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**The UCT Child Guidance Clinic:  
Changing Client Profile and Policies  
in the 1990s**

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## ABSTRACT

As UCT Child Guidance Clinic (CGC) practice and policy shifted markedly in response to the political turmoil and parallel crisis in South African psychology during the 1980s, this study investigates the effects of the “new” South Africa on CGC practice and clientele during the 1990s.

Smit (1997) documents the dramatic reversal of the Coloured-to-White ratio in the CGC clientele between 1982 and 1992 but notes the consistent under-representation of “Blacks” in both decades. The demographic analysis of the 1990s CGC clientele confirms that these trends have been sustained throughout the 1990s. The effects of age, gender, class and culture on other specified key variables are also investigated.

Interviews with the multicultural CGC staff team help to contextualise the demographic findings, particularly concerning the under-representation of African clientele. Indigenous cultural preferences and difficulties with language, access, costs and resource shortages are cited as the chief determinants.

The CGC’s proactive responses to the long-term challenge of providing adequate mental health care to all population groups are discussed with reference to the training and selection of clinical psychology interns. A call is made for greater exposure to local indigenous population groups during training. The study concludes with interviewees’ perceptions and desires for the future of clinical psychology in South Africa and suggestions are advanced concerning potential future research.

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## TABLE OF CONTENTS

<b>Abstract</b>	<b>i</b>
<b>Acknowledgements</b>	<b>ii</b>
<b>List of Tables</b>	<b>xii</b>
<b><u>Chapter 1:</u></b>	<b>1</b>
<b><u>The Background and Objectives of the Study</u></b>	
<b>1.1 Introduction</b>	<b>3</b>
1.1.1 The Historical Context of the Study	4
1.1.2 The UCT Child Guidance Clinic	4
1.1.3 Diversification of CGC Practice	5
1.1.3.1 Re-evaluation of the Maudsley Interview Format	6
<b>1.2 Further Objectives of the Study</b>	<b>7</b>
1.2.1 Discernment of Shifting Trends during the 1990s	7
1.2.2 Interactions amongst Key Variables	7
1.2.3 Treatment Variables	8
1.2.4 Clinical Psychology Training in the 90s	8
1.2.5 African Clientele in the 90s	8
<b>1.3 Literature Review</b>	<b>9</b>
1.3.1 <i>South African Literature</i>	9
1.3.1.1 Historical Roots of Mental Health Practice in South Africa	9
1.3.1.2 The Political Upheaval between the 1970s - 1990s	10
1.3.1.3 Issues of Language and Culture	11
1.3.1.3.1 <i>Theoretical Models</i>	13
1.3.1.4 The Emerging Face of Community Psychology	14
1.3.1.4.1 <i>Community Participation</i>	15
1.3.1.5 Calls for an Indigenous Psychology	16
1.3.1.6 Summary of Key Issues in the South African Literature	18

<b>1.3.2</b>	<b><i>Health and Mental Healthcare Information</i></b>	<b>19</b>
<b>1.3.2.1</b>	<b>Uses of the Mental Health Record</b>	<b>20</b>
<b>1.3.2.1.1</b>	<b><i>Clinical Purposes of the Case History</i></b>	<b>20</b>
<b>1.3.2.1.2</b>	<b><i>Quality Assurance</i></b>	<b>22</b>
<b>1.3.2.1.3</b>	<b><i>Administrative Practice</i></b>	<b>23</b>
<b>1.3.2.1.4</b>	<b><i>Training and Education</i></b>	<b>24</b>
<b>1.3.2.1.5</b>	<b><i>Research</i></b>	<b>26</b>
<b>1.3.2.1.6</b>	<b><i>Programme Evaluation</i></b>	<b>29</b>
<b>1.3.2.2</b>	<b>A Postmodern Perspective on Psychiatric Case Notes</b>	<b>30</b>
<b>1.3.3</b>	<b>Changing Information Needs</b>	<b>31</b>
<b>1.3.3.1</b>	<b>Multiple Users of Healthcare Information</b>	<b>31</b>
<b>1.3.3.2</b>	<b>Need for Accuracy and Completeness</b>	<b>31</b>
<b>1.3.4</b>	<b>Security and Confidentiality</b>	<b>32</b>
<b>1.3.5</b>	<b>Benefits from Good Management of Information</b>	<b>33</b>
<b>1.3.6</b>	<b>The Role of Information Technology</b>	<b>34</b>
<b>1.3.6.1</b>	<b>Accuracy of Computerised Data versus Case Notes</b>	<b>34</b>
<b>1.3.6.2</b>	<b>User Compliance</b>	<b>34</b>
<b>1.3.6.3</b>	<b>Savings in Time and Personnel</b>	<b>35</b>
<b>1.3.6.4</b>	<b>Summary of Key Issues in the Case Note Literature</b>	<b>35</b>
<b>1.4</b>	<b>Chapter Summary</b>	<b>36</b>
 <b><u>Chapter 2:</u></b>		<b>37</b>
<b><u>Method</u></b>		
<b>2.1</b>	<b>Introduction</b>	<b>38</b>
<b>2.2</b>	<b>DSM Diagnostic Criteria</b>	<b>38</b>
<b>2.3</b>	<b>The CGC Case File Format</b>	<b>38</b>
<b>2.4</b>	<b>Part I: Quantitative Analysis</b>	<b>40</b>
<b>2.4.1</b>	<b>Omission of the Clinician and Community Files</b>	<b>40</b>
<b>2.4.2</b>	<b>Social Science and Educational Psychology Interns</b>	<b>40</b>
<b>2.5</b>	<b>Racial Classification System</b>	<b>41</b>
<b>2.5.1</b>	<b>Omission of Client's Race and Social Class</b>	<b>41</b>
<b>2.6</b>	<b>Statistical Analysis of the Data</b>	<b>42</b>

2.6.1	Descriptive Statistics for Key Variables	42
2.6.2	Log-Linear Analysis of Frequency Tables	43
2.6.2.1	Descriptive Reporting of Standardised Residuals	43
2.7	Part II: Qualitative Analysis	43
2.8	Triangulation	45
2.9	Chapter Summary	46
 <b>Chapter 3:</b>		 47
<b><u>General Demographic Study of the Clientele from 1990 – 1999</u></b>		
3.1	Introduction	50
3.2	Descriptive Statistics for Variables of Interest	50
3.2.1	Gender Distribution of Clientele	50
3.2.2	Age Distribution of Clientele	51
3.2.3	Referring Agent	52
3.2.4	Racial Distribution of Clientele	53
3.2.5	Social Class Distribution of Clientele	55
3.2.6	The Social Class / Race Link in South Africa	56
3.2.7	Presenting Problem	58
3.3	The Psychological Assessment Process	59
3.3.1	The Clinical Interview	60
3.3.2	Factors for Consideration in the Presence of Scholastic Difficulties	60
3.4	Psychological Tests used at the CGC from 1990 – 1999	61
3.5	Tests of Cognitive or Intellectual Ability	61
3.5.1	Internationally Normed Intelligence Tests	62
3.5.2	South African Normed Intelligence Tests	62
3.5.3	School Readiness Assessment	63
3.5.4	Giftedness	63
3.6	Non-Language Tests of Intelligence	63
3.6.1	Goodenough-Harris Drawing Test	64
3.6.2	Draw a Person (DAP)	64

<b>3.7</b>	<b>Tests of Motor Functioning and Visual-Motor Integration</b>	<b>65</b>
3.7.1	Tests of Spatial and Manipulatory Ability	65
3.7.2	The Bender Visual Motor Gestalt Test	65
3.7.3	Beery Developmental Test of Visual-Motor Integration	65
<b>3.8</b>	<b>Tests of Visual Perception</b>	<b>66</b>
<b>3.9</b>	<b>Tests of Auditory Perception</b>	<b>66</b>
<b>3.10</b>	<b>Specified Scholastic Assessment Tests</b>	<b>67</b>
3.10.1	The Individual Scale for General Scholastic Aptitude	68
<b>3.11</b>	<b>Multimodal Assessment of Behavioural Problems</b>	<b>68</b>
3.11.1	Multifaceted Assessment	69
<b>3.12</b>	<b>Projective Tests of Personality and Emotional Adjustment</b>	<b>69</b>
3.12.1	Projective Techniques	69
3.12.2	The DAP-SPED	69
3.12.3	The Thematic Apperception Test (TAT)	70
3.12.4	The Children's Apperception Test (CAT)	70
3.12.5	The Kinetic Family Drawing (KFD)	70
3.12.6	The Bene-Anthony Family Relations Test	71
<b>3.13</b>	<b>Observation of Free Play</b>	<b>71</b>
<b>3.14</b>	<b>The DSM Differential Diagnosis</b>	<b>72</b>
3.14.1	Selection and Composition of the Five Most Frequent Diagnoses	76
3.14.2	Gender Distribution for the Five Most Frequent Diagnoses	76
3.14.3	Age Distribution for the Five Most Frequent Diagnoses	77
3.14.4	Racial Analysis of the Five Most Frequent Diagnoses	78
3.14.5	Social Class Analysis of the Five Most Frequent Diagnoses	79
<b>3.15</b>	<b>Treatment Options Used by the CGC</b>	<b>79</b>
3.15.1	Referrals	79
3.15.2	Other Treatment Options	79
<b>3.16</b>	<b>Duration of Treatment</b>	<b>80</b>
<b>3.17</b>	<b>Client Dropout</b>	<b>80</b>
3.17.1	Possible Factors in Client Dropout	80
3.17.1.1	Client factors	80
3.17.1.1.1	<i>Differential Diagnosis</i>	80
3.17.1.1.2	<i>Social Class</i>	80

3.17.1.2	Therapist / Client Factors	81
3.17.1.2.1	<i>Racial Differences</i>	81
3.18	Treatment Outcomes	82
3.18.1	Additional Referrals	82
3.19	Relationship between Treatment and Outcome	82
3.20	Chapter Summary	84
3.20.1	Individual Statistics	84
3.20.2	Assessment Process	84
3.20.3	The DSM Diagnosis	84
3.20.4	Treatment Options	84
3.20.5	Treatment Outcomes	85
<b>Chapter 4:</b>		86
<b><u>Interviews with Past and Present Staff Members of the CGC</u></b>		
4.1	Introduction	88
4.2	Main Findings from the Interviews	88
4.2.1	Period of Association with the CGC	88
4.2.2	Responses to the 1980s “Crisis” in Psychology	89
4.2.2.1	Political Background to the Crisis	89
4.2.2.2	Response in Psychological Circles to the Crisis	89
4.2.2.3	Individual and Institutional Responses to the Crisis	89
4.2.3	CGC Shift to a More Progressive Psychology	91
4.2.3.1	Extreme Responses to Prevailing Conditions	91
4.2.3.2	Shifts in Clientele	91
4.2.3.3	Revision of the Maudsley	92
4.2.3.4	Introduction of Community-Based Work	93
4.2.4	Shifts in Training and Treatments at the CGC	93
4.2.4.1	Establishing a Theoretical Framework for Community Psychology	93
4.2.4.2	Redefining the Scope of Training in Clinical Psychology	94
4.2.4.2.1	<i>Support Component</i>	95
4.2.4.2.2	<i>Consultation and Training Component</i>	95

4.2.4.3	Further Modifications to the Intern Training Programme	96
4.2.5	Under-representation of African Clientele	97
4.2.5.1	Access	97
4.2.5.2	Cost	98
4.2.5.3	Language Difficulties	99
	4.2.5.3.1 <i>Selection of Clinical Trainees</i>	99
4.2.5.4	Resource Shortages	100
	4.2.5.4.1 <i>Referral</i>	100
4.2.5.5	Failure to Advertise	101
4.2.5.6	Other Cultural Considerations	101
4.2.6	Further Modifications to the Maudsley?	103
4.2.6.1	Cultural Limitations of the Maudsley	103
4.2.6.2	The Maudsley as a Training Instrument	103
4.2.6.3	The Maudsley as an Initial Screening Device	104
4.2.7	The Future of Clinical Psychology in South Africa	105
4.2.7.1	Interviewee Perceptions of the Future of Clinical Psychology	105
	4.2.7.1.1 <i>Standardisation of Clinical Training</i>	105
	4.2.7.1.2 <i>Potential Undesirable Effects of Professionalisation</i>	106
	4.2.7.1.2.1 <i>Increased Costs for Therapists</i>	106
	4.2.7.1.2.2 <i>Consequences of Over-Professionalisation</i>	106
	4.2.7.1.2.3 <i>Polarisation within the Profession</i>	107
4.2.7.2	Interviewee Hopes for the Future of Clinical Psychology	107
	4.2.7.2.1 <i>Increasing the Range of Services</i>	107
	4.2.7.2.2 <i>Possible Community Service Component</i>	108
	4.2.7.2.3 <i>Mental Health Services in Remote Areas</i>	109
	4.2.7.2.4 <i>South African Solutions for South African Psychology</i>	109
	4.2.7.2.5 <i>Addressing the Problems of HIV/AIDS</i>	111
4.2.8	Interviewees' Additional Comments and Insights	111
4.2.8.1	Increasing Complexity of Cases seen at the CGC	111

4.2.8.2	Average Duration of Treatment at the CGC	112
4.2.8.3	Additional Cultural Considerations	112
4.3	Concluding Comments	113
<b>Chapter 5:</b>		114
<b><u>Discussion of Principal Findings</u></b>		
5.1	Introduction	116
5.2	Age Distribution of Clientele	116
5.2.1	Age and Referring Agent	116
5.2.2	Age and the Five Main DSM Diagnoses	117
5.2.2.1	ADHD and Age	117
5.2.2.2	Mental Retardation and Age	117
5.2.2.3	Learning Disorders and Age	118
5.2.2.4	Depressive Disorders, Relational Problems and Age	118
5.3	Gender Distribution of Clientele	119
5.3.1	Relative Distribution of Males and Females	119
5.3.2	Gender and Presenting Problem	120
5.3.3	Gender and the Five Main DSM Diagnoses	121
5.3.3.1	ADHD and Gender	122
5.3.3.2	Learning Disorder and Gender	122
5.3.3.3	Mental Retardation and Gender	123
5.3.3.4	Relational Problems and Gender	123
5.3.3.5	Depressive Disorders and Gender	123
5.4	Racial Distribution of Clientele	124
5.4.1	Racial Distribution in Cape Metropolitan Area	124
5.4.2	Shifts in Racial Distribution at the CGC during the 1990s	124
5.4.3	Under-representation of African Clientele	125
5.4.3.1	Factors Associated with the Under-representation of Africans	125
5.4.3.1.1	<i>Language Difficulties</i>	126
5.4.2.1.2	<i>Cultural Preferences and Practices</i>	126
5.5	The Link between SES and Psychiatric Illness	127

<b>5.6</b>	<b>Additional Cultural Considerations</b>	<b>128</b>
5.6.1	Potential Areas of Cultural Bias	128
5.6.2	Cultural Aspects of the Maudsley Interview Format	128
<b>5.7</b>	<b>Multiple Diagnoses</b>	<b>129</b>
<b>5.8</b>	<b>Treatment Offered</b>	<b>129</b>
<b>5.9</b>	<b>Duration of Treatment</b>	<b>130</b>
<b>5.10</b>	<b>Treatment Dropout</b>	<b>130</b>
5.10.1	Factors Related to Dropout	131
5.10.1.1	Racial Status	131
5.10.1.2	Client Defenses	132
5.10.1.3	Therapist Defenses	133
<b>5.11</b>	<b>Chapter Summary</b>	<b>133</b>
 <b><u>Chapter 6:</u></b>		<b>135</b>
<b><u>Concluding Comments</u></b>		
<b>6.1</b>	<b>Introduction</b>	<b>136</b>
<b>6.2</b>	<b>Strengths and Limitations of the Study</b>	<b>136</b>
6.2.1	Strengths of the Study	136
6.2.1.1	Resources	136
6.2.1.2	Personnel	136
6.2.2	Limitations of the Study	137
6.2.2.1	Time Constraints	137
6.2.2.2	Lack of Specific Focus	137
6.2.2.3	The Need for a Computerised Database	137
6.2.2.4	Retrospective Insights Concerning the Project	138
<b>6.3</b>	<b>Clinical Significance of the Findings</b>	<b>139</b>
6.3.1	Significance of the Clinical Findings	139
6.3.1.1	Changes in Client Profile	139
6.3.1.2	Comparison with International Findings	139
6.3.1.3	SES and Psychiatric Illness	139
6.3.2	Significance of the Interview Findings	140
<b>6.4</b>	<b>Possible Areas for Further Research</b>	<b>140</b>

