more leverage when it came to accessing the health system than paraprofessionals.

Recently, about a year after the initial interviews, the policeman spoke positively about newly forged working relationships between the police and various sectors (including school nurses, health education officer, social workers) around difficult teenage cases. He was still counselling and was seeing two cases for follow-up involving adolescent suicidal behaviour at the time. These intersectoral developments were confirmed by the above mentioned professionals and paraprofessionals.

4.6.2. The interstitial position of paraprofessionals in the mental health care network

Interviewees (3) articulated frustration at their interstitial position between the community and health services. For one interviewee (paraprofessional) the position represented powerlessness and a diffuse sense of accountability. This is predominantly because she is accountable to a manager who represents a professional rather than a paraprofessional area of work. Her work involves running health education programmes for teenagers from the hospital premises which takes the form of a counselling service and teenage club. She described her position as:

I'm like the spokesperson for the hospital ... I've got to make the transition easier ... making bad look good ... I feel bitter ... angry ... I battle for people ... unhappy patients come to me to complain about their treatment at the hospital ...

For other interviewees (4) who have a professional identity, their frustration at their interstitial position was about the lack of boundaries it represented. Often it meant being the first contact in an crisis situation, over weekends or at night. One minister added that the position between the community and services demanded a wide range of areas of expertise. He describes his position as follows:

We have a strange position in the community ... people want an ambulance service ... even though they might have tried to hide things from you ... in the countryside like this, in an emergency, a minister has to be lawyer ... midwife ... marital counsellor ...

A few interviewees (4) felt there were advantages to their interstitial position. The feeling was that position is highly regarded by community members and that one is

trusted and allowed access to sensitive information to family background dynamics. One of the teachers said:

I feel if a child is comfortable with you and says 'I want to speak with you' there are many advantages ... you know the character of the child ... his behaviour ... personality ... and are maybe better placed to deal with the problem ...

For paraprofessionals their interstitial position was associated with relative powerlessness, marginalization and lack of recognition by formal health structures. High levels of credibility and trust, particularly as perceived by the youth, were seen as advantages of the interstitial position.

4.7. STIGMA AND THE SILENCING PROCESS IN THE COMMUNITY

All the respondents in the focus groups agreed that the stigma associated with suicidal behaviour was a major obstacle to successful interventions. Interviewees described the myths about suicidal behaviour as follows: A tendency to view such problems as running in cycles in families; that suicidal behaviour triggers a "chain reaction" amongst peer group; that only "mad" people try to commit suicide, and that suicide is associated with the devil. There was acknowledgement of interviewees' own stereotyped attitudes towards suicidal behaviour. Intense anger was evoked in respondents when speaking about parents and teachers. It was felt that these authority figures participated in and perpetuating the stigmas, either overtly or covertly. A typical scenario which interviewees encountered is: that any suggestion of a psychological problem is met with complete denial by parents:

... selfmoord is iets binne in die huis ... al wat hulle gaan se is dat dit gebeur nie in my familie nie..alles is gelukkkig daar ...

Or that there is partial acknowledgment by the less powerful parent, but nothing is done about the problem:

The mother might see the problem but is unable to speak to the father because she is afraid of him ... and knows that the father won't acknowledge the problem ... or speak to anyone else because he is too proud ...

The role of the church was raised in the discussion around suicidal behaviour and stigma. There are 14 churches in Atlantis, with the New Apostolic Church, NG Sending Kerk and the Old Apostolic Church, having the biggest memberships (FCR, 1992). One respondent in an individual interview described the role of the church in perpetuating the stigma associated with suicidal behaviour:

The church is very influential ... the Pentecostal churches say it's something of the devil ... if you commit suicide you go to hell ... and that it's a sin ...

Others (6) felt that the church had softened its stance:

A while back my church would have condemned such things but there is a move to accommodate psychological problems like depression or suicide.

There was also acknowledgement amongst respondents (5) in the individual interviews that a silencing process was active around suicidal behaviour in their places of work:

We have a therapy group in which we discuss different topics ... but suicide has never been a topic of discussion which is something we are going to have to look at ... you have now really made me think. It seems to be something we are avoiding ... leaving it like that ... it's comfortable that way.

Respondents all expressed concern about the damaging impact of myths and stigmas around suicidal behaviour on their work and agreed that only through far-reaching educational programmes and consciousness raising efforts, could this be addressed in the community.

4.8. SUMMARY OF RESULTS

The aim of the research was to explore factors that disorganise the work of mental health professionals and paraprofessionals in Atlantis, and contribute to their high levels of stress. Adolescent suicide is used as an authentic clinical example to explore these issues. In summary the results suggest that the following play a disordering role for respondents:

1. Adolescent suicidal behaviour is evocative for mental health workers.
2. The lack of a discourse around feelings impinges on the counselling process.
3. Mental health workers feel ambivalent about their intense countertransference reactions in such cases.
4. Mental health workers develop defences against their own feelings in the absence of structures which may help contain and relieve such feelings.
5. Mental health workers lack confidence with regards to psychological knowledge and skills.
6. The lack of crisis intervention services in Atlantis contributes to high stress levels amongst mental health workers.
7. The lack of communication and networking amongst mental health workers leaves individual workers feeling isolated as they work under difficult conditions.
8. The lack of recognition for paraprofessionals by state health services undermines their role in the referral network.
9. The interstitial position of mental health workers between the person in crises and state services, places them under great pressure to respond to problems in the absence of an adequate health infrastructure.
10. The stigma associated with psychological problems like suicidal behaviour, perpetuated by the church, schools, and parents impedes the ability of mental health workers to address the source of the problem which often lies in the family.