6.4.1	Responses to the HIV/AIDS Pandemic	141
6.4.2	Multicultural Issues	141
6.4.3	Further Areas for Research	141
6.5	Chapter Summary	142
	References	143
	Appendix A	159
	Appendix B	182
	Appendix C	183

University of Cape Town

## LIST OF TABLES

### Tables from Chapters 3 and 5

<u>Table 3-1</u>	
Two-Way Summary Table: Observed Frequencies - Gender by Year	50
<u>Table 3-2</u>	
Two-Way Summary Table: Observed Frequencies - Age Range by Year	51
<u>Table 3-3</u>	
Observed Frequencies: Referring Agent: 1990 – 1999	53
<u>Table 3-4</u>	
Summary Frequency Table: Observed Frequencies - Client Race by Year	54
<u>Table 3-5</u>	
Two-Way Summary Table: Observed Frequencies - Social Class by Year	55
<u>Table 3-6</u>	
Two-Way Summary Table: Observed Frequencies - Client Race by Social Class	57
<u>Table 3-7</u>	
Two-Way Frequency Table: Gender by Presenting Problem: 1990 – 1999	59
<u>Table 3-8</u>	
Individual Intelligence and Developmental Assessment Tests by Age Category	63
<u>Table 3-9</u>	
Two-Way Frequency Table: Drawing Test by Age Category: 1990 – 1999	64
<u>Table 3-10</u>	
Scholastic Assessment Tests	67
<u>Table 3-11</u>	
Two-Way Frequency Table: CRS-R by Age Category	68
<u>Table 3-12</u>	
Two-Way Frequency Table: Projective Test by Age Category: 1990 – 1999	72
<u>Table 3-13</u>	
Primary Clinical Diagnoses: 1990 – 1999	73
<u>Table 3-14</u>	
Two-Way Frequency Table: Gender by DSM Diagnosis: 1990 – 1999	77
<u>Table 3-15</u>	
Two-Way Frequency Table: Client Race by DSM Diagnosis: 1990 – 1999	78

<u>Table 3-16</u>	
Frequency Table: Treatment Options: 1990 – 1999	79
<u>Table 3-17</u>	
Subtable within Dropout Variable of Clients Dropping Out of Treatment	81
<u>Table 3-18</u>	
Summary Frequency Table: Treatment Outcome: 1990 – 1999	82
<u>Table 3-19</u>	
Two-Way Frequency Table: Treatment by Outcome: 1990 – 1999	83
<u>Table 5-1</u>	
South African Census 1996: Population Weighted, Cape Metropolitan Area	124

### Tables from Chapter 3

#### Appendix A

<u>Table A-1</u>	
Two-Way Summary Table: Year by Referring Agent	159
<u>Table A-2</u>	
Log-linear Analysis: Standardised Residuals – Year by Racial Classification	160
<u>Table A-3</u>	
Log-linear Analysis: Standardised Residuals – Year by Social Class	161
<u>Table A-4</u>	
Two-Way Summary Table: Social Class Subtable within RACE: African	162
<u>Table A-5</u>	
Two-Way Summary Table: Social Class Subtable within RACE: Coloured	162
<u>Table A-6</u>	
Two-Way Summary Table: Social Class Subtable within RACE: White	163
<u>Table A-7</u>	
Two-Way Summary Table: Social Class Subtable within RACE: Unknown	163

Tables of Standardised Residuals: Social Class by Race: Tables A-8 – A-17

Table A-8

Standardised Residuals: Social Class by Race: 1990 164

Table A-9

Standardised Residuals: Social Class by Race: 1991 164

Table A-10

Standardised Residuals: Social Class by Race: 1992 165

Table A-11

Standardised Residuals: Social Class by Race: 1993 165

Table A-12

Standardised Residuals: Social Class by Race: 1994 166

Table A-13

Standardised Residuals: Social Class by Race: 1995 166

Table A-14

Standardised Residuals: Social Class by Race: 1996 167

Table A-15

Standardised Residuals: Social Class by Race: 1997 167

Table A-16

Standardised Residuals: Social Class by Race: 1998 168

Table A-17

Standardised Residuals: Social Class by Race: 1999 168

Table A-18

Three-Way Table: Year by Gender by Presenting Problem 169

Table A-19

Summary Frequency Table - BGT by Age Category: 1990 – 1999 170

Table A-20

Summary Frequency Table – VMI by Age Category: 1990 – 1999 170

Table A-21

Summary Frequency Table – ADT by Age Category: 1990 – 1999 170

Table A – 22

Summary Frequency Table: Bene-Anthony by Year 171

Table A – 23

Secondary DSM Diagnoses: 1990 – 1999 171

Table A – 24

Two-Way Table: Observed Frequencies of Five Most Frequent DSM Diagnoses 173

<u>Table A-25</u>	
Standardised Residuals: DSM Diagnosis by Gender: 1990 – 1999	174
<u>Table A-26</u>	
Two-Way Frequency Table: Age Group by DSM Diagnosis: 1990 – 1999	174
<u>Table A-27</u>	
Standardised Residuals: DSM Diagnosis by Age Category: 1990 – 1999	175
<u>Table A-28</u>	
Standardised Residuals: DSM Diagnosis by RACE: 1990 – 1999	175
<u>Table A-29</u>	
Two-Way Frequency Table: Social Class by DSM Diagnosis: 1990 – 1999	176
<u>Table A-30</u>	
Two-Way Frequency Table: Referral by Year	177
<u>Table A-31</u>	
Two-Way Frequency Table: Year by Treatment Option: 1990 – 1999	178
<u>Table A-32</u>	
Number of Client Sessions: 1990 – 1999	179
<u>Table A-33</u>	
Two-Way Frequency Table: Dropout by Year	179
<u>Table A-34</u>	
Two-Way Table: DSM Diagnosis by Dropout	180
<u>Table A-35</u>	
Two-Way Frequency Table: Social Class by Dropout Rate: 1990 – 1999	180
<u>Table A-36</u>	
Standardised Residuals: Intern Race by Dropout Client Race	181
<u>Table A-37</u>	
Standardised Residuals: Outcome by Treatment Offered: 1990 – 1999	181

## Chapter 1

### The Background and Objectives of the Study

#### Chapter Outline

<b>1.1</b>	<b>Introduction</b>	<b>3</b>
1.1.1	The Historical Context of the Study	4
1.1.2	The UCT Child Guidance Clinic	4
1.1.3	Diversification of CGC Practice	5
1.1.3.1	Re-evaluation of the Maudsley Interview Format	6
<b>1.2</b>	<b>Further Objectives of the Study</b>	<b>7</b>
1.2.1	Discernment of Shifting Trends during the 1990s	7
1.2.2	Interactions amongst Key Variables	7
1.2.3	Treatment Variables	8
1.2.4	Clinical Psychology Training in the 90s	8
1.2.5	African Clientele in the 90s	8
<b>1.3</b>	<b>Literature Review</b>	<b>9</b>
1.3.1	<i>South African Literature</i>	9
1.3.1.1	Historical Roots of Mental Health Practice in South Africa	9
1.3.1.2	The Political Upheaval between the 1970s - 1990s	10
1.3.1.3	Issues of Language and Culture	11
1.3.1.3.1	<i>Theoretical Models</i>	13
1.3.1.4	The Emerging Face of Community Psychology	14
1.3.1.4.1	<i>Community Participation</i>	15
1.3.1.5	Calls for an Indigenous Psychology	16
1.3.1.6	Summary of Key Issues in the South African Literature	18
1.3.2	<i>Health and Mental Healthcare Information</i>	19
1.3.2.1	Uses of the Mental Health Record	20
1.3.2.1.1	<i>Clinical Purposes of the Case History</i>	20
1.3.2.1.2	<i>Quality Assurance</i>	22
1.3.2.1.3	<i>Administrative Practice</i>	23

	1.3.2.1.4	<i>Training and Education</i>	24
	1.3.2.1.5	<i>Research</i>	26
	1.3.2.1.6	<i>Programme Evaluation</i>	29
	1.3.2.2	<b>A Postmodern Perspective on Psychiatric Case Notes</b>	30
1.3.3		<b>Changing Information Needs</b>	31
	1.3.3.1	<b>Multiple Users of Healthcare Information</b>	31
	1.3.3.2	<b>Need for Accuracy and Completeness</b>	31
1.3.4		<b>Security and Confidentiality</b>	32
1.3.5		<b>Benefits from Good Management of Information</b>	33
1.3.6		<b>The Role of Information Technology</b>	34
	1.3.6.1	<b>Accuracy of Computerised Data versus Case Notes</b>	34
	1.3.6.2	<b>User Compliance</b>	34
	1.3.6.3	<b>Savings in Time and Personnel</b>	35
	1.3.6.4	<b>Summary of Key Issues in the Case Note Literature</b>	35
1.4		<b>Chapter Summary</b>	36

## Chapter 1

### The Background and Objectives of the Study

#### **1.1 Introduction**

The policies and practice at the University of Cape Town (UCT) Child Guidance Clinic (CGC) shifted quite markedly in response to the political upheaval that shook South Africa during the late 1970s and 1980s. By contrast, the 1990s heralded a time of unprecedented hope for the peaceful resolution of past inequities. Following the first democratic election in April 1994 and the establishment of a government of national unity, the nation has been steadily engaging in a process of transformation that is being increasingly reflected in every sector of society. The main objective of this study therefore, in consultation with the CGC management, was to investigate whether the ongoing sociopolitical changes of the past decade have had any further discernible effects on the policies and clientele of the 1990s.

The study was conducted against the backdrop of two previous studies of the CGC that were undertaken during the 90s. Whereas Hay's (1990) historical analysis traces the history of the clinic between 1935 - 1971, Smit's (1997) two-part study documents how the political upheaval of the middle-to-late 70s and the 1980s precipitated a parallel crisis in psychological circles. She describes how at the CGC the latter crisis led to a diversification of psychological practice and the birthing of community psychology in the early 1990s. Smit's demographic analysis of the 1982 and 1992 CGC clientele reveals how these policies were reflected in the altered profile of the clientele of 1992. These two years were selected as they corresponded roughly to the beginning and end stages of the political upheaval. In the second part of her study Smit uses discourse analysis to situate her statistical findings, as she puts it, "within the social and political context of clinic practice" (Smit, 1997, p. 1) during the early 80s and 90s.

Like Smit's (1997) study, the present research has been conducted in two parts. In the first part of this study statistical analysis has been used to construct a retrospective demographic portrait of the CGC clientele seen by first year clinical psychology interns during the 90s. The second stage of the study is qualitative. It aims to contextualise and amplify the statistical findings by means of information obtained through semi-structured interviews with eight present or former CGC staff members.

### **1.1.1 The Historical Context of the Study**

The international Child Guidance movement for the psychological guidance of children began in the 1920s (Hay, 1990). Hay reports that the practice of psychology was originally ensconced in education and that the Cape Town CGC was established in 1935 under the directorship of Professor Reyburn, then professor of psychology at UCT. She notes that the development of clinical psychology in South Africa reflected international developments in clinical psychology and that the growth and development of the CGC paralleled the growth of clinical psychology in South Africa. Furthermore, Hay notes that the role of the clinical psychologist expanded in conjunction with the developing knowledge base of the profession and that the professionalisation of psychology occurred as a result of the growth in practical and applied psychology.

### **1.1.2 The UCT Child Guidance Clinic**

The UCT CGC is situated in a formerly white middle-class area. Hay (1990) documents how, during the apartheid era, because the CGC was under the jurisdiction of the white government-controlled Department of Education, clinic practice was dictated by state policy. In essence, this meant that until 1971 the clinic clientele consisted predominantly of white, upper middle-class children of school age. Although a formal policy of desegregation was only adopted by the CGC in the 1980s, Dowdall (personal communication, June 2000) reports that the CGC began an informal move towards desegregation during the mid-70s.

### 1.1.3 Diversification of CGC Practice

The intense civil unrest in South Africa during the 80s was precipitated by the crisis in Black education. D. Foster (1986, p. 54) states that Black schools had become “key sites of resistance” from 1976. The resistance escalated in the 80s and Smit (1997) reports that the period between 1980 – 1990 was characterised by demonstrations, strikes, stayaways, school boycotts and the burning and vandalism of schools. When stringent government measures to curb the rebellion through detention without trial, torture, and the deployment of armed troops at black schools and university campuses failed, a State of Emergency was declared in 1985. This continued until the early 90s.

Smit (1997, p. 6) reports that the State of Emergency precipitated a ‘crisis’ of a different kind in psychological circles. The disparity between the traditional neutral, apolitical, professional role of clinical psychologists in South Africa and the needs of those who had been physically and psychologically tortured for their political involvement highlighted the need for a more progressive psychology. The crisis in psychology and its effects on traditional psychology have been well documented (e.g., Berger & Lazarus, 1987; Dawes, 1986; D. Foster, 1986; L. Swartz, 1986; L. Swartz, Gibson & S. Swartz, 1990; S. Swartz, Dowdall & L. Swartz, 1986).

During the 80s concerned staff and students of the CGC were instrumental in establishing the Western Cape branch of the anti-apartheid mental health organisation, OASSSA (Organisation for Appropriate Social Services in South Africa), which was located at the CGC at the time (Dowdall, personal communication, June 2000). This was strictly an extramural activity. Smit (1997, p. 6) alleges that the clinic found itself in a “precarious position” at this time as CGC clinicians offered support to a number of the political activists and torture victims who were engaged in the “Struggle.” The clinic’s sessional government grant was subsequently withdrawn because of the CGC staff’s refusal to submit to the apartheid policies of the Department of Education. Smit states (p. 8):

It was against this backdrop of civil unrest and political change that the Cape Town CGC became actively involved in forging a new community-conscious identity. Writings by those working at the clinic have shown how the CGC has grappled with the problems inherent in these transformations and the strategies used to resolve them (Gibson & Swartz, 1996; Swartz, 1996; Swartz, Gibson & Swartz, 1990). Gibson and Swartz (1996) argue that psychological skills were not discarded but integrated within the clinical programme as a whole. In training, 'clinical staff are expected to formulate and conceptualise all clinical work within the context of community work and challenges' (Gibson & Swartz, 1996, p. 6). This allowed a much broader, community-orientated definition to emerge, moving away from its roots in the traditional guidance movement. Its similarities to the traditional movement is [sic] still discernible in the multidisciplinary team; its base as training centre for the interns; its connection to schools for referrals; its administration of mental testing and its close adherence to psychodynamic theory (Parker, 1986). Its differences, though, are revealed in its strong commitment towards the needs of the surrounding communities.

The term "community" as used by Smit (1997, p. 50) refers loosely to "all groups of all social classes within the Western Cape." She states that since the previous clientele of the CGC was predominantly upper middle-class and white,

The shift towards community-orientation or community-representation should be interpreted as a movement towards the low socio-economic groups and other racial groups if this imbalance is to be corrected.

#### **1.1.3.1 Re-evaluation of the Maudsley Interview Format**

One of the practical outworkings of the shift was a re-evaluation of the Maudsley history-taking format (See Appendix C). The "Maudsley," a psychiatric diagnostic instrument taking its name from the Maudsley Hospital in London where it originated, was introduced at the CGC in 1977 by Dowdall, then Director of the CGC, in a move to obtain accreditation of psychology by the international psychiatric fraternity. However, during the 80s it became increasingly apparent to CGC clinicians that the Maudsley format, "which located pathology within the individual and assumed the existence of the nuclear family as the norm" (Smit, 1997, p. 9), did not adequately reflect the needs of the victims of apartheid and violence who were then being treated at the clinic. Many of these clients had "chaotic" family circumstances and they were not part of a nuclear family unit.

Dowdall (personal communication, June 2000) reports that in 1982 the Maudsley was informally reworked by CGC clinicians and that the updated version was introduced formally at the clinic in 1987. The modified version contains a 'social history of caretaking nexus' section and makes provision for the index patient to be seen together with his/her significant family members during the initial history-taking consultation. This practice allows the clinician to observe the interactions that occur amongst family members within the family context, and it lays the foundation for family therapy should this be later indicated in the light of the clinical findings. The revised Maudsley also makes provision for information concerning the religious and political affiliations of clientele.

## **1.2 Further Objectives of the Study**

### **1.2.1 Discernment of Shifting Trends during the 1990s**

Because of the partial overlap in 1992 of the two research periods, the study uses Smit's (1997) findings as a point of departure and builds upon them. Smit reports (p. 21) the inclusion of a new category of 'self-referrals' in 1992 that was absent in 1982, and a corresponding increase in clientele over the age of 16 years (2.5% and 12.0%, respectively). She also records significant shifts in the racial distribution of the clientele between 1982 and 1992. In addition, her findings confirm the well-documented correlation during the apartheid era between race and social class. A further objective of the present study therefore included, but was not restricted to, a comparison of Smit's observations concerning certain variables with the annual figures for the 10-year period. Shifting trends in other key variables of interest were also a focus of the present study.

### **1.2.2 Interactions amongst Key Variables**

The large sample size ( $N = 647$ ) prompted my decision to concentrate more fully on certain findings and to omit others. For example, although the primary and secondary diagnoses were established for every client, only the five main primary diagnoses for the 10-year period were selected for further discussion. I also planned to investigate the effects of age, gender and socioeconomic status (SES) on these and other variables of interest.

### **1.2.3 Treatment Variables**

Although broadly defined, a further aim of the study was related to the treatment variable. The factors of interest included a study of the average duration and nature of treatment and an investigation of the association between the treatment offered and the treatment outcome. This part of the study was prompted by my interest in the growing move by medical aid societies towards the implementation of managed health care. As I was also interested in the factors associated with client dropout, these were examined in relation to client and therapist variables.

### **1.2.4 Clinical Psychology Training in the 90s**

The semi-structured interviews with CGC staff members greatly extended the scope of the study and afforded additional insights into the changing face of clinical psychology training at UCT during the 90s. Although the case files related to community projects were not included in this study, I was interested in investigating the ways in which the CGC had adapted its community module in response to the challenges of meeting the mental health care needs of vast previously neglected sectors of the community.

### **1.2.5 African Clientele in the 90s**

Meherali (1993, p.12) uses the term 'black' in the political sense to define those citizens living in a predominantly white culture, "whose skin is not white, and whose common experience of racism is not differentiated by language, culture or tradition." As the trend at the CGC in the past decade has increasingly been towards the selection of more black interns, one of my objectives was to investigate whether this practice had resulted in an increase in African clientele during the 90s. However, as most of the interviews had to be delayed until after the statistical findings had been completed, the semi-structured interview questionnaire (See Appendix B) was adapted to the actual findings pertaining to African clientele. This allowed me to conduct a more in-depth investigation into the factors that had potentially contributed to these findings.

### **1.3 Literature Review**

The literature review is divided into two sections. The first relates to the content of the study and provides an overview of some of the more recent South African literature concerning the development and implementation of mental health policy in South Africa. The second section relates to the method of data collection used in the demographic analysis. It comprises a representative review of the literature on health and mental health care that supports the use of client records for data retrieval and analysis.

#### **1.3.1 South African Literature**

The interviews with eight present and former key members of CGC staff, many of whom have been proactively engaged in the struggle to remain relevant in a rapidly transforming South Africa, provide an enlightening glimpse into the multiple challenges that the profession will face in the 21st Century. Although by no means exhaustive, the following review of South African literature traces some of the major developments to date. The review centres on issues pertinent to this study and at key points general issues are linked back to the particular challenges facing the CGC.

##### **1.3.1.1 Historical Roots of Mental Health Practice in South Africa**

Foster and S. Swartz (1997, p. 10) note that the concept of mental health “is not a timeless invariant” but one that changes “over historical time and across cultural boundaries.” Moreover, as the practice of mental health involves relations of power, they observe that it is “contested, resisted and fought over.”

The concept of mental health has its origins in 19th Century Europe. However, Foster and Swartz (1997) allege that it is essentially a 20th Century construct, which in South Africa is rooted in imperialism and colonialism, of which, together with its antecedents of racism and patriarchy, it still carries traces. They suggest that although the concept of “mental health” only emerged after 1910 in South Africa, the three main foundations of 20th century mental health policy in this country were laid during the

1880s. These include the medical control of mental illness, legislation concerning the classification and property rights of the insane, and the racialisation of insanity.

Foster and Swartz (1997) note that while in the early 1800s the insane were not classified along racial lines, by the mid 1860s the Robben Island asylum inmates were classified by “race” and gender. A policy of racial segregation had been adopted within and between asylums by the 1890s. They state (p. 11):

Segregation facilitated the emergence of racialised diagnostic and treatment practices, with sharp distinctions being made between “European” and “Native” patient populations.

### **1.3.1.2 The Political Upheaval between the 1970s - 1990s**

Foster and Swartz (1997) submit that there was little change in these three basic tenets of mental health policy during the following 100 years, and that at the time of writing the features of medical and legislative control were still in place. They note, however, that during the apartheid years (1948 - 1994) the divisions along racial lines became even more firmly entrenched (p. 13):

Above all, this period saw the systematic extension and entrenchment of racism in all aspects of life, including mental health. Differences, segregation and discrimination were now gradually legislated, and not merely reliant on customs, bias or neglect.

Whereas between 1967 - 1977 there was an active period of attempted reform in the mental health arena, Foster and Swartz (1997) observe that the reforms “were enmeshed within the racist confines of apartheid policy” and that there were increasing divisions and discrimination along racial lines within the profession. They report that conditions became more “war-like” in the 1980s, with “mental health becoming part of the ‘struggle’ zone, divided along the fault-lines of apartheid” (p. 15).

As I have outlined a brief overview of the political upheaval that occurred in this country between the mid-70s and the early 90s, and the corresponding effects of the upheaval on

CGC policies and practice (See Section 1.1.3), these findings will not be further elaborated. However, it is noteworthy that because the CGC found itself to be strategically positioned between the community and the educational system, many of the significant writings for this period have emanated from concerned UCT psychologists who were at the forefront of the changes. The writings include publications by Berger and Lazarus (1987), Dawes (1986), D.Foster (1986; 1989; 1991), D. Foster and Sandler (1985), Gibson and L. Swartz (1996), J. Louw and D. Foster (1992), Parker (1986), L. Swartz (1986; 1991), L. Swartz, Gibson and S. Swartz (1990), L. Swartz and Levett (1989) and S. Swartz, Dowdall and L. Swartz (1986).

Many of the writings by South African academics document the struggle during this period to move into a psychology free of racial bias. L. Swartz (1991, p. 245) observes:

We are not (even in 'the new South Africa') on the verge of curing or abandoning racism in mental health care. Racism is woven historically into the very fabric of mental health care .... Mental health care contains within it both the promise of personal and collective liberation and the inevitability of social reproduction. To accept this offers one way of moving towards modifying racism in mental health care; to say we can simply decide not to be racist may help to some degree but it may also relieve us, inappropriately, of an important responsibility and challenge.

Despite continuing concerted efforts to eradicate racism from the profession, Foster and Swartz (1997) observe that although racialisation has gradually been formally dismantled since the 90s, its impact will continue to be felt for many years to come.

### **1.3.1.3 Issues of Language and Culture**

The influence of apartheid is still evident in the arenas of language and culture. A number of earlier studies (Hickson & Christie, 1989; Hickson, Christie & Shmukler, 1990; Kriegler, 1993; Y. G. Pillay & Petersen, 1996) highlight the prevailing disparities between training practices and the needs of the majority of South Africans. Pillay and Petersen surveyed the attitudes and practice patterns of 635 mainly white urban, English or Afrikaans speaking clinical and counselling psychologists. They conclude that

because of language and cultural differences the services of the majority of psychologists are rendered inaccessible to the majority of South Africans, whose first language is neither English nor Afrikaans.

L. Swartz, Drennan and Crawford (1997) endorse the desirability of receiving mental health care in one's indigenous language but they maintain that in South Africa to date issues of language policy in mental health care have not been manifestly prioritised. Whereas the issue of language diversity in mental health practice has traditionally been dealt with in terms of either of two approaches that they term the "Add-on" approach, or the "Add-in" approach, Swartz et al. contend that both practices have disadvantages for patients and practitioners. The former employs interpreters to mediate between patient and clinician, and the latter is the term they ascribe to the practice of using existing staff members as interpreters. They therefore propose a third alternative, namely the "Cultural Change" model.

Whilst emphasising the importance of making room for local initiatives and practice, Swartz et al. (1997, p. 178) propose that "a starting point for equality" is to treat all people in the same way, regardless of their racial or cultural origins. They propose that the following "enabling basics" should be implemented at national level:

- 1) all health workers should be trained in multilingualism
- 2) trainees should be examined (both clinically and practically) in an African language
- 3) it should be regarded as "fundamentally unethical" not to have access to an interpreter if the patient's ability to communicate is hampered without one
- 4) it should be possible to define the conditions that require the presence of an interpreter.

They also advocate that local enterprises should be evaluated and, where practicable, adapted to other settings.

Swartz et al. (1997) conclude that success in transformation of services with respect to languages hinges ultimately on the cooperation of service providers and consumers. As change is inevitably slow in coming, they advocate that policy makers should adopt a facilitatory role and avoid the imposition of premature solutions.

#### **1.3.1.3.1 Theoretical Models**

Until the past decade or so, psychodynamic psychotherapy teaching and training in South Africa has traditionally been associated with some of the historically white institutions and especially English medium institutions. S. Swartz (1999, p. 46) notes that this has inevitably resulted in mostly white clinicians trained at these institutions offering their services to a relatively wealthy, mostly white middle-class clientele, which is “exactly the population which the theories themselves assume as the norm.” However, Swartz maintains that one of the advantages of working in a multicultural country is:

That there is ample opportunity to reflect on the cultural specificity of psychodynamic theory, to challenge those values which conflict with the cultures of our patients, and to modify theory where necessary. Clearly, to undertake a serious challenge to basic psychoanalytic tenets is a formidable task, but it is inappropriate for South African practitioners to continue to buy into a system of thought which may at best obscure cultural difference, and at worst, however unwittingly, perpetuate racist practice ....

Swartz (1999, p. 47) contends that all trainees should be “encouraged to think dynamically about all their patients in every setting as a matter of routine [...] which will assist them in coming to a psychodynamic (as opposed to a psychiatric) diagnosis.” Furthermore, she advocates that trainees should be encouraged to consider the “shaping effects of racial classification, culture, class and gender on the presentation of symptoms, on defensive strategies, and on early development.” Swartz’s views are supported by Peltzer and Reichmayr (1999), who assert that the emergence of ethnopsychanalysis during the 1990s can be viewed as a major contribution to psychoanalytic research in the African continent.

#### **1.3.1.4 The Emerging Face of Community Psychology**

Smit (1997, p. 8) has described how, as a response to the political struggle and the parallel professional crisis within its own ranks, the CGC “became actively involved in forging a new community-conscious identity.” Writings by Gibson and L. Swartz (1996), L. Swartz, (1996) and L. Swartz, Gibson and S. Swartz (1990) document some of the struggles along the way. Gibson and Swartz (1996, p. 6) describe how in the community-oriented approach to training at the CGC, “clinical staff are expected to formulate and conceptualise all clinical work within the context of community work and challenges.”

As Smit (1997) documents, clinic practice at the CGC during the 90s remained rooted in its traditional psychodynamic origins. However, because UCT was among the first South African universities to include a fully integrated community component in its clinical psychology training during the early 90s, it differed in this respect from other South African clinical training programmes. The current UCT model of community psychology differs in many respects from the early 90s model and has two main objectives, namely support and consultation and training. Both are carried out within a psychodynamic framework. The CGC model will be further elaborated in Chapter 4 as part of the interview findings.

Various authors have documented ways in which other South African training institutions have grappled with the challenges of remaining relevant in a climate of rapid sociopolitical change. They include writings by Butchart and Seedat (1990), Lupuwana, Simbayi and Elkonin (1999), Richter, Griesel, Durrheim, Wilson, Surendorff et al. (1998), Van der Ryst (1996), D. J. Viljoen, Beukes and D. A. Louw (1999), Wilson, Richter, Durrheim, Surendorff and Asafo-Agyei (1999). Selection criteria and training issues have also been a focus of considerable debate. Related writings include those by Chippindall and Watts (1999), Edwards (1993), Kriegler (1993), Skuy (1993), and Visser and Cleaver (1999).

These writings will not be reviewed here; suffice it to say that many of the themes of change at the CGC are reflected in these writings as well.

#### **1.3.1.4.1 Community Participation**

The notion and practice of community psychology has undergone considerable development during the past decade. Petersen, Parekh, Bhagwanjee, Gibson, Giles et al. (1997) highlight some of the major factors that determine the success or otherwise of community work. They note that communities are frequently conceptualised as homogeneous groups of people who live within geographically demarcated areas and share the same values, interests and goals. However, according to Panzetti (cited in Petersen et al., 1997), geographical communities are frequently sharply divided into “relational” communities that are drawn together by common needs, ideologies, or in response to shared life circumstances like poverty or disaster.

Petersen et al. (1997, p.56) outline three models of community participation in health care. They include the “medical approach,” in which health is simply conceptualised as the absence of disease, or the “health services approach,” in which health is defined more holistically in terms of the (1990) World Health Model as “the physical, mental and social well being of the individual.” In the third approach, participation is “firmly linked to social, economic and political development.” The first two models frequently fail because they are externally imposed upon communities without prior consultation with community leaders. The third alternative perceives community participation as “the active involvement of communities in addressing these issues at their source, through activities aimed at development.”

Petersen et al. (1997) emphasise the strategic importance of working within the framework of community initiatives. They state (p. 57):

Participation seems to be more effective when it takes into account the importance of mobilising target groups in the community around an integrated approach which is open to community priorities rather than being located strictly

in health care itself. *This allows for the reality that health care (and perhaps even less so mental health care) is often not a priority within communities* (emphasis added). Following from this, community members are able to participate more fully when their own experience of need is acknowledged rather than when they are confronted with pre-planned visions of health care.

My involvement via the CGC in the establishment and evaluation of a community project confirmed exactly this point (Melvill, 2000). A brief description of the project will illustrate the point. In 1999 the CGC, in partnership with a local youth care organisation, were granted access to an “historically disadvantaged” community by the leadership concerned. The community leaders and members were initially justifiably sceptical about the proposed intervention as it had been preceded by a number of other projects in which other well meaning “outsiders” had attempted to impose their own preconceived solutions to the community situation. In each instance they had failed dismally, leaving community members feeling frustrated and disillusioned.