Recommendations from respondents include:

1. An interdisciplinary consultancy group for mental health workers in Atlantis.
2. In-service training opportunities, focusing on micro-skills.
3. An adolescent counselling centre, with a 24 hour crisis intervention service.
4. Advocacy and information around adolescent suicidal behaviour as a public health problem.

CHAPTER FIVE: DISCUSSION AND RECOMMENDATIONS

5.1. INTRODUCTION

Issues raised from the thematic analysis of results are discussed in chapter five. Recommendations, largely drawn from the psychodynamic consultation approach, are suggested to counter anxiety, stress and lack of confidence experienced by mental health workers.

PART A: DISCUSSION

5.2. AMBIVALENCE ABOUT FEELINGS

The intense emotional reactions to counselling material expressed by respondents is in keeping with Menzies'(1960) and Obholzer's (1994) findings that clients evoke powerful feelings in those who care for them. Furthermore, both authors make it clear that processing these feelings is an integral part of consultation. This framework is considered contentious in the consultation literature, with some of the most influential writers in the area taking the stance that dealing with countertransference reactions falls outside the boundaries of consultation, and is best left to private psychotherapy (Caplan & Caplan, 1993; Heller *et al.*, 1984; Steinberg, 1989).

In weighing up what is most appropriate for mental health workers in Atlantis, a number of issues need to be considered. The first issue relates to the context of Atlantis. There are few available resources for psychotherapy or clinical psychodynamically orientated supervision. In most cases a refusal to make space for emotional reactions to material means that the consultee misses out on an opportunity to deepen her understanding of complex feelings. The consequences of this may be as Menzies (1974) argues that mental health workers then become threatened,

defensive and caught up in protecting their own vulnerabilities, which mitigates against the primary task of being empathetic. As was highlighted in the previous chapter this may lead to counselling which is either more advice orientated (this is not to rule out that in some circumstances this is called for in the context of Atlantis, see Holdsworth, 1994), or less containing and empathetic because of the need to circumvent feelings.

Failure to acknowledge feelings on the part of the consultant may be experienced as insensitive or unsupportive by the consultee. There is already a perception amongst respondents that personal reactions to case material are negative or "get in the way". Thus not acknowledging countertransference reactions may perpetuate the view that "good counsellors don't feel". This may increase feelings of inadequacy and guilt in mental health workers who feel overwhelmed with intense, and sometimes hostile, feelings towards clients.

Advantages for making space for countertransference material in consultation include: allowing consultees to talk openly about feelings may go a long way to normalise, particularly negative feelings.

The consultant can use such opportunities to model how one works with a client, which could contribute enormously to the consultees' professional development. This promotes learning that is experientially based, an effective way of transferring micro-skills. Increased skills in turn promote a sense of expertise and boost consultees' confidence levels. Therapeutic work with the anxiety or depression of a consultee could "free the consultee up" to work more empathetically and sensitively with clients.

This is not to say that the concerns Caplan & Caplan (1993) raise in their guidelines for consultation are not important. I think that many of their concerns about the consultation process are pertinent and require careful thought, particularly those questions raised around dependency, power, and transference between consultant and consultee (see Caplan & Caplan, 1993). However, I disagree with their strategy to deal with these issues. I would argue that Caplan & Caplan's (1993) strategy of circumventing reactions will not work. Rather reactions and experiences of the

consultee need to be incorporated into the process of consultation. In terms of Atlantis, I would argue that it is expected that these issues come to the fore and need attention, reflection and exploration.

The rather brash axiom "It doesn't matter what happens in psychotherapy, as long as it is processed" springs to mind. What I am suggesting is that working with the transference in consultation can be a powerful, immediate learning experience for mental health workers. And also one that is beneficial for clients, whose feelings may then be more accommodated in counselling. They are more likely to feel heard by the counsellor.

5.3. THE 'PSYCHODYNAMIC' PART OF CONSULTATION

The choice to work with issues like countertransference immediately shifts the work into a more psychodynamically orientated framework. This may not be immediately acceptable to mental health workers. In many ways the process of introducing consultation to Atlantis needs to be seen developmentally as something which has been negotiated.

Initially the approach was met with resistance from potential consultees in Atlantis who wanted to make referrals rather than take on the added role of counsellor (see Holdsworth, 1994). However, gradually the consultation method has gained support from consultees who began to experience it as containing and contributing to their professional development. Potential consultees have benefited through training workshops run by the psychology team.

Similarly, consultation represents a new method for consultants. This method has been grappled with amongst interns at MCHP and has developed both at a clinical and theoretical level. Increased levels of trust between consultee and consultant has produced a more secure container for a therapeutic alliance to develop. It is within this context that questions about the parameters of consultation are raised.

An attempt to integrate a more psychodynamic approach to an understanding of stress and anxiety in organisations is illustrated below.

5.4. GAP BETWEEN REAL-WORLD EXPERIENCE AND ASPIRATIONS AS COUNSELLORS

In many ways there is a parallel between the experiences of adolescents and mental health workers in Atlantis. In the same way that adolescents are acutely aware of the gap between what they aspire to being and what is possible given the disadvantaged context, so too are counsellors painfully aware that their counselling is debilitated by their lack of theory, skills, infrastructure and resources. According to Bibrings's (1953) formulation the gap between what they aspire to being as counsellors, and the reality of their experience, leads to high levels of stress, feelings of inadequacy, low self-esteem and despair. This resonates with Rakoff's (1989, 1994) formulation of the unrealised aspirations of adolescents which produces despair, frustration, depression and self-destructive activities like suicide.