In contrast to this, community members were now invited to identify and prioritise their own needs. Among the many primary health care needs they identified, community members prioritised the need for a netball club for the girls in the community, and community members were rapidly mobilised to set about meeting this objective. The success of this particular project paved the way for their subsequent enthusiastic participation in the health-related concerns they themselves had identified.

#### **1.3.1.5 Calls for an Indigenous Psychology**

As psychology has frequently been criticised for its Eurocentrism and irrelevance within the African continent, there has been much debate and counter-debate concerning the need for an indigenous psychology. Nell (1990) strongly opposes the principle on the grounds that “intellectual and political separatism” has propagated two deeply damaging notions concerning psychology in developing countries, and particularly in Africa. These are: that there is a third-world working class who are supposedly at a lower evolutionary level than first-world psychologists and other professionals and, secondly, that until an indigenous third-world or African version of psychology has been evolved, the profession will remain

irrelevant in a third-world context. As Nell considers both the world and the profession of psychology to be unitary, he argues for a unitary psychology that is applicable across all contexts.

By contrast, various authors promote the concept of an indigenised psychology. They include Peltzer (1998), who emphasises the more holistic approach of African culture, Mashegoane (1998), who attempts to operationalise the concept of indigenisation and calls for psychologists to include aspects of African culture in a future indigenous psychology, and Bakker (1999) who calls for a *South African* perspective in psychology.

B. J. Pillay (1996), who investigated the health beliefs and practice of 892 urban Blacks (Africans) in South Africa, reports that urban Blacks adopt an holistic view of health and healing and that physical and/or psychological symptoms are regarded as “trigger factors” for seeking help. Pillay distinguishes between four broad help-seeking behaviours that include self-help, prayer, and cultural (e.g., faith healers, *izangoma*, diviners, herbalists), or medical options. He calls for more cross-cultural research to be undertaken so that more effective treatment can be provided for “previously disenfranchised” sectors of the population.

In similar vein, Bodibe and Sodi (1997) contend that both rural and urban Africans make use of traditional healers, whether they do so “openly or clandestinely.” They call for an interchange of Western and other forms of psychology, and state (p. 190):

Understanding traditional healing practices and respecting and gaining understanding of other cultures may see us understanding this integration. Indeed, Western trained counsellors and therapists must learn to be elastic and flexible. They must trust the processes of transformation and change more convincingly than they now are doing. In addition, they should learn to come out of their zones of comfort. As Nwachuku and Ivey (1992) suggest, they should strive to find a compromise between Western oriented approaches and traditional healing practices.

Lund and L. Swartz (1998) support these recommendations. Their study of Xhosa-speaking schizophrenic patients attending a community psychiatric clinic in Cape Town, reports that while patients frequently employed a “mystical” explanatory model of *amafufunyana* or “nerves” to describe their condition, patients “used a combination of consultation with the sangoma and the psychiatrist” (p.68). Lund and Swartz note that the general trend for these patients was to consult first with traditional healers, and only later to resort to psychiatric services when they became disillusioned with the traditional healers. However, as three of the sample quite clearly indicated that they would continue to seek treatment from traditional healers, Lund and Swartz caution against “the claim that Xhosa-speaking patients show a migratory pattern from traditional healers to psychiatric services.” They contend, furthermore, that it was not possible in their study “to measure the number of people who consult traditional healers, and are sufficiently satisfied with the treatment they receive, to never need to use psychiatric services” (p. 68).

This study further highlights the false dichotomy that has been set up between “traditional African” and “western psychiatric” diagnostic categories, as in terms of patients’ own explanatory systems and their clinically observable signs and symptoms and response to psychiatric intervention, these patients show clear evidence of *both* *amafufunyana* *and* psychosis. In view of these findings, Lund and Swartz (1998, p. 68) recommend that:

Further research needs to be conducted into the work of traditional healers to assist co-operation in the many cases (as shown in this study) in which patients avail themselves of both traditional healers and psychiatric services. Though partnerships between traditional healers and biomedicine may be complex, and have not been well explored in the South African literature ..., findings such as those of this study indicate the importance of engaging with this issue.

#### **1.3.1.6 Summary of Key Issues in the South African Literature**

In summary, the review of the South African literature that is pertinent to this study focuses on the historical roots of mental health in South Africa. Its three main tenets include the medical control of mental illness, legislation regarding the classification and property rights of the insane, and the racialisation of insanity. The review reflects the

systematic legislation of “differences, segregation and discrimination” into the mental health arena during the apartheid years (Foster & Swartz, 1997, p. 13) and the post-apartheid struggle to eradicate racism from all sectors of the profession.

The review highlights some of the key areas in which the ongoing struggle to eliminate the influence of racism from the mental health arena are being conducted. They include a brief review of the major principles and pitfalls of community development and issues related to language, culture and theoretical orientation. The growing call for a more integrated approach between traditional westernised psychodynamic psychology and indigenous African practice is documented (e.g., Bodibe & Sodi, 1997; Lund & Swartz, 1998). Bakker (1999) takes the debate further and argues for the emergence of a specifically *South African* psychology. Interestingly, this argument was also advanced by a respondent during the semi-structured interviews and will be developed in Chapter 5.

### **1.3.2 Health and Mental Healthcare Information**

The second part of this literature review is related to the methodology that was employed in the quantitative part of the research. The national report by the British National Health Service (NHS) Audit Commission (1995) on information management and systems in the acute hospital highlights the strategic importance of information as one of the most vital resources that is held by an institution. In the health and mental healthcare fields clinical decisions regarding client care are frequently based on previously collected data, for example, reports, the results of investigations, letters of referral and case notes. The report asserts that accurate information leads ultimately to better client care.

The NHS Audit Commission (1995) alleges that one of the main obstacles to efficient information keeping is the fact that staff members frequently fail to see the value or potential of information. Accordingly the report strongly recommends that data collection needs to be actively managed in order to change both staff perceptions and practice.

### **1.3.2.1 Uses of the Mental Health Record**

Psychiatric records were originally used for teaching purposes. However, Siegel and Fischer (1981) note that due to the growing complexity of the mental healthcare delivery system, they are now also used for clinical purposes, quality assurance, administration, training and education, research and programme evaluation.

#### **1.3.2.1.1 Clinical Purposes of the Case History**

Siegel and Fischer (1981) maintain that as the case history is essentially a clinically generated document, its clinical utility should equal or supersede its other functions. The case history has the following three primary clinical purposes:

##### **a) Provision of a Longitudinal Case History**

As the case history forms the basis for planning, treatment and consultation during subsequent admissions, record keeping needs to be diligently maintained. Siegel and Fischer (1981, p. 6) recommend that the following questions should be asked when evaluating the extent to which the clinical record actually fulfils its primary purpose:

1. Does the record provide the facts to help in clinical decision-making?
2. Does it play a dynamic role in diagnoses and treatment planning?
3. Does it serve a current here-and-now purpose in the clinicians' day to day interactions with patients?

Case notes were used as the primary data source in three longitudinal follow-up studies of schizophrenia conducted by Heads, Taylor and Leese, (1997); McGovern, Hemmings, Cope and Lowerson, (1994); and TARRIER, Barrowclough, Porceddu and Fitzpatrick, (1994). In a comparative study of the childhood experiences of patients with a diagnosis of schizophrenia and a history of violence, Heads, Taylor and Leese (1997) report that a majority of the women patients had grown up in dysfunctional families. They conclude that for patients with evidence of conduct disorders or social difficulties and/or

socioeconomic disadvantage, there is a strong likelihood of complex interactions between these factors and illness symptoms.

In McGovern et al.'s (1994) long-term study of British Afro-Caribbean and White schizophrenic patients, follow-up studies undertaken between 4 years 9 months and 10 years after first admission revealed significant psychosocial factors in the Afro-Caribbean group that allegedly contributed to the different outcomes in the two groups. Case history notes were central to the authors' developing an understanding of what had occurred.

#### **b) Transmission of Information Between Staff Members**

The first and second purposes of the clinical history are closely related. Good record keeping facilitates rather than complicates staff communication. Hardman and Joughin (1998, p. 31) provide a good example of where records can complicate matters. They cite a retrospective audit of the case notes of 30 children referred to a Child Development Centre and Communication Disorder Clinic over a 4-year period that was complicated by poor communication among the professionals concerned. The audit was additionally complicated by the fact that there were five sets of case notes per child and that vital information was frequently found to be missing from the records.

Standardised record keeping has been argued to assist communication. For example, Kareem and Ashby (2000) investigated the recording, dating, timing and signing of Mental State Examination (MSE) findings by psychiatric trainees using data obtained from 60 randomly selected case notes at three acute psychiatric units. They report a decline from 69% to 58% in MSE recording at a follow-up audit. As trainee record keeping improved by 83% following the introduction of a standardised MSE format and consultant supervision of records, and there was reportedly also a greater adherence to medico-legal standards, Kareem and Ashby allege that a standardised MSE format would help to alleviate the problem of inadequate record keeping.

Blakey (2000), however, contests Kareem and Ashby's recommendation on the grounds that whereas it would be relatively simple to tick off the various headings and checklists on a standardised form, the content and quality of the MSE are the crucial factors in the investigation. Moreover, Blakey contends that the MSE should accurately reflect the condition of the patient at the time of administration, and he maintains that it is the responsibility of the trainees' superiors to monitor the quality and accuracy of trainee records. Checklists may be easy to fill in and to monitor, but they may yield superficial information.

### **c) Documentation of the Success or Failure of the Intervention**

Case records can teach us about strengths and weaknesses of interventions. Tuma's (1996) retrospective study based on the case notes of hospital-treated depressive adult and elderly patients in the UK yielded significant corroborative findings on the predictors of poor outcome in both groups. In another UK study, Akerman and McCarthay (1999) used case notes to conduct a retrospective analysis of the treatment outcome in 191 psychiatric patients from three different psychiatric settings. These included a psychiatric day hospital, a psychiatric ward in a general hospital and an intensive care ward in a psychiatric hospital. Akerman and McCarthay found that while case notes offer an economical way of measuring treatment outcome in routine psychiatric care, the records were often insufficiently detailed. They conclude that more attention should be given to recording the outcome assessment upon discharge of the patient.

#### **1.3.2.1.2 Quality Assurance**

Quality assurance is concerned with the provision and ongoing evaluation of services for specific patient populations and for the purposes of accreditation. Siegel and Fischer (1981, p. 231) state that "Due to the increasing costs of mental health care and issues of third party providers [...], the professional clinician is having to become much more accountable than ever before."

There is, however, considerable debate about the appropriateness of using psychiatric records for these purposes as it has been alleged that they cannot adequately reflect quality of care. Siegel and Fischer (1981) contend that because client records have not been standardised and are often incomplete, their usefulness for review purposes has also been debated. Kareem and Ashby's (2000) recommendations concerning a standardised MSE format support this viewpoint.

### **1.3.2.1.3 Administrative Practice**

#### **a) Decision Making and Planning**

Siegel and Fischer (1981) allege that as the administration of a mental health facility is comparable to that of a multi-faceted business organisation, informed decisions are required in the areas of budgeting, planning, staffing and resource allocation. However, they point out that whereas in theory it should be possible to derive much of the requisite information from patient records, in practice the process often becomes unwieldy without access to a computerised database. They also draw attention to the fact that because the psychiatric record has been designed to report which services are provided and not those that are needed, the record has limited uses as a planning instrument.

#### **b) Evidence for Funders**

In a highly competitive fiscal climate, funders are increasingly demanding evidence that supports the continued allocation of funds. Although UK-based, Hardman and Joughin's (1998) practical systematic guide to the clinical audit process in child and adolescent mental health services is generalisable across other mental health care settings. Clinical audit is defined thus (p. 3):

Clinical audit involves systematically looking at the procedures used for diagnosis, care and treatment, examining how resources are used and investigating the effect care has on the outcome and quality of life for the patient (Department of Health, 1993).

Hardman and Joughin (1998) claim that audit findings can demonstrate to others the effectiveness and cost-effectiveness of the service that will ensure its continued

development. They allege that without some form of clinical audit “it is very difficult to know whether you are practising effectively and even more difficult to demonstrate this to others” (p. 3).

#### **1.3.2.1.4 Training and Education**

##### **a) Insights into Mental Health and Disease Problems**

Siegel and Fischer (1981) and Hardman and Joughin (1998) emphasise the importance of the psychiatric record in training and education. Despite the considerable advances that have occurred in the etiological understanding and classification of major mental disorders during the past two decades, valuable insights into the course and management of particular mental health problems are frequently discernible from a study of patient records.

Simpson, Kazmierczak, Power and Sharp (1994) used general practice case notes in a retrospective study of the characteristics of 100 patients who had been previously diagnosed using DSM-III (Diagnostic and Statistical Manual of Mental Disorders) criteria for Panic Disorder. They were compared with normal control subjects who had been matched for age and gender. The subjects with Panic Disorder had had significantly higher rates of general practice consultation during the 10-year period prior to the DSM-III classification of Panic Disorder. They had also been prescribed significantly higher amounts of both psychotropic and non-psychotropic medications, and had experienced higher rates of predominantly minor illnesses and psychiatric comorbidity with depression than the controls during the 10-year period prior to the DSM-III classification of Panic Disorder.

Although selective eating is not classified in the DSM system, Timimi and Tsiftopoulou (1997) report on the findings from a retrospective study of the case notes of 33 children aged between 4 - 14 who presented with selective eating. In this particular cohort the male-to-female ratio was 2:1. The study provides a descriptive clinical profile of the 33 children, of whom a number also presented with school and social difficulties. A history

of depression in at least one parent was found in 33% of the parents. These findings are of clinical interest, despite their exclusion from official diagnostic systems.

In a comparative study using case notes as data, Cote, Lesage, Chawky and Loyer (1997) found significant clinical differences between the symptoms of a prison inmate population with severe mental disorders ( $N = 69$ ) and a matched control group of 60 psychiatric inpatients with similar mental disorders. Cote et al. conclude that as the clinical specificity of prison inmates clearly differentiates them from the psychiatric inpatient population, these factors should be taken into account during assessment and treatment of the mentally ill prison population.

A study of the case notes of 59 Caucasian male and 59 female (34 African and 25 Caucasian) HIV positive patients at a London hospice revealed important clinically significant, gender-related differences in the symptom profile of HIV positive patients (Kelleher, Cox & McKeough, 1997). As there were also clinically significant ethnic differences in patient profile, Kelleher et al. conclude that the multidisciplinary health team should be educated with respect to these differences.

All the above findings, based on case records, contributed information important for trainee clinicians to know.

#### **b) Supervision and Planning of Training Procedures**

As previously discussed, Blakey (2000) emphasises the need for supervision of psychiatric trainee records. This practice allows supervisors to monitor trainees' diagnostic and treatment acumen, and is incidentally found to enhance the standard of trainee record keeping.

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### **1.3.2.1.5 Research**

#### **a) Questions of Validity**

Siegel and Fischer (1981) observe that a particular advantage of using case notes is the availability of data for large numbers of subjects. Siegel and Fischer note, however, that some researchers contest the validity of data obtained from client records on the grounds that the treatments are not randomly allocated. Nevertheless, as they point out, there are other researchers who contend that the potentially confounding effects of non-randomised studies can be eliminated by using large numbers of records from a wide variety of settings.