It is expected that the process and perspective of a psychodynamically orientated consultation will address some of these feelings of inadequacy and despair.

5.5. ANGER TOWARDS PARENTS // ANGER TOWARDS MANAGERS

One of the assumptions made in the psychodynamic consultation literature is that there are unconscious processes in organisations which like unconscious processes in individuals, impact powerfully on functioning (Halton, 1994). An example of this is the number of interviewees who spoke about their anger towards authority, particularly parents of suicidal adolescents. Parents are seen to deny problems, or, be derisive about the seriousness of adolescent problems, referring to it as 'naughtiness'. Parents are seen as afraid to expose the family dynamics to scrutiny.

Following Halton's (1994) guidelines to making sense of hidden meanings, it may be that the anger expressed by mental health workers is in part an unconscious reference to managers. This is most evident in relation to managers in hospital and clinic settings who do not take consultees' counselling work seriously. Managers are portrayed as derisive towards counselling, calling it 'a waste of time'. In the follow-up interviews one (paraprofessional) interviewee spoke about being overlooked for a merit award because the manager said it 'wasn't for lazy staff members'. Also the manager constantly told her should help out in the casualty section when it gets busy which made her less available for counselling.

What is interesting is that both professionals and paraprofessionals raised the lack of support from managers as a problem. However paraprofessionals felt doubly undermined not only by managers of institutions, but also by other professionals as well. These feelings produced conflict and tension. This will be discussed below.

5.6. HIERARCHY AMONGST PROFESSIONALS AND PARAPROFESSIONALS

The tension between professionals and paraprofessionals is produced largely by a rigid hierarchy which marginalises the work of paraprofessionals. For example a paraprofessional, who is based at the day hospital, was nominated to represent the institution on the peer support group working committee. However, one of the nursing staff complained about this nomination and wanted it over-turned on the basis that the paraprofessional did not have the authority to represent the day hospital in this forum. The fact that the paraprofessional is the most suitable candidate seemed unimportant. The decision was made on the basis of position in the hierarchy. In the face of powerful nursing structures, she has no other body with whom she could lodge a complaint and thus challenge this power structure. Instead her nomination was blocked.

One of the difficulties is that paraprofessionals are not recognised as a category of health workers in health policy.

Many referrals or follow-ups to state institutions are un-acknowledged. It also means that their voice is often not heard in meetings, or decision-making forums.

5.7. STIGMA, SILENCING PROCESS AROUND SUICIDAL BEHAVIOUR

Stigma attached to suicidal behaviour was cited by all those interviewed as an overwhelming obstacle to their counselling work. Using Moylan's (1994) formulation of projective identification processes in institutions, one can make the following hypothesis: Mental health workers deal with adolescents who are often in desperate need. Often these adolescents are unable to communicate this to counsellors and thus rely on projective identification processes as a way of communicating their distress.

Mental health workers do not have the theoretical knowledge to make sense of these processes. As a result projective processes are ignored, leaving mental health workers overwhelmed, stressed, but unable to give their experience a name. Without a name, these projections are invisible, and thus neglected in staff groups or supervision. The desire to keep such projections invisible is encouraged by the taboo around talk of suicide. As one social worker pointed out it suits everybody not to talk about suicidal behaviour. Moylan (1994) says that "the only recourse for the staff [is] to leave the clinic, or to attempt to get rid of the pain by avoiding knowledge of it in themselves (p.56) ... there is a strong pull in these circumstances to use the same defences as the clients" (p.57).

Many of the mental health workers are tangled up in the projective identification processes with adolescent clients. The same defences of silence and denial around suicidal behaviour in counselling is mirrored in supervision and case conferences. One could take the argument further – that in many ways the stigma and silencing process around suicidal behaviour in Atlantis is active in a similar way around counselling.

Possibly, the resistance of the community, particularly the authority figures, to exposing adolescent suicidal behaviour, is that it means taking responsibility for what

they have failed to provide in terms of nurturance, care, and support. In a similar way, it is possible that the resistance of the day hospital staff to counselling involves exposing the inadequacy of the medical response to the problem of adolescent suicidal behaviour.

PART B: RECOMMENDATIONS

5.8. NEGOTIATION OF PSYCHODYNAMIC APPROACH

A more psychodynamically orientated approach to consultation would need to be negotiated with consultees. The aim is to ensure they make an informed decision as to whether this way of working is acceptable or not. This could take place in groups or workshops to facilitate discussion and debate. Such a forum could also be used as an opportunity to introduce psychological ways of understanding problems. Reed *et al.* (1990) reflect on their intervention with a group of teachers, and speak about the initial ground work that needed to be done:

... for the first half of the sessions considerable time was spend exploring what was on offer and questioning whether that was what was wanted. Such deliberations are always a painful but necessary part of the process of developing a therapeutic alliance (Sandler, Dare & Holder, 1973). In consultancy, as in psychotherapy, the task of engagement at the right level and negotiating an agreed contract is very instructive. However to be effective this task is stressful and time consuming.
(p. 398)

5.9. PSYCHODYNAMIC CONSULTATION GROUP

The need for an interdisciplinary peer support group was discussed enthusiastically by the respondents. This would be the first of its kind in Atlantis. In order for the group to function as a 'container' it would need to hold regular meetings and encourage regular attendance. Mawson sees the objective of the group being that "participants can begin to tolerate bringing more of their feelings than they are used to doing in

other work activities, in an atmosphere which encourages openness and self examination" (1994, p. 69).

Menzies (1974) points out that there is always ambivalence about participating in a support group. As Reed *et al.* (1990) found, consultees are easily threatened by exposing the tensions and conflicts in their agencies to the group. In Atlantis professionals and paraprofessionals struggled to communicate their tensions with staff and management in a direct manner. The criticisms were usually veiled, projected or displaced. Under such circumstances, Mawson (1994) highlights the need for an experienced and containing consultant to provide a sense of security for group members.

5.10. THE ROLE OF THE CONSULTANT

For the consultant, a psychodynamic perspective to consultation requires flexibility in terms of the role of the consultant, and the boundaries of the consultation activity. At times consultation may enter into the territory of psychotherapy, where personal experiences are processed, and then shift back to consultation, with the role of the consultant shifting accordingly from that of therapist, to that of consultant. The consultant needs to guard against "overpsychologising" problems (Mosse, 1994), particularly given the prominence of poverty and socio-economic difficulties in Atlantis, and the anxiety of some of the respondents about psychology.

It is important that the consultant has had psychotherapy (Mosse, 1994). A psychodynamic method demands that the consultant's unconscious be reasonably accurate. The interns working as consultants in Atlantis are bound by the guidelines of the Masters' Clinical Psychology Internship Programme, at the University of Cape Town. Personal psychotherapy is strongly recommended during the internship. Supervision, specifically for consultancy work at Mamre and Atlantis, as well as psychotherapy supervision, is structured into the programme. Hence multiple auxiliary

supervisory networks are built into the training to help scrutinise one's own unconscious processes and defence mechanisms.

5.11. PARAPROFESSIONALS AS A RECOGNISED CATEGORY

According to the Draft Provincial Health Plan, mental health has been identified as a priority in the Reconstruction and Development Programme (RDP). The important role played by paraprofessionals, particularly in disadvantaged rural communities, is at last being recognised and incorporated formally into health and welfare service planning (Freeman, 1992).

As paraprofessionals become part of the public health sector, it is likely that the dominant biomedical ideology will extend its influence into their area of work. Many paraprofessionals in Atlantis support a progressive psychological approach to psychosocial problems. However they occupy a position of relative powerlessness, and may well be co-opted by the dominant model. Empowerment of mental health workers as a recognised category, through the benefits of formal training, status, career prospects, and remuneration, may provide the autonomy needed to help prevent this from happening.

5.12. CONSULTATION WITH MANAGERS IN INSTITUTIONAL SETTINGS

Managers have been neglected in the attempt to introduce the consultation method to agencies in Atlantis. Traditionally managers focus on difficulties that relate to financial or administrative matters and neglect staff difficulties. According to Obholzer (1994) consultation needs to extend to working with managers. The objective is to evaluate their management styles and encourage an approach to management which is more sensitive to intra-and interstaff processes.

Secondly, consultation at any level in an agency needs the support of management. Without such support, consultees are not given the space to practice and develop their newly-acquired counselling skills which can 'be frustrating, and contribute to tension and stress.

5.13. CRISIS INTERVENTION SERVICES

Katschnig & Konieczna's (1994) findings suggest that a shift to a primary health care approach results in a de-focus away from emergency services. This is a cause for concern for rural areas like Atlantis, given the high prevalence of mental illness (see Chapter Two), the lack of trained personnel and the geographic isolation from other referral resources. Crisis intervention services become extremely important in such an under-resourced, isolated area. The absence of such services contribute to the high levels of stress and anxiety of health workers in Atlantis, particularly when a psychosocial emergency happens at night or over the weekend. A proposed 24 hour crisis intervention service was mooted by respondents. Respondents envisaged a core team of a psychologist, psychiatric nurse and social worker. A number of interviewees envisaged a volunteer network comprising of professionals and paraprofessionals to assist with the after hour shifts.

5.14. THE NEED FOR ADVOCACY

As Mosse & Zagier Roberts (1994) point out, requests for consultation are often made when organisations are threatened with subsidy cuts, funding difficulties, or frozen posts. In the case of Atlantis, referrals from mental health workers came when a part-time (public sector) post for a psychologist was withdrawn. Funding for MCHP was insecure, and industries in Atlantis were closing rapidly due to the de-industrialization processes. All of these events increased the stress levels of workers and aggravated the sense of neglect and abandonment integral to the 'lost city' syndrome. In reflecting

on their experiences of consultancy under these conditions, Mosse & Zagier Roberts (1994) conclude that:

Threats to survival stir up primitive anxieties about annihilation and fragmentation. Very often the response is to withdraw from reality, which seriously compromises the capacity for problem-solving ... The question 'Who needs to say what to whom?' is often a useful prelude to planning how to manage the threat facing a group or organisation (p.154) ... It is crucial to have the right fight with the right people, so to speak; otherwise the fight will be displaced in ways that undermine the task ... Sometimes the threat can be overcome. Even when this does not happen, it is possible to regain some inner sense of having the power to affect one's own experience, rather than being a silenced victim.
(p.155)

Some writers regard consultation as synonymous with advocacy (see Conoley, 1981c), while others view advocacy as one theoretical perspective of consultation (see Meyers, 1984). Regardless of one's stance on the issue, the consultation activity plays a useful role when resources are threatened. Often workers deny threats of closure. Consultation can help to deconstruct the denial and provide a space for consultees to process their anger and respond to threats in a more constructive manner.