Because unsystematic record keeping leads to invalid research results, meticulous data keeping is essential if clinical records are to be used for research purposes. Hale, Thomas, Bond and Todd (1997) studied the use of the nursing record as a research tool to identify nursing interventions in a hospital setting. Data obtained from three primary sources included a retrospective examination of patients' case notes, interviews with a nurse who had cared for the patient, and interviews with senior ward nurses about ward policies and practice for the patients concerned. In this study Hale et al. report that patient records were sometimes incomplete and did not always accurately reflect actual clinical practice.

#### **b) Demographic Studies of Clinical Populations**

A number of studies using case notes as data have provided demographic information concerning specific clinical populations. Locally, S. Swartz's (1996a) doctoral research on colonialism and the production of psychiatric knowledge in the Cape from 1891 – 1920 was partially based on a retrospective analysis of case notes from asylums for the mentally ill. In the UK Wilkins' (1993) retrospective analysis of the case notes of the youth who were admitted to the Bethlem Royal (Bedlam) Hospital during the nineteenth century yielded information about gender-based differences in the incidence of delusional symptoms that occurred in 700 of the 1,069 inmates. Wilkins also reported specific gender-based differences in treatment outcomes.

Case notes were used in Suhail and Cochrane's (1998) study of seasonal variations in 992 hospital admissions for affective disorders by gender and ethnicity (Asian, White and Black). Whereas no seasonal variability was found in the overall number of admissions, they report a significant seasonal pattern in the incidence and number of hospital admissions during winter. A gender effect was reported on the seasonal variability of admissions for affective disorders. Significant winter peaks for depression and summer peaks for bipolar disorder were observed in female patients. These findings are interpreted as maladaptive individual responses to specific seasonal variations. The Asian group was reported as the only ethnic group that showed significant seasonal variation in depression, with a higher incidence of depression in winter.

A number of the retrospective studies were related to suicide. Nasr, Vostanis and Winkley (1997) examined the case notes of 54 youth aged between 9 – 16 years who had overdosed during a 6-month period. They report that arguments (67%) and school-related stressors (19%) had preceded 86% of the attempted suicides. Analgesic tablets had been used in 70.4% of cases. Fifty-one percent of the cohort was diagnosed with a psychiatric disorder. At follow-up six months after the suicide attempt, 5.5% ( $n = 3$ ) had overdosed a second time, and 13% were still in treatment. In view of these findings, Nasr et al. recommend that child mental health services should aim to provide prompt assessment, follow-up and communication with other agencies, particularly in the case of high-risk youth and their families.

In another study of suicidal behaviours in adolescents, Fombonne (1998) analysed the case notes of 6,091 subjects aged between 8 – 18 years who were referred for psychiatric treatment between 1970 – 1990. Following the detailed analysis of a random sample of 80 records, Fombonne reports that there had only been an increase in the suicidal behaviours of adolescent males during this 21-year period, and that the rates of both substance misuse and suicidal behaviour had almost doubled between 1979 and 1990. As the suicidal behaviours had generally been preceded by substance misuse and alcohol was the only

substance used by this cohort that had a strongly positive association with suicidal behaviour, Fombonne attributes the increase in suicidal behaviour to the misuse of alcohol.

In another suicide-related study Hawton, Simkin, Fagg and Hawkins (1995) conducted a retrospective analysis of the case notes of 22 Oxford University students who died between October 1976 and September 1990. There were 21 definite suicides and one open verdict in the cohort. Hawton et al. found that although there had been no conclusive evidence of any association with final examinations, two-thirds of the students had allegedly been concerned about their academic achievement and almost half had a previously diagnosed psychiatric disorder. In most cases this was depression.

Two other retrospective studies of suicide cases focus on various aspects of depression and suicide. In a comparative study of 103 lithium-treated versus 109 antidepressant-treated outpatients, Waddington and McKenzie (1994) report that one subject in the lithium group and 15 subjects in the antidepressant group were admitted to hospital for self-poisoning (SP). As lithium was used as part of the overdose in only 0.74% of the SP cases in this cohort, Waddington and McKenzie conclude that lithium-treated patients are less likely than other patients with affective disorders to self-poison.

In the second study Milne, Matthews and Ashcroft (1994) analysed the primary care case notes of 665 suicide victims in Scotland who died between 1988 – 1989. They found that single persons and those with low socioeconomic status (SES) were less frequently diagnosed as depressed, and that antidepressants were seldom prescribed even when a diagnosis of depression had been made. In this study, death by drug overdose occurred more commonly among patients on antidepressant medication. While no association was found between chronic physical illness and psychiatric morbidity in this study, Milne et al. allege that these findings suggest that treating physicians had overlooked psychiatric illnesses in these patients.

In a South African study of 40 physically ill, hospitalised adolescents aged between 15 – 20 years, Pillay and Wassenaar (1996) compared their scores on psychiatric disturbance and hopelessness with those of 40 healthy controls. The physically ill adolescents scored significantly higher than the control group on both counts. At follow-up six months later, whereas the scores on psychiatric disturbance in the physically ill group had generally declined, the scores on hopelessness were still significantly high. Pillay and Wassenaar conclude that these findings suggest that insufficient clinical attention is given to psychiatric symptomatology in physically ill hospitalised patients. Their findings support Milne et al.'s (1994) contentions concerning psychiatric symptomatology in the physically ill Scottish suicide victims.

#### **b) Development of Research Instruments in the Healthcare System**

Von Zerksen, Poessl, Hecht, Black, Garzynski et al. (1998) used psychiatric case notes to obtain clinical data used in the preliminary phase of developing the Biographical Personality Interview (BPI). The BPI is a research instrument that is being tested by the authors for the assessment of premorbid personality traits in psychiatric patients. In this study the biographical details from patients' case notes were compared with the findings of two specially trained interviewers who were kept 'blind' to the clinical status of patients. The results from both data sets were rated against a number of purely descriptive items and individual patient scores were categorised in terms of six principal personality 'types'. These 'types' related to the Six Factor Test which was developed earlier by the first author together with other colleagues (von Zerksen, 1994). The obtained scores were then further ranked according to the dominant intra-individual personality type of each patient.

#### **1.3.2.1.6 Programme Evaluation**

Hardman and Joughin (1998) and Siegel and Fischer (1981) note that client records are generally assessed in terms of demographic information, client characteristics, presenting problems, diagnosis and treatment plans, in addition to their primary function as an ongoing record of the interactions with the client. Because of the potential limitations of

using only case notes, these authors note that for the purposes of programme evaluation they are usually used in conjunction with other data sources.

### **1.3.2.2 A Postmodern Perspective on Psychiatric Case Notes**

S. Swartz (1996b, p. 150) provides a refreshing alternative perspective on the psychiatric record. She writes perceptively about the “familiar and comforting ritual” of the clinical psychiatric history-taking procedure and maintains that the process is designed to construct an “explicable narrative which positions the patient as being in need of intervention, and the clinician as having the skills to undertake that intervention.” Swartz observes that by “working systematically through a set of questions, and noting down the ‘facts’ of a life - a birth and a childhood, adolescence and awakening sexuality, schools and jobs, lovers and relationships, voices inside and outside the head, butterflies and nightmares,” structure is provided for “an encounter which is often raw with both need and feeling.”

Swartz (1996b) contends that whereas for the clinician “the history headings provide a reassuring fiction of thoroughness, a sense of documenting everything of salience to the description and understanding of this person’s distress,” patient histories are in reality, like photographs, highly selective in their portrayal. Through a process whereby authorship of the patient’s (hi)story is assumed by the clinician and in which “fragments are offered as wholes,” Swartz asserts that case histories, like photographs, inevitably “foreground some events, render some invisible, and seek to enter the world without authorial signature” (p. 150).

An earlier comparative study by H. Foster, Lieberman and Watson (1994) lends support to Swartz’s (1996b) allegations. In a retrospective analysis of 100 psychiatric inpatient case notes, Foster et al. compared the family history recorded in the notes with that obtained from interviews with 100 patients and 35 close family members. They report that whereas relatives contributed a relatively small amount of additional information, the case notes reflected only a mean 34% of the information provided by patients. These

findings have important implications for the assessment, diagnosis and management of patients.

Wurr and Partridge (1996) investigated the prevalence of a history of childhood sexual abuse in an acute adult inpatient population ( $N = 120$ ). They found that whereas in a self-administered questionnaire 46% reported a history of childhood abuse, analysis of the relevant case notes revealed only a 14% previous disclosure rate. They conclude that whereas a high proportion of psychiatric inpatients has suffered sexual abuse, many fail to disclose the abuse to their clinicians. These findings support Swartz's (1996b) contentions.

### **1.3.3 Changing Information Needs**

#### **1.3.3.1 Multiple Users of Healthcare Information**

Information needs are constantly changing. With the increasing complexity of healthcare and the availability of more specialised services, a single client is frequently seen by a number of healthcare professionals during a single course of treatment.

Notwithstanding Swartz's (1996b; 2000) perspicacious insights into the constricting effects of the clinical history-taking process, it therefore becomes increasingly important for administrative purposes that the salient information is accessible in a standardised format that can be readily interpreted by all users.

#### **1.3.3.2 Need for Accuracy and Completeness**

The NHS Audit Commission (1995) notes that within the hospital system information must frequently be shared with individuals and groups outside of the particular hospital setting. Whereas modern technology has made it increasingly possible for all information systems to be integrated with other computerised databases, the need for the complete and accurate documentation of data cannot be emphasised sufficiently. In a worst case scenario, clinical decisions that are based on inaccurate or incomplete documentation can lead to dire consequences for the client, the practitioner and ultimately the institution.

concerned. For example, in H. Foster et al.'s (1994) study (See Section 1.3.2.2), 41 of the 100 records were deemed to be inadequate for the purposes of diagnosis, assessment and treatment, and four had missing information that could have biased patient management.

As previously reported, Hardman and Joughin (1998) note that an audit conducted in 1993 of the case notes of 30 children in two separate settings was complicated by the fact that there were five sets of case notes per child. Moreover, vital information was frequently found to be missing from the records. A computerised database would have eliminated many of the frustrations of this particular audit. The NHS Audit Commission (1995) recommends that data entry should be made as simple as possible for all concerned.

Within the CGC information is shared among supervisors, clinicians, and fellow trainees. Collateral is frequently sought from external sources and clients are sometimes referred to other members of the health or mental health professions. In every instance good outcomes are largely dependent on timely and meticulous record-keeping practices.

#### **1.3.4 Security and Confidentiality**

The NHS Audit Commission (1995) notes that most personal health information is highly sensitive. Whereas individual health practitioners and institutions are bound by professional confidentiality clauses, the widespread use of computerised information management systems has increased the possibility of confidential information being accessed illegally.

In view of this controversy Cohen, Dolan and Eastman (1996) examined the responses of 12 local research ethics committees to a proposal to conduct a study of supervision registers using data from case notes. The responses ranged considerably from approval to outright refusal on the grounds that patient consent had not been granted for access to the confidential material contained in the case notes. These and similar concerns have led to the implementation in Britain of the Data Protection Act, which protects personal computerised data. There are also a host of other international directives and mandates

that have been promulgated in order to safeguard the confidentiality of healthcare information.

### **1.3.5 Benefits from Good Management of Information**

The NHS Audit Commission (1995) outlines the following benefits from the better management of information:

1. Better coordination and organisation of individual care.
2. The availability of data in several places simultaneously minimises the possibility of duplicated treatments and the risks of incompatible care plans.
3. The rapid and reliable communication of information is permitted.
4. Resource allocation can be matched with client needs.
5. Duplication of data can be eliminated.
6. Costing of services can be more accurately determined.
7. Analysis of workload statistics can identify variation in productivity.

These benefits were stated as pertaining primarily to the acute healthcare system but they are applicable across most settings. However, the NHS Audit Commission (1995) notes that many of the benefits can only be optimally achieved through the use of computerised technology.

Whereas the CGC is still a relatively small self-contained institution, students, supervisors and administrative staff need ready access to individual case notes. Whilst at the CGC the notes for the current year are easily accessible, the case notes from previous years are filed away and ultimately archived after ten years have elapsed. The rapid technological advances and the subsequent explosion of information that have occurred in the past two decades make it almost imperative for growing institutions to keep abreast and make the change to computerised information systems and it is recommended that the CGC follow suit.

### **1.3.6 The Role of Information Technology**

With this recommendation in mind, some of the legitimate concerns and benefits of computerised technology will be briefly discussed in the following section.

#### **1.3.6.1 Accuracy of Computerised Data versus Case Notes**

In a study that was designed to retrieve and validate the accuracy of the consultation data from four UK-based general practices, Neal, Heywood and Morley (1996) found that after an initial adjustment period the computerised records were more complete than the written records. They note, however, that the transition phase during the switch from written to computerised records was characterised by uncertainty and unpredictability and that initially the written records were more complete than the computerised records. They also reported differences in the completeness of records between practices. These findings are not unexpected in view of the relative newness of computerised technology and the lack in some cases of previous exposure to computers.

By contrast, Maresh, Dawson and Beard (1986) assessed an on-line computerised perinatal data collection and information system that had been in operation in a British maternity hospital since 1984. They report that the system had been fully operational from the start and that it had resulted in improved communication between the hospital and the community. An analysis of 253 consecutive computerised case notes demonstrated a high level of accuracy in the data, which was recorded by secretaries and midwives on readily accessible microcomputers in the maternity wards. Maresh et al. report that the perinatal reports and audits could be readily obtained from the local system, from standard programmes on the regional mainframe computer and from a mainframe computer at London University.

#### **1.3.6.2 User Compliance**

In an assessment of the quality of data collected from the Manchester orthopaedic hospital over a period of thirty months, Barrie and Marsh (1992) retrospectively reviewed case notes, computerised data from the orthopaedic database and the Hospital Activity Analysis

data. They conclude that even in a system that had been designed for simple and efficient data capture, user compliance was poor and data entry was often incomplete. Overall accuracy was relatively high, suggesting that users understood the principles underlying data capture. They conclude that user compliance could be improved by providing users with feedback on performance and the potential benefits of the system.

#### **1.3.6.3 Savings in Time and Personnel**

K. N. Williams, Brooksby, Morrice, Houseago and Webb-Peploe (1982) report that the cardiac department of St Thomas' Hospital in London has been using computerised cardiological case notes since 1976. Three patient reports, that include the clinician's initial findings in the outpatient department, the results of patient investigations, and the significant findings at cardiac catheterisation, are fed into computers that in turn generate full clinical reports that are used both as case notes and reports to colleagues. Williams et al. report that much valuable secretarial and clinical time has been saved by the computerised system. There have been phenomenal advances in information technology since 1982 but the savings in time and personnel and consequent increased efficiency are still amongst the most important benefits of computerisation.

#### **1.3.6.4 Summary of Key Issues in the Case Note Literature**

The advantages and disadvantages of using case notes as data were discussed with reference to clinical purposes, quality assurance, administrative practice, training and education, research and programme evaluation. S. Swartz's (1996b) perspective on the limitations of using case notes was reviewed and contrasted with the needs of multiple users of healthcare information with respect to conciseness and completeness. Issues pertaining to security and confidentiality of client details were also highlighted.

The benefits of effective management were outlined with reference to the benefits of using computerised information. In conclusion, it was suggested that poor user compliance could be enhanced through providing users with performance-related feedback on accuracy and the more economical use of time and personnel.

#### **1.4 Chapter Summary**

A summary of Hay's (1990) historical findings and Smit's (1997) demographic findings provided a broad framework for this study. The main objectives of the study were contextualised within this framework.

The chapter concluded with a two-part literature review. The first part was related to content and examined some of the South African literature that is pertinent to this research project. The second part of the review was related to method. As data for the demographic analysis was obtained from case notes, this section focused chiefly on the literature pertaining to health and mental healthcare information.