On a practical level consultants, in their role as advocates, can help consultees locate their work in the 'bigger picture' of mental health care in South Africa. They can assist with funding proposals, needs assessments and facilitate contact with policy-makers. In this way psychologists can work along side community structures which is in keeping with the need to affirm such collective responses to psychosocial problems. By participating in advocacy initiatives, consultees can learn a wide range of 'professional skills' which is likely to increase competence and confidence levels.

CONCLUSION

This dissertation deals with the experiences of mental health workers in Atlantis. I have been particularly interested in the factors which disorganise these workers and contribute to high levels of stress, anxiety and lack of confidence when dealing with complex cases like adolescent suicidal behaviour. I discussed a psychodynamic consultative approach as a way of containing their work-related difficulties.

The literature suggests that the effects of dislocation and isolation as a consequence of forced migration are being felt by the next generation. Evidence for this emerges in youth talk about Atlantis as the 'lost city', as having a diffuse sense of identity, and request for a counselling centre. In Atlantis, mental health workers are part of the generation that were directly affected by forced migration. I argue that workers' involvement with troubled adolescents may be a compensatory response to the lack of support for the youth by their parents, as babies. Both youth and health workers are struggling against the same social processes and sense of anomie.

Durkheim's concept of anomie is applied to the context of Atlantis. I argue that the complexities of the apartheid system need to be included in the formulation. More specifically, that aspirations have been restricted or denied to individuals in South Africa on the basis of race. Awareness of the contradictions around aspirations is discussed. It is argued that awareness of alienation can promote social activism. However, vulnerable individuals may be overwhelmed by the experience of anomie. This may reflect in one of the "disorders of aspirations". I argue that youth in Atlantis are vulnerable to the effects of anomie; that aspirations, opportunities, and identity issues are linked to the developmental phase of adolescents.

I argue that for a community like Atlantis, in the midst of economic crisis, support for the aspirations of adolescents is not feasible. Following Rakoff's formulation (1989) this produces frustration, despair, depression, and self-destructive behaviour in vulnerable individuals. South African studies on adolescent suicidal behaviour are discussed. I

highlight the degree to which local studies integrate an analysis of apartheid into their understanding of adolescent suicidal behaviour. This perspective is supported by studies in the international literature which investigate the relationship between socio-economic change, stress and adolescent suicidal behaviour.

Current state health care services are inadequate and are unable to cope with the increased demand for psychosocial interventions. Rural areas are particularly under-resourced and reliant on the biomedical services provided by the day hospital. To a limited degree, health workers are exposed to a more psychologically orientated approach to psychosocial problems through contact with MCHP. The differences in approach to psychosocial problems are discussed. In the absence of adequate and accessible mental health care facilities, community health workers have been forced to find ways of dealing with psychological problems themselves. This has led to the emergence of a category of paraprofessionals.

Areas of difficulty commonly experienced by paraprofessionals and professionals are discussed. These include lack of theoretical knowledge, clinical skills, and of confidence, all producing high levels of stress and anxiety. Primitive, personal and work-related anxiety are distinguished. Often anxiety is communicated in unconscious ways which if not understood can undermine counselling work. Health workers develop collective defence mechanisms to circumvent awareness of their anxiety. The idea of a 'container' is introduced to address worker anxiety and stress.

I use the psychodynamic consultancy model to explore issues which affect mental health worker, as raised in the findings. Firstly, there is a parallel between the experiences of adolescents and mental health workers in Atlantis. In the same way that adolescents are aware of the gap between what they aspire to be and what is feasible, so too are mental health workers painfully aware that their work as counsellors is debilitated by their lack of skills and theoretical knowledge. In the case of paraprofessionals, their work is undermined by the lack of professional identity. This predicament can lead to despair, anxiety, low self-esteem and depression. Secondly, the anger expressed by mental health workers towards parents reflects unconscious

anger towards managers who were unsupportive, derisive and try to undermine their counselling work. Thirdly, there is tension between professionals and paraprofessionals, produced largely by a rigid hierarchy which marginalised the work of paraprofessionals. One of the difficulties is that paraprofessionals are not recognised as a category of workers in health policy. As a result, often their voice is not heard in decision-making forums. Fourthly, there is a stigma attached to suicidal behaviour which encourages a silencing process. This silencing process allows projective processes to flourish in counselling, supervision, and agencies.

Other issues which are raised in the discussion include the following: Mental health workers express ambivalence about their countertransference reactions to case material. I argue that the exploration of countertransference reactions needs to be incorporated into the consultation process. Recognising countertransference issues immediately shifts the work into a more psychodynamically orientated framework. This would need to be negotiated with workers.

Recommendations which emerge from the findings include: Firstly, the need for an interdisciplinary peer support and supervision group. The aim would be to provide a 'container' for workers to increase awareness of their anxieties so that these processes can be understood and dealt with. Secondly, that consultation extends to working with managers to increase their sensitivity to staff difficulties. Thirdly, there is a need for a 24 hour crisis intervention service in Atlantis which has the resources to respond to psychological emergencies. Fourthly, that paraprofessions need to be empowered through legislation, training and remuneration. Finally, psychologists need to use their status to influence policy makers, planners, and state departments for resources so that the legend of Atlantis as the 'lost' and forgotten city is not perpetuated. Policy innovations would assist developments in other marginalised communities in the country.

Although this dissertation has focused on the difficulties and problems experienced by mental health workers in Atlantis, I would like to salute their resilience, their creativity, and 'real-world' successes under trying conditions.

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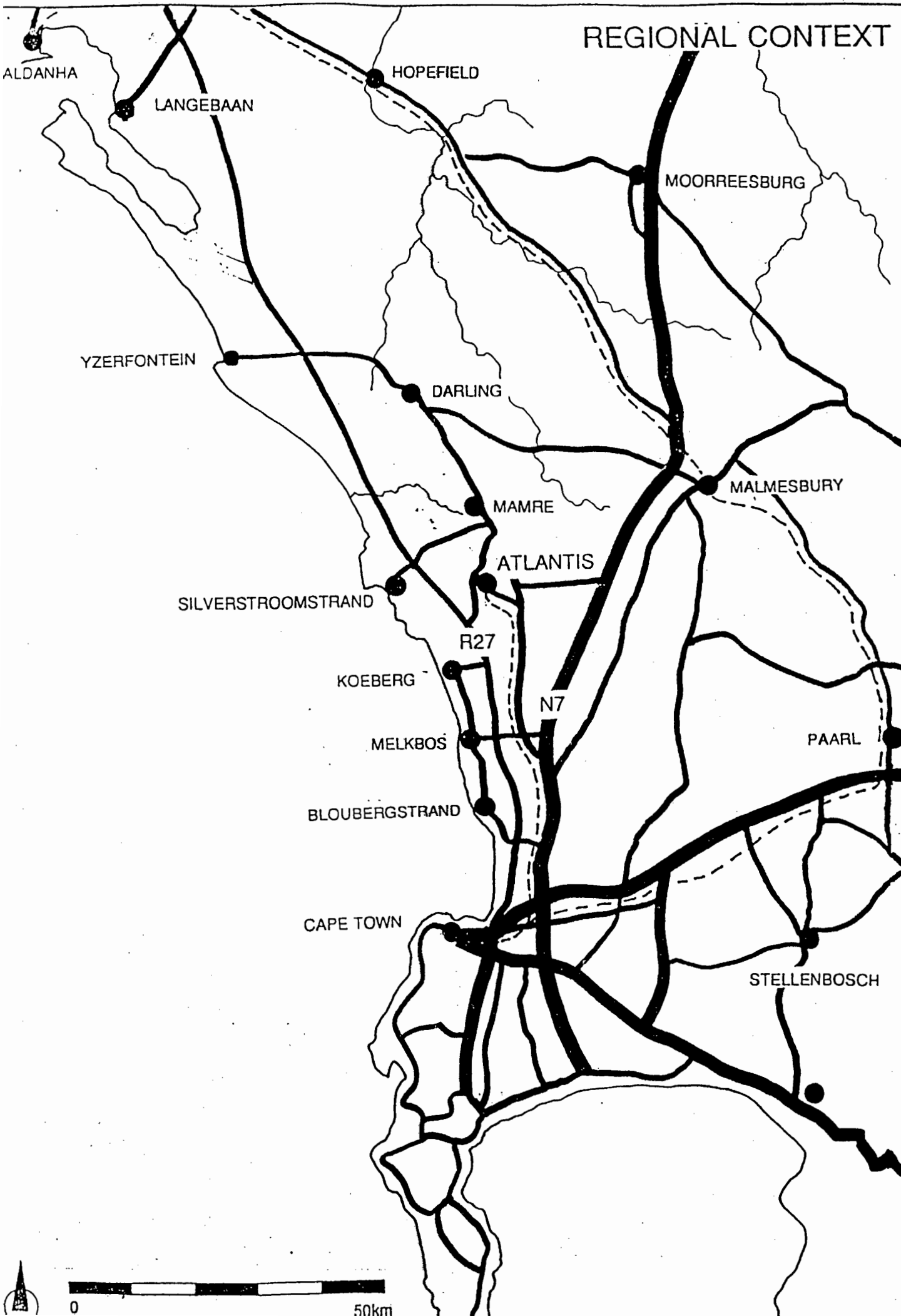
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APPENDIX A



REGIONAL CONTEXT

ALDANHA

LANGEBAAN

HOPEFIELD

MOORREESBURG

YZERFONTEIN

DARLING

MAMRE

MALKESBURY

ATLANTIS

SILVERSTROOMSTRAND

R27

KOEBERG

N7

MELKBOS

PAARL

BLOUBERGSTRAND

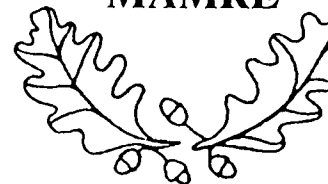
CAPE TOWN

STELLENBOSCH

0 50km

APPENDIX B

MAMRE



COMMUNITY HEALTH PROJECT GEMEENSKAP-GESONDHEIDSPROJEK

POSBUS/P.O. BOX 103 . MAMRE . 7347 . TEL. 0226-61020 . KAAPSTAD/CAPE TOWN 021-40662

10 April 1994

Dear

Training Workshop on Depression and Suicidal Behaviour Amongst Adolescents

There is a growing concern regarding the extent of suicidal behaviour among adolescents in Atlantis. This has been asserted by service providers in community organisations, welfare agencies and local clinics, as well as by the youth themselves in a recent research study focusing on adolescent problems, conducted by an Intern Psychologist, Kim Richardson, from the Mamre Community Health Project, in conjunction with the Atlantis Development Forum.