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## Chapter 2

### Method

#### Chapter Outline

<b>2.1</b>	<b>Introduction</b>	<b>38</b>
<b>2.2</b>	<b>DSM Diagnostic Criteria</b>	<b>38</b>
<b>2.3</b>	<b>The CGC Case File Format</b>	<b>38</b>
<b>2.4</b>	<b>Part I: Quantitative Analysis</b>	<b>40</b>
<b>2.4.1</b>	<b>Omission of the Clinician and Community Files</b>	<b>40</b>
<b>2.4.2</b>	<b>Social Science and Educational Psychology Interns</b>	<b>40</b>
<b>2.5</b>	<b>Racial Classification System</b>	<b>41</b>
<b>2.5.1</b>	<b>Omission of Client's Race and Social Class</b>	<b>41</b>
<b>2.6</b>	<b>Statistical Analysis of the Data</b>	<b>42</b>
<b>2.6.1</b>	<b>Descriptive Statistics for Key Variables</b>	<b>42</b>
<b>2.6.2</b>	<b>Log-Linear Analysis of Frequency Tables</b>	<b>43</b>
<b>2.6.2.1</b>	<b>Descriptive Reporting of Standardised Residuals</b>	<b>43</b>
<b>2.7</b>	<b>Part II: Qualitative Analysis</b>	<b>43</b>
<b>2.8</b>	<b>Triangulation</b>	<b>45</b>
<b>2.9</b>	<b>Chapter Summary</b>	<b>46</b>

## **Chapter 2**

### **Method**

#### **2.1 Introduction**

The research was conducted in two stages. The first part of the study consisted of a retrospective quantitative statistical analysis of the client data for the 10-year period between 1990 - 1999. The second part of the study was qualitative. For this part of the analysis semi-structured interviews were conducted with eight key past and present staff members of the CGC whose overall period of association with the clinic ranged from a maximum of over twenty-five years to a minimum of six years.

#### **2.2 DSM Diagnostic Criteria**

The DSM-IV was released in 1994. However as the DSM-III-R was in use at the CGC until 1996, both DSM-III-R and DSM-IV diagnostic criteria have been used to define and describe the original Primary and Secondary Diagnosis categorical variables in this study.

#### **2.3 The CGC Case File Format**

Smit (1997) has provided a comprehensive description of the format and contents of the CGC case files but, as the information is pertinent to this study, it will be summarised briefly in the following section.

The outside cover of the confidential case file is designated as an administrative information summary sheet. It summarises the following information: the names of the intern and the supervising clinician, the referral source, the clinical diagnosis, the nature of the intervention/s, the intake and discharge dates, the treatment outcome, the client's social class, and the number of 60-minute treatment sessions for the calendar year. The client's full name, address and contact details are documented on the inside of the cover,

which also contains a record of the client's previous and present problems. Space is allocated for a photograph of the index patient on the inside of the cover but these spaces generally remained empty in the 1990s.

Further identifying information including details of the gender, school, class teacher and family doctor of the index patient is recorded on a small referral slip located at the front of the file. The referral slip is followed by the formal admission slip which is both an information-gathering document and a consent form that is completed by the referring agent on arrival. This form is also used to record details pertaining to the presenting problem.

These documents are followed by a composite confidential patient history that is obtained by the clinician during the initial clinical interviews. As documented by Abrahams, Berger, Ensink, Hay, Ngqakayi et al. (1988) and Smit (1997), a modified version of the Maudsley history-taking interview is used for this procedure (See Appendix C). During the history-taking interview further identifying data concerning the index client are documented, the names of family members accompanying the client to the initial interview are noted, and details of the social history of caretaking nexus and personal history of the client are recorded. This information is followed in the case files by the results of the Mental State Examination (MSE), the provisional clinical formulation, the provisional diagnosis and the provisional management plan.

Copies of all correspondence concerning the client and, where pertinent, the results of all psychometric assessments are found in the following section. The therapist's notes and the supervision notes are filed in the next section. The termination summary is located in the final section of the case file. It comprises a review of the presenting problem, the clinical formulation, a detailed report of the assessment process and the final clinical diagnosis on all five DSM axes, a summary of the clinical findings and any additional recommendations concerning the client. The termination summary concludes with the clinician's estimate of the client's prognosis.

## **2.4 Part I: Quantitative Analysis**

In the first part of the study the case files from 1990 – 1999 were retrospectively analysed in order to obtain an overview of the demographic profile of the clientele who had been seen at the CGC during this period. As a block of 20 consecutive case files were missing from the 1992 folders and could therefore not be included in the analysis, this may account in part for any discrepancies that are found between Smit's (1997) findings for 1992 and the results of this analysis.

### **2.4.1 Omission of the Clinician and Community Files**

Smit's (1997) study was limited to the files that had been completed by clinical psychology interns. She states (p. 17): "intern's [sic] files, in contrast to those completed by clinicians, were homogeneous and meticulously completed, allowing in-depth investigation." Smit also excluded the case files related to community projects from her study on the grounds that the files had been completed by a number of interns, and that the different format from that of the individual case files would "complicate the analysis."

Whereas all the community files were omitted from the present study from the outset, in the initial stages of data collection all of the individual and family case files from 1991 – 1996 were scrutinised in detail. The data from these files ( $N = 810$ ) were computerised as specifically and as comprehensively as possible. However, as some of the clinicians' case files were incomplete and important data were found to be missing from them, this frequently proved to be a time-consuming and frustrating experience. A decision was therefore taken in March 2000 to omit all the clinician case files from the analysis. In effect, this meant that of a potential 1,189 individual client files, a total of 647 intern files were analysed in detail. A computerised database that rated each client on 32 categorical variables was drawn up for each of the ten years concerned.

#### **2.4.2 Social Work and Educational Psychology Interns**

The maximum annual total numbers of clients were seen between 1990 – 1993 ( $N = 78$ , 108, 65 and 81, respectively). This is partially accounted for by the fact that during this period social work students and educational psychology interns were still completing a portion of their training at the CGC but the practice was subsequently discontinued. Cuts in external funding also resulted in further reductions in the number of clients who could be accommodated by the CGC. For example, in 1999 the total clientele was only 40, in contrast to the maximum number of clients ( $N = 108$ ) who were seen in 1991.

#### **2.5 Racial Classification System**

As Smit notes, variables are somewhat “arbitrary descriptors” whose main purpose is to facilitate analysis of the data. However, where certain categorical variables coincided with those described in Smit’s (1997) comparison of the CGC case files for 1982 and 1992, care was taken to match the categories within each variable concerned with those she specified. This includes the apartheid racial classification system. Smit states (p. 50):

The terms ‘White’, ‘Black’ and ‘Coloured’ will be used in this discussion as established by the 1948 racial classification act. Since this discussion examines the effect of the apartheid legislation on the formation of racialised identities it necessitates some form of signification and hence categorisation. In accordance with Foster (1995) the use of these terms does not imply an ontological status; racial classifications are empty signifiers and have lost its [sic] meaning through many decades of use and abuse in South Africa, as well as internationally.

I have elected to substitute the term “African” for the category Smit specified as “Black”.

I wish to point out that the use of these terms is neither intended to be racist nor pejorative and that unless otherwise stated, in other parts of the discussion the term “black” will be used in its political sense as defined by Meherali (1993).

##### **2.5.1 Omission of Client’s Race and Social Class**

Smit (1997) found that whereas in 1982 all the case files routinely carried information pertaining to the client’s race and social class, in 1992 some of the interns had simply

omitted these details from their records. However, as Smit notes, it was frequently possible to infer the missing information through a careful scrutiny of the records because racial segregation had been effectively reinforced by means of the Group Areas Act and knowing where the client lived generally made it possible to discern his/her racialised identity. Smit also draws attention to the race/social class correlation for the two periods. This largely mirrors the discriminatory education and employment practices of apartheid South Africa that sustained high SES and privileged status for most whites.

The tendency by some interns to omit information regarding a client's race and class has continued throughout the 1990s. This has necessitated the inclusion of an Unknown category in both the Race and Social Class variables that are included in the database. As the Unknown categories signify an emerging trend in the 90s, they were maintained in the descriptive statistics for the two variables but were later omitted from the log-linear analyses in an effort to minimise the "noise" level.

## **2.6 Statistical Analysis of the Data**

The ten annual databases (1990 – 1999) were subsequently merged into a single large database that was analysed with the aid of the computerised *Statistica* programme. Following the merge, certain of the original categorical variables had to be redefined more broadly, as they contained too many categories to permit meaningful analysis of the data. This occurred in the case of the Primary and Secondary Diagnosis variables, where the original 70 categories were collapsed to 28. In other instances the small sample size necessitated collapsing the data across two or more variables. All details of amendments to data will be outlined in Chapter 3.

### **2.6.1 Descriptive Statistics for Key Variables**

The quantitative analysis was performed in two stages. In the first stage simple descriptive statistics were obtained for specified key variables over the 10-year period. In view of the partial overlap with Smit's (1997) study, the present study also investigated, but was not confined to the age, racialised identity, social class, referring agent, presenting

problem and treatment categorical variables. Other variables that were analysed statistically included gender, the various diagnostic tests, the primary and secondary diagnoses according to DSM-III-R and DSM-IV criteria, the number of client sessions, the racialised identity of the interns, the overall client dropout rate and the annual treatment outcomes.

### **2.6.2 Log-Linear Analysis of Frequency Tables**

In the second stage of the quantitative analysis log-linear analysis was used to investigate the associations between various specified key variables. As log-linear analysis computes both the traditional Pearson chi-square statistic and the maximum-likelihood-ratio chi-square statistic ( $L-R\chi^2$ ), it should be noted that the  $L-R\chi^2$  statistic has been reported throughout this study. An alpha value of .05 was used for all statistical tests.

With the exception of a single three-way analysis, the study was confined to the analysis of various specified two-way interactions (e.g., Race by Year). In the case of the three-way analysis, the hypothesis of independence between Race, Social Class, and Year was tested and disconfirmed. Inspection of all marginal and partial associations informed the selection of the best model, which proved to be a good fit (See Chapter 3 for details of all results). An analysis of the standardised residuals revealed the major trends and shifts that had occurred across the 10 years.

#### **2.6.2.1 Descriptive Reporting of Standardised Residuals**

In view of the large number of residuals, a decision was taken not to conduct significance tests because doing so would inflate the likelihood of Type I errors (Hays, 1994). The standardised residuals have therefore been discussed descriptively throughout the study, without any reference to the significance of the findings.

## **2.7 Part II: Qualitative Analysis**

The second part of the research was conducted with the objective of amplifying and contextualising some of the findings of the statistical analysis. For this part of the study

I constructed a semi-structured questionnaire as a guide to the interviews that were conducted with eight present or former CGC staff members. A copy of the semi-structured questionnaire is enclosed as an appendix (See Appendix B).

The multicultural staff team was selected because of their active involvement with the CGC, initially as students and then later as staff members. The overall period of association with the CGC ranged from a maximum of over two and a half decades (mid-1970s – 1990s) to a minimum of six years. With the exception of one person who declined to be interviewed, the sample included all of the permanent and two of the temporary members of the CGC teaching staff during the 90s. It also included all the persons who have acted as Director of the CGC since 1977. Two of the interviewees are currently self-employed in the private sector and the other six are employed as members of the staff team in the Department of Psychology at UCT, either on the main campus or at the CGC.

The interviews were conducted between May and August 2000. The semi-structured questionnaire was used as a general interview guide but in certain cases I included additional questions about particular aspects of an interviewee's field of interest and expertise. The interviews lasted between 45 minutes and an hour and were recorded, transcribed and thematically analysed. In one instance, at the request of the interviewee, the interview was not recorded but written notes were compiled during the interview and later analysed.

A very simple coding method as described by Miles and Huberman (1994) was used to analyse the data. The interview transcripts were initially grouped in terms of individual responses to the question concerned. Following this, the responses were scanned for identifiable topics ('or themes or gestalts') and their related sub-topics. The emergent themes were then coded for easy identification, and at a later stage similar and related topics were assembled together, or clustered, for further analysis. Whereas the first stage of coding is purely descriptive and requires little elucidation, the second stage calls for a more interpretative understanding of the data. Miles and Huberman identify a

third, even more explanatory and inferential level of pattern codes that are used in the next phase to identify the causal links between events, relationships and themes. All three levels of coding were employed during the various stages of analysis of the transcripts.

## 2.8 Triangulation

The concept of triangulation is borrowed from land surveying and navigational practices in which it is recognised that at least two landmarks are necessary in order to determine one's exact position on a map. In social science research triangulation commonly refers to the practice of using a combination of methodological approaches to the collection and analysis of data. While there is growing concurrence about the benefits of using a multi-dimensional approach in social science research (e.g., Brewer & Hunter, 1989; Budlender, 1996; Macdonald & Tipton, 1993), Hammersley (1990, p. 84) observes: "What is hoped for in triangulation, of course, is that the different data sources will confirm one another. But frequently this does not happen."

The relationship between quantitative and qualitative research methods therefore remains complex and Macdonald and Tipton (1993) allege that successful triangulation requires a considered evaluation of each method, both in relation to other proposed methods and with reference to the particular research problem in question. In relation to discourse analysis, S. Swartz (1996a, p. 65) contends:

[...] Textual analysis of statistical data interrogates the construction of the categories against which the numbers are recorded. Instead of assuming a transparent or 'factual' arrangement between counted instances and categories in which they are placed, *analysis draws attention to the arbitrariness of both categories and categorisation* (emphasis added). It also draws attention to authorship, taking into account the discursive position of those doing the counting.

MacDonald and Tipton (1993) identify four kinds of triangulation that were proposed by Denzin in 1970. They include (a) data triangulation, which includes the three subtypes of time, space and person, (b) investigator triangulation, (c) theory triangulation and (d)

methodological triangulation, which comprises the two subtypes of within-method and between-method triangulation.

Strictly speaking, the division of this study into a two-part descriptive statistical analysis of the client population of the 1990s and a qualitative content analysis of the semi-structured interviews with CGC staff members does not fall into any of the four categories.

Nevertheless, while the statistical data provide a demographic representation of the changing client profile of the past decade, the interviews with past and present CGC staff members help to contextualise the findings of the demographic analysis.

## **2.9 Chapter Summary**

The CGC case file format was described briefly and an explanation advanced for the omission of the community and clinician files from the analysis. The rationale behind my adherence to the discriminatory racial classification of the apartheid era was also explained with reference to Smit's (1997) study. The successive stages of the statistical analysis of the data were described and the interview process was outlined. The chapter was concluded with a brief discussion of the concept of triangulation.