We have held discussions with service providers who have identified the need for training on assessing the severity of depression and suicide risk as the most pressing issues. You are invited to participate in an one day training workshop which is specifically aimed at persons who have counselling experience and who work directly with adolescents in youth groups, schools, community organisations etc.

The workshop will be held on Monday, 16 May 1994 from 8.30 - 4.00 in the Boardroom at SaxonSea Housing Office, Atlantis. Issues we will deal with include: reasons why youths become suicidal, warning signs which alert us to possible suicide risk, how to ask difficult questions when an adolescent admits to feeling suicidal, and ideas about management.

Please respond by 9 May 1994 to book your place as numbers are to be limited. A contribution of R10.00 for lunch costs would be appreciated. Please pay Belinda Rayners in advance.

We look forward to hearing from you.

Yours sincerely

Carol Sterling

Carol Sterling

Clinical Psychologist

(on behalf of the Mamre Community Health Project)

Merran Welsh

Merran Welsh

Intern Clinical Psychologist

RSVP by 11 April :

Mercia Arendse 61020/Belinda Rayners 21290

APPENDIX C: UNSTRUCTURED INTERVIEW SCHEDULE

Have you ever had to deal with suicidal behaviour in the course of your work with troubled teenagers? If yes, how often have you had to deal with teenage suicide?

Could you describe the first contact you had with a teenager who felt suicidal?

Could you describe your most recent contact with a suicidal teenager?

Do you feel that you have adequate training to deal with suicidal behaviour?

Do you think you could benefit from more training, information or counselling skills in this area of work?

APPENDIX D: SEMI-STRUCTURED INTERVIEW SCHEDULE (FOCUS GROUPS)

A tape recorder is provided to ensure that no contributions to the discussion are lost. As previously discussed, the transcriptions will be used as research material in conjunction with the Social Fabric Commission. Please do not allow the presence of the tape recorder to restrict your participation, as no names will be attached to comments in the reports.

The following questions are provided to guide the group discussion:

1. What do you think teenagers are trying to say when they engage in suicidal behaviour?
2. What are your experiences of dealing with teenage suicidal behaviour?
3. How have you managed teenage clients who have said they are suicidal? (counselling, family work, home-visit, referral, follow-up).
4. Do you feel you have adequate training to deal with suicidal behaviour?
5. What further training, would help you deal with suicidal behaviour in the course of your work? How could this take place?
6. How do you feel personally when counselling a teenager who is suicidal? Are there particular feelings that suicidal behaviour evokes in you? How do you understand these feelings? Do your own feelings help your counselling work, or do you think they "get in the way"?

7. Counselling teenagers who are so troubled, depressed, or suicidal, can be very stressful. Who supports you? Is the support adequate? How much support do you receive from your agency or place of work?

8. Are there any other difficulties, not already mentioned, which you as a counsellor face when dealing with suicidal behaviour in teenager clients?

APPENDIX E: SEMI-STRUCTURED SCHEDULE

1. You attended a workshop on Adolescent Depression and Suicidal Behaviour in Atlantis last May. Could you feed back any developments which may have evolved as a result of the workshop by answering the following questions?
 - do you attend any of the peer support and supervision groups?. If so, is it useful?
 - do you receive individual consultation? If so, do find it useful? Could you say in what way it is useful?
 - at the time of the focus groups, mental health workers spoke about difficulties making referrals to state institutions. Is this still a problem? Have there been any positive changes? If so, what do you think has facilitated the change?
 - we discussed the lack of interdisciplinary networking and collaboration on specific cases. Have there been any changes in this regard? If so could you give examples of joint work? Did you find it useful? In what way was it useful?
 - micro-skills were identified as an area of weakness by mental health workers at the workshop last year. How do you feel about your ability to ask sensitive questions in a counselling situation?
 - would you say you feel more confident as a counsellor than you did a year ago? If yes, could you say what you think may have facilitated the change?
 - at the time of the focus groups, mental health workers felt very stressed. How are your stress levels at the moment? Have there been any changes in your stress levels over the past year? If so, could you say what in your opinion has contributed to this change?

APPENDIX F: AN EXAMPLE OF AN UNSTRUCTURED INTERVIEW

MW: Have you ever had to deal with suicidal behaviour in the course of your work with troubled teenagers?

SS: I have had about I'd say "min of meer", twenty adolescents come to me since I started my club in September 1993 saying that they had felt suicidal.

MW: That is a very high number. That's then 20 in the past seven or eight months then. Could you tell me something about the club and how it works?

SS: The teenage club offers counselling and advice to teenagers.

MW: How did it get started?

SS: I was employed to run a family planning service from the day hospital, but soon my office became full of teenagers who wanted to speak about problems at home. I just left my door open, and the teenagers came in until I couldn't cope any more and put up a notice on my door saying we are going to start a club for teenagers and it meets on this day at this time. Well, soon I had 60 teenagers coming along. It got so big that I had to run clubs two afternoons every week, instead of one.

MW: What kind of problems?

SS: Sexual abuse is the majority. Abuse is the main cause of teenagers trying to take their own lives. Also parental pressure especially in our coloured community where parents have too many children.