## Chapter 3

### General Demographic Study of the Clientele from 1990 – 1999

#### Chapter Outline

<b>3.1</b>	<b>Introduction</b>	<b>50</b>
<b>3.2</b>	<b>Descriptive Statistics for Variables of Interest</b>	<b>50</b>
<b>3.2.1</b>	<b>Gender Distribution of Clientele</b>	<b>50</b>
<b>3.2.2</b>	<b>Age Distribution of Clientele</b>	<b>51</b>
<b>3.2.3</b>	<b>Referring Agent</b>	<b>52</b>
<b>3.2.4</b>	<b>Racial Distribution of Clientele</b>	<b>53</b>
<b>3.2.5</b>	<b>Social Class Distribution of Clientele</b>	<b>55</b>
<b>3.2.6</b>	<b>The Social Class / Race Link in South Africa</b>	<b>56</b>
<b>3.2.7</b>	<b>Presenting Problem</b>	<b>58</b>
<b>3.3</b>	<b>The Psychological Assessment Process</b>	<b>59</b>
<b>3.3.1</b>	<b>The Clinical Interview</b>	<b>60</b>
<b>3.3.2</b>	<b>Factors for Consideration in the Presence of Scholastic Difficulties</b>	<b>60</b>
<b>3.4</b>	<b>Psychological Tests used at the CGC from 1990 – 1999</b>	<b>61</b>
<b>3.5</b>	<b>Tests of Cognitive or Intellectual Ability</b>	<b>61</b>
<b>3.5.1</b>	<b>Internationally Normed Intelligence Tests</b>	<b>62</b>
<b>3.5.2</b>	<b>South African Normed Intelligence Tests</b>	<b>62</b>
<b>3.5.3</b>	<b>School Readiness Assessment</b>	<b>63</b>
<b>3.5.4</b>	<b>Giftedness</b>	<b>63</b>
<b>3.6</b>	<b>Non-Language Tests of Intelligence</b>	<b>63</b>
<b>3.6.1</b>	<b>Goodenough-Harris Drawing Test</b>	<b>64</b>
<b>3.6.2</b>	<b>Draw a Person (DAP)</b>	<b>64</b>
<b>3.7</b>	<b>Tests of Motor Functioning and Visual-Motor Integration</b>	<b>65</b>
<b>3.7.1</b>	<b>Tests of Spatial and Manipulatory Ability</b>	<b>65</b>
<b>3.7.2</b>	<b>The Bender Visual Motor Gestalt Test</b>	<b>65</b>
<b>3.7.3</b>	<b>Beery Developmental Test of Visual-Motor Integration</b>	<b>65</b>
<b>3.8</b>	<b>Tests of Visual Perception</b>	<b>66</b>

<b>3.9</b>	<b>Tests of Auditory Perception</b>	<b>66</b>
<b>3.10</b>	<b>Specified Scholastic Assessment Tests</b>	<b>67</b>
<b>3.10.1</b>	<b>The Individual Scale for General Scholastic Aptitude</b>	<b>68</b>
<b>3.11</b>	<b>Multimodal Assessment of Behavioural Problems</b>	<b>68</b>
<b>3.11.1</b>	<b>Multifaceted Assessment</b>	<b>69</b>
<b>3.12</b>	<b>Projective Tests of Personality and Emotional Adjustment</b>	<b>69</b>
<b>3.12.1</b>	<b>Projective Techniques</b>	<b>69</b>
<b>3.12.2</b>	<b>The DAP-SPED</b>	<b>69</b>
<b>3.12.3</b>	<b>The Thematic Apperception Test (TAT)</b>	<b>70</b>
<b>3.12.4</b>	<b>The Children's Apperception Test (CAT)</b>	<b>70</b>
<b>3.12.5</b>	<b>The Kinetic Family Drawing (KFD)</b>	<b>70</b>
<b>3.12.6</b>	<b>The Bene-Anthony Family Relations Test</b>	<b>71</b>
<b>3.13</b>	<b>Observation of Free Play</b>	<b>71</b>
<b>3.14</b>	<b>The DSM Differential Diagnosis</b>	<b>72</b>
<b>3.14.1</b>	<b>Selection and Composition of the Five Most Frequent Diagnoses</b>	<b>76</b>
<b>3.14.2</b>	<b>Gender Distribution for the Five Most Frequent Diagnoses</b>	<b>76</b>
<b>3.14.3</b>	<b>Age Distribution for the Five Most Frequent Diagnoses</b>	<b>77</b>
<b>3.14.4</b>	<b>Racial Analysis of the Five Most Frequent Diagnoses</b>	<b>78</b>
<b>3.14.5</b>	<b>Social Class Analysis of the Five Most Frequent Diagnoses</b>	<b>79</b>
<b>3.15</b>	<b>Treatment Options Used by the CGC</b>	<b>79</b>
<b>3.15.1</b>	<b>Referrals</b>	<b>79</b>
<b>3.15.2</b>	<b>Other Treatment Options</b>	<b>79</b>
<b>3.16</b>	<b>Duration of Treatment</b>	<b>80</b>
<b>3.17</b>	<b>Client Dropout</b>	<b>80</b>
<b>3.17.1</b>	<b>Possible Factors in Client Dropout</b>	<b>80</b>
<b>3.17.1.1</b>	<b>Client factors</b>	<b>80</b>
<b>3.17.1.1.1</b>	<i>Differential Diagnosis</i>	<b>80</b>
<b>3.17.1.1.2</b>	<i>Social Class</i>	<b>80</b>
<b>3.17.1.2</b>	<b>Therapist / Client Factors</b>	<b>81</b>
<b>3.17.1.2.1</b>	<i>Racial Differences</i>	<b>81</b>
<b>3.18</b>	<b>Treatment Outcomes</b>	<b>82</b>
<b>3.18.1</b>	<b>Additional Referrals</b>	<b>82</b>
<b>3.19</b>	<b>Relationship between Treatment and Outcome</b>	<b>82</b>

<b>3.20 Chapter Summary</b>	<b>84</b>
<b>3.20.1 Individual Statistics</b>	<b>84</b>
<b>3.20.2 Assessment Process</b>	<b>84</b>
<b>3.20.3 The DSM Diagnosis</b>	<b>84</b>
<b>3.20.4 Treatment Options</b>	<b>84</b>
<b>3.20.5 Treatment Outcomes</b>	<b>85</b>

University of Cape Town

## Chapter 3

### General Demographic Study of the Clientele from 1990 – 1999

#### **3.1 Introduction**

Simple descriptive statistics were obtained for each of the main variables that are pertinent to this study. While the descriptive statistics gave some indication of the major shifts that had occurred during the 10-year period, chi-square analysis was used to determine the extent and significance of the shifts. Analysis of the standardised residuals using a log-linear model indicated which of the major categories in each variable had been responsible for the significant shifts. An alpha level of .05 was used for all statistical tests. The principal findings are summarised in this chapter and will be discussed in Chapter 5.

#### **3.2 Descriptive Statistics for Variables of Interest**

##### **3.2.1 Gender Distribution of Clientele**

**Table 3-1**

**Two-Way Summary Table: Observed Frequencies - Gender by Year**

YEAR	Gender and % of <u>N</u>				Total:
	Male	% of <u>N</u>	Female	% of <u>N</u>	<u>N</u>
1990	54	69.2%	24	30.8%	78
1991	68	63.0%	40	37.0%	108
1992	35	53.9%	30	46.1%	65
1993	49	60.5%	32	39.5%	81
1994	32	55.2%	26	44.8%	58
1995	39	61.9%	24	38.1%	63
1996	30	51.7%	28	48.3%	58
1997	26	59.1%	18	40.9%	44
1998	25	51.0%	24	49.0%	49
1999	22	55.0%	18	45.0%	40
<u>N</u>	380	59.1%	264	40.9%	644

The relative numbers and percentages of male and female clients who were seen during the 1990s are summarised in Table 3-1. The percentage of male clients was higher in each of the ten years concerned, with maximum and minimum values of 69.2% in 1990 and 51.0% in 1998, respectively, ( $\underline{M} = 58.1\%$ ,  $SD = 5.73$ ). The corresponding minimum and maximum values for female clients were 30.8% in 1990 and 49.0% in 1998, respectively, ( $\underline{M} = 41.9\%$ ,  $SD = 5.73$ ).

### 3.2.2 Age Distribution of Clientele

A total of 647 clients were seen during the 10-year period. Of these, the ages of 643 index clients were available. The other four were family members whose ages were not recorded in the files. Although the exact age of clients was recorded in the database, clients were later grouped for ease of analysis into the seven categories shown in Table 3-2.

**Table 3-2**

**Two-Way Summary Table: Observed Frequencies – Age Range by Year**

YEAR	AGE RANGES OF CLIENTELE							Total:
	0-<5	5-<10	10-<15	15-<20	20-<30	30-<40	>40	<u>N</u>
1990	3	43	23	3	5	1	0	78
1991	7	54	29	10	5	2	1	108
1992	4	31	21	2	5	2	0	65
1993	10	35	19	6	7	1	3	81
1994	4	27	17	5	0	3	2	58
1995	6	25	17	8	6	1	0	63
1996	0	24	14	5	8	2	5	58
1997	2	19	11	3	3	3	2	43
1998	2	27	8	2	7	3	0	49
1999	1	19	8	5	2	3	2	40
<u>n</u>	39	304	167	49	48	21	15	643
<u>% of N</u>	6.1%	47.3%	26.0%	7.6%	7.5%	3.3%	2.3%	

In Table 3-2 a 5-year interval between groups has been used in the first four columns, e.g., the first column represents all children from birth to 4 years 11 months. A 10-year interval has been used from the age of 20 onwards, e.g., column five represents all clients aged between 20 – 29 years.

It will be observed that the majority of clients seen during the 1990s fall into the 5-14 years 11 months range. Of these, children aged between 5 - 9 years 11 months were seen most frequently at the clinic ( $n = 304$ ). They account for 47.3% of the total clientele seen between 1990 - 1999. The 10-14 years 11 month old group were next in frequency ( $n = 167$ ) and account for a further 26.0% of the 643 clients whose ages were known. As reflected in Table 3-2, these trends were substantiated throughout each of the ten years concerned.

In this study 79.4% of the total clientele were aged between 0 – 14 years 11 months. Smit (1997) noted that whereas in 1982 only 2.5% of the index patients were over the age of 16, the figure had increased to 12.5% in 1992. The increase was attributed to the fact that clinic practice had diversified from “strict child guidance” in the 1980s to include adult and family problems. Smit also reported the inclusion in 1992 of a self-referral category in the Referring Agent variable that had not been present in 1982. The self-referral category accounted for 9% of the referrals in 1992.

### **3.2.3 Referring Agent**

Possible referral sources in this study included the categories of father, mother, friend or family member, school, health professional, mental health professional, welfare agency, self and the church. The health and mental health professional categories and the welfare agency and church categories were later collapsed into two single categories for analytical purposes. The main findings are summarised in Table 3-3.

A two-way summary table (Table A-1) of the observed frequencies for each category of referrals is included in Appendix A. The annual figures confirm the main finding that mothers are the primary referring agents.

**Table 3-3**

**Observed Frequencies: Referring Agent: 1990 – 1999**

<b>Referring Agent</b>	<b><u>n</u></b>	<b>% of <u>N</u></b>	<b><u>N</u></b>
Father	67	10.4%	67
Mother	407	62.9%	474
Friend/Family	24	3.7%	498
School	36	5.6%	534
Professional	46	7.1%	580
Welfare/Church	7	1.1%	587
Self	60	9.3%	647

**3.2.4 Racial Distribution of Clientele**

The inclusion of the Unknown category in the Race variable was discussed in Chapter 2. The main findings are summarised in Table 3-4.

It is of interest to note that whereas until the 1970s the CGC catered largely for white upper middle-class children (Hay, 1990), the clinic's policy of desegregation in the 1980s has been significantly reflected in the clientele of the 1990s. Where the relevant information about a client's race could be inferred through further inspection of the data, it has been included.

The Coloured population was most frequently represented in each of the ten years ( $\underline{M} = 52.3\%$ ,  $SD = 8.11$ ) with maximum and minimum values of 61.5% in 1992 and 40.0% in 1999, respectively. The figures for Whites were,  $\underline{M} = 29.6\%$ ,  $SD = 7.37$ , with a maximum value of 37.2% in 1990 and a minimum value of 14.3% in 1998. The percentage of African clientele was consistently low throughout the 1990s ( $\underline{N} = 59$ ), ranging from a minimum of 0.0% in 1990 to a maximum of 27.6% in 1996 ( $\underline{M} = 10.3\%$ ,  $SD = 8.36$ ).

**Table 3-4****Summary Frequency Table: Observed Frequencies – Client Race by Year**

Year & %	CLIENT RACE				Row
	African	Coloured	White	Unknown	Totals: <u>N</u>
1990	0	42	29	7	78
Row %	0.0%	53.9%	37.2%	8.9%	
1991	2	65	40	1	108
Row %	1.9%	60.2%	37.0%	0.9%	
1992	3	40	22	0	65
Row %	4.6%	61.5%	33.9%	0.0%	
1993	8	48	25	0	81
Row %	9.9%	59.3%	30.8%	0.0%	
1994	4	35	18	1	58
Row %	6.9%	60.3%	31.0%	1.7%	
1995	8	32	21	2	63
Row %	12.7%	50.8%	33.3%	3.2%	
1996	16	24	14	4	58
Row %	27.6%	41.4%	24.1%	6.9%	
1997	3	24	10	10	47
Row %	6.4%	51.1%	21.3%	21.3%	
1998	9	22	7	11	49
Row %	18.4%	44.9%	14.3%	22.5%	
1999	6	16	13	5	40
Row %	15.0%	40.0%	32.5%	12.5%	
<b>TOTAL: <u>n</u></b>	59	348	199	41	647
<b>% of <u>N</u></b>	9.1%	53.8%	30.8%	6.3%	

The Unknown category in the Race variable ( $n = 41$ ) was excluded from the analysis. Log-linear analysis using the model (Race Year), revealed that the Race and Year variables were dependent:  $L-R\chi^2(18, N=606) = 54.55, p < 0.00002$ . Analysis of the standardised residuals revealed that Africans were significantly under-represented

between 1990 – 1994. Africans were also under-represented in 1997 but were significantly over-represented in 1996 ( $n = 16$ ,  $N = 58$ ) when compared with the entire population of clients in the 1990s. They were also slightly over-represented in the 1998 and 1999 clientele.

Apart from 1990, when Whites were over-represented, the figures for Coloureds consistently exceeded those for the Whites. Interestingly, in 1996 the relatively large increase in African clientele resulted in under-representation of both the Coloured and White populations. The full results are recorded in Table A-2 (See Appendix A).

### 3.2.5 Social Class Distribution of Clientele

The Social Class variable was divided into the six categories that were described in the case files. The annual distribution for each category is summarised in Table 3-5.

**Table 3-5**

**Two-Way Summary Table: Observed Frequencies – Social Class by Year**

YEAR	SOCIAL CLASS							Total:
	P	SP	S	SS	US	UE	U	<u>N</u>
1990	3	16	36	14	5	3	1	78
1991	11	21	42	21	8	2	3	108
1992	13	15	28	3	2	3	1	65
1993	8	27	35	6	1	3	1	81
1994	11	28	9	5	2	3	0	58
1995	10	12	21	6	5	3	6	63
1996	9	11	21	8	2	4	3	58
1997	8	11	18	6	2	2	0	47
1998	4	11	17	4	3	3	7	49
1999	2	11	19	4	2	2	0	40
<u>n</u>	79	163	246	77	32	28	22	647
% of <u>N</u>	12.2	25.2	38.0	11.9	4.9	4.3	3.4	

P = Professional, SP = Semi-professional, S = Skilled, SS = Semi-skilled,  
US = Unskilled, UE = Unemployed, U = Unknown.

As with the Race variable, the inclusion of an Unknown category in the database reflects the practice of certain interns to omit the pertinent information from the records in the 90s. The Professional, Semi-professional and Skilled categories incorporate the upper-middle and middle classes, respectively. The Professional category incorporates professionals, business executives and owners of large companies, the Semi-professionals include semi-professionals, entrepreneurs and small business owners, and the Skilled group comprises students and skilled and clerical workers. The lower socioeconomic classes are represented by the other three categories.

These figures reflect the overall shift in clientele towards a different socioeconomic bracket from that of the predominantly white upper middle-class of the 70s and the early 80s. The following overall percentages were calculated for each category: Professional, 12.2%, Semi-professional, 25.2%, Skilled, 38.0%, Semi-skilled, 11.9%, Unskilled, 4.9%, Unemployed, 4.3% and Unknown, 3.4%.