MW: It sounds like you are really meeting a need in Atlantis. What kinds of things do you do at the club?

SS: We talk about things like sexuality, relationships, peer pressure, and problems with parents. So many of the teenagers have experienced sexual abuse of some kind. We have discussion groups, we go on outings to the library, we do role-plays. They love doing role-plays and so much comes up in them.

MW: What kind of things?

SS: Well they act out things that have happened to them. Like sexual abuse or a boyfriend putting pressure on them to take drugs or have sex. You see what is happening in their homes and how fighting in the home affects them.

MW: And in what way does it affect them?

SS: How it makes them feel bad about themselves, unwanted, and unloved and how this makes them feel they cannot cope and want to end their lives.

MW: Do you mean 'think of suicide' when you say 'end their lives?'

SS: Yes.

MW: Could you remember the first time you had to deal with a teenager saying that they felt suicidal, or acted out suicidal feelings in a role play?

SS: Merran, honestly I cannot really remember nicely the details of the first one. It is so common. I hear teenagers saying it a lot.

MW: Okay, then perhaps you could describe your most recent contact with a suicidal teenager?

SS: I had one girl yesterday morning. She had taken an overdose of pills and had come into the casualty section. It turns out that there is no money at home, her parents are drunk and the conditions at home "is nie lekker nie". Now this girl has to take on too much responsibility for looking after her younger brothers

and sisters and its too much for her. She goes out and she becomes pregnant all because she is unhappy at home and very lonely. Now she doesn't know which way to turn.

MW: How did you deal with her?

SS: Doctor felt I should refer her to you as I thought you would be coming yesterday. I phoned Mamre but you were not there. I tried to talk to her for a while but then she was just discharged by the doctor.

MW: Was any follow-up arranged for her?

SS: No, nothing from the hospital's side.

MW: Is that usual for the day hospital?

SS: In a few cases patients get referred to Sonstraal or Groote Schuur. But its very far. Most times they just get discharged the same day.

MW: It must have been hard for you not to have Carol or me at the end of the phone yesterday, even if it meant just speaking about your own feelings, but it sounds like you did a lot for her because she opened up to you.

SS: Ja, I find that teenagers trust me and end up telling me what's on their minds.

MW: Can you tell me how you talk about suicidal feelings or thoughts with a teenager? I mean do you ask straight out if a teenager is so unhappy that they have thought of putting an end to their life, or do you wait for them to say it?

SS: No, I wait for them to say it. I find that it doesn't come up fast. One has to win their confidence first. Its difficult to suspect it when they walk around or they come in here. In most cases its the last thing that I think when they come in here. Sometimes they may come two or three times and one doesn't really

know what is wrong with this kid, and then they only tell you that they have suicide on their mind.

MS: How do you think listening to a young person, like the girl yesterday, who is so troubled, affects you?

SS: It's difficult for me because I am a mother of teenage children too. I mean to think that if my child doesn't confide in me with their feelings I mean when I don't know what my child thinks I may be unaware that there is something wrong or worrying them. That is what I always think when I look at this child, I think about my own child. I always think about my own children.

MW: So you feel for that teenager, as you would for one of your own. What happens to you after the session? I mean you must be left with a whole lot of feelings?

SS: When the adolescent walks out of the door I worry about him and when I see him again I feel quite relieved. I try never to lose contact with them. I just feel that they are so young. They have had so little out of life. Most of them have had nothing out of life. Kids are very unhappy. Some of them have never had a happy home. Some of them haven't even started life yet you could say. To me it seems so unfair to be so young yet to be so burdened. The thing is that if you look at their contexts it is not unnatural but to accept it is very difficulty.

MW: It sounds like the problems of these teenagers are very close to your hearts.

SS: Ja, Merran it makes a person feel angry sometimes and sad also.

MW: Do you feel you have had enough training to deal with suicidal behaviour?

SS: No, I'm not trained 'om so diep te gaan nie' which is one of my problems. They come and they go and they come back still feeling the same. They keep coming back and expecting me to help them. It makes me feel so helpless. I feel I can't live up to it.

MW: What do you mean by that last bit 'you can't live up to it?'

SS: To be honest I don't feel confident enough to counsel the person myself. I usually refer them to a doctor or in some cases a social worker.

MW: If you did have some counselling skills training and support, say through consultation with one of the UCT interns, like myself or the next intern, as we have discussed, would you then be happy to see suicidal adolescents yourself?

SS: Ja, definitely. That is why I felt so relieved when Sister Boucher told me about this workshop and about you. There is a great need for it.

MW: For what, counselling skills or skills particularly in the area of teenage depression and suicide?

SS: Both, I think. People never speak about suicide. I think its very difficult. People don't want to accept it. Something that isn't real or that will never happen to them. Something far not near them. People are ignorant I think. It's not a nice idea even to myself.

MW: And in terms of training, is there anything in particular that you want to see included in the workshop?

SS: I want to know what to tell them. I want to be know how to go about dealing with their problems.

MW: What if you could speak about the case in consultation with an intern, as we have discussed, or even if we got a group of service providers together on a regular basis to talk about similar cases, would you be prepared to see teenagers who come through the casualty section after say an overdose, for counselling?

SS: Ja, I think I would manage if I had some guidance from the interns. What I do now, I do in the best of my abilities but mostly I refer to a doctor or a social worker because I don't feel confident about my skills.

MW: Thank you for your time, and sharing your experiences with me, SS, and I look forward to seeing you at the workshop.