The Unknown category was omitted from the Social Class variable in the log-linear analysis. The model (Class Year) proved to be a poor fit and showed that the Social Class and Year variables were dependent:  $L-R \chi^2 (45, N = 625) = 65.16, p = .0263$ . Analysis of the standardised residuals revealed that between 1990 – 1991 the middle and lower socioeconomic classes were most frequently represented. There was a shift towards the upper and middle classes from 1992 – 1997 and a slight shift towards the middle and lower socioeconomic classes in 1998 and 1999. The full results of the analysis of the standardised residuals in the Social Class variable are recorded in Table A-3 (See Appendix A).

### **3.2.6 The Social Class / Race Link in South Africa**

The incontrovertible link between race and social class in South Africa during the apartheid years has been widely recognised in the literature (e.g., Berger & Lazarus, 1987; Dawes & Donald, 1994; Vogelman, 1987) and has also been demonstrated by Smit (1997).

The relationship between the race and social class of the CGC clientele of the 1990s is summarised in Table 3-6.

**Table 3-6**

**Two-Way Summary Table: Observed Frequencies – Client Race by Social Class**

RACE	SOCIAL CLASS							Total:
	P	SP	S	SS	US	UE	U	<u>N</u>
African	13	13	12	3	10	4	4	59
Coloured	25	70	144	63	18	17	11	348
White	38	71	71	9	1	4	5	199
Unknown	3	9	19	2	3	3	2	41
<u>n</u>	79	163	246	77	32	28	22	647
% of <u>N</u>	12.2%	25.2%	38.0%	11.9%	4.9%	4.3%	3.4%	

P = Professional, SP = Semi-professional, S = Skilled, SS = Semi-skilled, US = Unskilled, UE = Unemployed, U = Unknown.

From even a cursory inspection of Table 3-6 it will be observed how the alleged relationship between race and class is borne out in the Coloured and White sectors of the CGC clientele. Whereas only 27.2% ( $n = 95$ ) of the Coloured population ( $N = 348$ ) fell into the Professional and Semi-professional brackets, 41.3% ( $n = 144$ ) of the Coloured clientele were categorised as Skilled. By contrast, 54.8% ( $n = 109$ ) of the Whites ( $N = 199$ ) belonged to the Professional and Semi-professional classes. A further 35.7% of Whites ( $n = 71$ ) were classified as Skilled, with only 9.5% ( $n = 19$ ) of the total White population falling into a lower socioeconomic group. Of the African clientele who were seen during the 1990s ( $N = 59$ ), 64.4% ( $n = 38$ ) were from the higher social classes, and of the remaining 35.6% ( $n = 21$ ), 16.9% ( $n = 10$ ) were categorised as Unskilled.

After omitting the Unknown categories from the Race and Social class variables, a three-way log-linear analysis of the associations between Race (1), Social Class (2), and Year (3), was conducted. Following an inspection of all marginal and partial associations, a log-linear model positing three main effects and two 2-way

interactions was tested (Model = 21 31). This model posits all main effects and two 2-way interactions (21 and 31), but omits the 3-way interaction and the 23 interaction. The result showed a good fit:  $L-R\chi^2 (135, N = 586) = 115.29, p = .8888$ .

Whilst the good fit of the model obviated the need for analysis of the standardised residuals, inspection of the standardised residuals for each of the 10 years indicated that Africans tended to be over-represented in the Professional and the Unskilled and Unemployed social classes. No singular trends were observed in the Coloured group. Not unexpectedly, in most years Whites tended to be slightly over-represented in the Professional and Semi-professional social classes and marginally under-represented in the other classes.

These trends were substantiated throughout the 10-year period, except in 1996 when the relatively high proportion of African clients for that year ( $n = 16, N = 58$ ), resulted in Africans being quite substantially over-represented in the Professional class (See Table A-14). The full results of the analysis of the standardised residuals are recorded in Tables A-8 – A-17 (See Appendix A).

### **3.2.7 Presenting Problem**

The Presenting Problem variable was divided into the five categories adopted by Smit (1997). They included school and/or academic problems (School), attention-deficit and disruptive behaviour disorders (Conduct), psychosomatic and other specified medical conditions recorded on Axis III of the DSM diagnostic system (Somatic), mood and/or anxiety disorders (Emotions) and Habits. The Habits category included enuresis, encopresis, nail biting and one instance of trichotillomania.

The overall breakdown ( $N = 647$ ) for each category over the 10-year period was School, 45.3%, ( $n = 293$ ); Conduct, 30.4%, ( $n = 197$ ); Somatic, 0.9%, ( $n = 6$ ); Emotions, 22.6%, ( $n = 146$ ) and Habits, 0.8%, ( $n = 5$ ). The gender distribution pattern for each of the five categories of presenting problems over the 10-year period is shown in Table 3-7. Of the total clientele ( $N = 647$ ), 643 were included in the analysis, as the gender of four clients was unknown.

**Table 3-7**

**Two-Way Frequency Table - Gender by Presenting Problem: 1990 – 1999**

Gender	Presenting Problem					Row
	School	Conduct	Somatic	Emotion	Habits	Total: <u>N</u>
Males	197	128	3	47	5	380
Females	96	68	3	97	0	264
<b><u>n</u></b>	293	196	6	144	5	644

It is clinically significant that whereas males predominated in both the School and the Conduct categories (67.2% and 65.3% respectively), the proportions were reversed in the Emotions category (Females, 67.4%). The annual breakdown figures confirmed these trends and are recorded in Table A-18 (Appendix A).

As could be hypothesised from the descriptive statistics, log-linear analysis using the model (Gender Presenting Problem) proved to be a poor fit and confirmed that the Gender and Presenting Problem variables were dependent:  $L-R \chi^2 (4, N = 644) = 55.61, p < 0.00001$ . As these findings will be linked to the discussion of the findings for the most frequent DSM diagnoses, analysis of the Presenting Problem variable was not pursued beyond this stage.

### **3.3 The Psychological Assessment Process**

The assessment process used at the CGC is modelled on the four pillars of assessment as outlined by Sattler (1992). They include (a) norm-referenced tests, (b) interviews, (c) observations and (d) informal assessment. As the four pillars are complementary they contribute together to the formation of an integrated picture on which clinical evaluations and treatment decisions can be made.

The assessment procedure adopted by the CGC begins with an initial screening process. Potential clients are referred elsewhere at this stage should the referral question be considered as inappropriate, unethical or impractical.

### **3.3.1 The Clinical Interview**

The first appointment is generally scheduled for the clinical interview. Particularly if the index client is a child, significant family members are actively encouraged to be present during the initial interviews. This practice allows the clinician to observe the client within the family context. A modified version of the Maudsley history-taking format, as introduced at the CGC in 1987, is used together with the Mental State Examination (MSE) for the clinical interviews. Additional collateral information may be sought from family members, teachers and other professionals.

### **3.3.2 Factors for Consideration in the Presence of Scholastic Difficulties**

As CGC policy, the following factors are considered when assessing a child who presents with scholastic problems, as one or more of them may contribute to the experienced difficulty (Bidoli, 1999):

1. Visual acuity.
2. Auditory acuity.
3. Health factors, for example, allergies, asthma, ear and general infections, epilepsy.
4. Overall level of motor functioning. This includes the level of postural and muscle tone, the level of postural control, motor planning, bilateral integration and laterality, gross motor control and fine motor control.
5. Visual motor integration.
6. Visual perception. This includes figure/ground perception, visual discrimination, visual sequencing, visual memory and visual sequential memory.
7. Spatial factors. These include spatial organisation, position in space, for example, the relative positions in space of b and p, and laterality.
8. Auditory perception. This includes auditory discrimination, auditory analysis, auditory synthesis, auditory sequencing, auditory memory and auditory sequential memory.
9. Level of intellectual functioning.
10. Language ability. This includes receptive vocabulary, expressive reasoning and conceptual reasoning.
11. Speech.
12. Attention and concentration.
13. Attitudinal, emotional and personality factors.

14. Peer relationships.

15. Familial factors, for example, family relationships, SES, substance abuse, et cetera.

A working hypothesis is drawn up following the clinical interview. The hypothesis incorporates a provisional formulation, a provisional diagnosis and a provisional management plan. In the case of children the provisional management plan will frequently include the administration of various appropriate norm-referenced tests and any additional informal tests that are considered necessary. The test results assist in the formulation of the differential diagnosis and the treatment plan or intervention.

### **3.4 Psychological Tests Used at the CGC from 1990 – 1999**

The test instruments most frequently used by the CGC interns fall into two broad categories. They include (a) tests of ability, which include the measurement of individual intelligence, aptitude, achievement and neuropsychological functioning, and (b) the personality tests, which are used to assess personal motivation, adjustment, social competence, attitudinal characteristics, personality traits and psychiatric symptomatology (Gregory, 1996).

The psychometrics committee of the South African Professional Board for Psychology (now part of the Health Professions Council of South Africa) has classified these as Class C Tests. The C tests may only be used by a psychologist or a psychometrist under the guidance and supervision of a psychologist, or by trainees in these fields, under a supervisor (Prinsloo, 1989).

For analytical purposes the diagnostic tests were divided into eleven categorical variables and every client ( $N = 647$ ) was rated on a Yes / No basis for each of the eleven tests. The results of the tests are summarised in Sections 3.5 – 3.13.

### **3.5 Tests of Cognitive or Intellectual Ability**

These include the following individual intelligence tests and developmental assessment tests. The results and age ranges for the tests are summarised in Table 3-8.

### **3.5.1 Internationally Normed Intelligence Tests**

The following internationally normed intelligence tests were used during the 1990s:

1. **Griffiths Mental Development Scales:** These tests are used in the developmental assessment of children aged between 0 – 8 years 11 months.
2. **Wechsler Pre-School and Primary Scale of Intelligence Revised (WPPSI-R):** Intelligence test for children aged between 4 – 6 years 11 months.
3. **Wechsler Intelligence Scale for Children (WISC-III):** Intelligence test for children aged between 6 – 16 years 11 months.
4. **Vineland Adaptive Behaviour Scales:** This test is used to assess the personal and social maturity of individuals from 0 – 18 years 11 months old, to low-functioning adults.

### **3.5.2 South African Normed Intelligence Tests**

The Junior South African Individual Scales (JSAIS) was released in 1981 by the HSRC (Human Sciences Research Council). The JSAIS was developed as a general test of intelligence that also evaluates certain non-cognitive behaviours in South African children between the ages of 3 – 7 years 11 months.

The Senior South African Individual Scale (SSAIS) was developed for South African children aged from 5 – 16 years 11 months whose mother tongue is English or Afrikaans. A revised standardised version (SSAIS-R) was released in 1991 for Afrikaans or English speaking children aged between 7 – 16 years 11 months, who have not been socioeconomically disadvantaged. The test is used both as a measure of general intellectual ability and as separate measures of various specified verbal and nonverbal constructs. During the 10-year period a total of 161 children were assessed by means of the JSAIS or the SSAIS-R. The distribution and age ranges of the children are recorded in Table 3-9.

**Table 3-8:**

**Individual Intelligence and Developmental Assessment Tests by Age Category**

Test	AGE CATEGORY				Total: <u>n</u>	% of <u>N</u>
	0-<5	5-<10	10-<15	15-<20		
Griffiths	13	29	0	0	42	6.5%
WPPSI-R	1	5	0	0	6	0.9%
WISC-III	0	65	52	6	123	19.0%
J / SSAIS-R	0	94	54	13	161	25.0%
Vineland	0	2	1	0	3	0.5%

**3.5.3 School Readiness Assessment**

School readiness was assessed using either the Griffiths Mental Development Scales or the WPPSI-R. Twelve children or 1.9% of the total clientele were assessed for school readiness during the 10-year period.

**3.5.4 Giftedness**

In the US the prevalence of giftedness is estimated to be between 3% - 5% of the total population. The attributes associated with "giftedness" include one or more of the following: an exceptionally high IQ of 130 or more, the achievement of outstanding prominence in a particular field, excellence in art or music, and high scores on tests of creativity (Sattler, 1992).

Seven of the children, or 1.1% of the total clientele (N = 647) were identified as being gifted. Of these, five were males between the ages of 6 – 13 years, and two were females aged 4 and 6 years, respectively. The children were identified using age-appropriate versions of either the Wechsler Intelligence Scales or the SSAIS-R.

**3.6 Non-Language Tests of Intelligence**

Gregory (1996) notes that there are large sectors of the population for whom the traditional tests of intelligence are not suitable, for example, children who are very young, physically or intellectually challenged individuals, or persons whose home language differs from the test language.

### 3.6.1 Goodenough-Harris Drawing Test

Of the many tests that have been devised to meet these criteria, the Goodenough-Harris Drawing Test (1963) is described as a brief, nonverbal test of intellectual maturity that can be administered to children either individually or in a group. After being instructed to draw “the very best picture of a person that you can,” the child is rated on separate 73 items that include the individual body parts and their details, the degrees of proportion and perspective, and a sense of freedom of movement. The test can also be used as an adjunct to the individual tests of intelligence that have been previously described.

### 3.6.2 Draw a Person (DAP)

The Goodenough-Harris Drawing test was widely used for twenty years as the main estimate of intellectual ability using children’s drawings. The test was shown to have good inter-rater reliability and to correlate well with the standardised Binet and Wechsler intelligence tests but was criticised towards the late 1980s as being in need of updating. The Draw A Person: A Quantitative Scoring System (DAP) was released in 1988 in response to the need for an updated, recently normed, and bias-free scoring system for use with the human figure drawings by children and adolescents (Naglieri, 1988).

**Table 3-9**

**Two-Way Frequency Table – Drawing Test by Age Category: 1990 – 1999**

Drawing Test	AGE CATEGORY					Row
	0-<5	5-<10	10-<15	15-<20	20-<30	Total: <u>N</u>
DAP	4	157	71	8	1	241
Row %	1.7%	65.1%	29.5%	3.3%	0.4%	

The relative frequencies and age distribution of the 241 clients who underwent either Goodenough-Harris Drawing or the DAP test are summarised in Table 3-9. They accounted for 37.3% of the total clientele. Ideally the tests are most suitable for children aged 3 – 10 years but they can be used with adolescents up to the age of 15 years 11 months (Sattler, 1992). The single test result in the 20 -<30 age bracket is unusual and may therefore be indicative of intellectual or language difficulties in that particular client.

### **3.7 Tests of Motor Functioning and Visual-Motor Integration**

#### **3.7.1 Tests of Spatial and Manipulatory Ability**

Tests of spatial and manipulatory ability are alternatively classified as tests of constructional performance. Tests of constructional performance combine perceptual activity with motor response and always involve the use of a spatial component. Because constructional ability involves a number of complex functions, Gregory (1996) notes that even mild forms of brain dysfunction will lead to impaired constructional performance. The performance deficits may include difficulties with concentration, spatial confusion, perceptual deficiency, motivational problems and apraxias, which Gregory describes as “a variety of dysfunctions characterised by a breakdown in the direction or execution of complex motor acts”(p. 372).

#### **3.7.2 The Bender Visual Motor Gestalt Test**

Tests of constructional performance are broadly classified as drawing and assembling tests. The Bender Visual Motor Gestalt Test, more commonly known as the Bender Gestalt Test (BGT) is the most widely used of the drawing tests. It consists of nine figures which the examinee is instructed to copy as precisely as possible. In children the BGT is used to assess the visual-perceptual developmental level. The BGT may also serve as an index of visual motor difficulties that are related to brain damage.

A total of 89 children or adolescents, 13.8% of the total clientele, were tested using the BGT during the 10-year period. Of these, 85 were aged between 5 – 14 years 11 months. The remaining four were adolescents aged between 15 – 19 years 11 months. The relative ages and frequencies for the 10-year period are summarised in Table A-19 (See Appendix A).

#### **3.7.3 Beery Developmental Test of Visual-Motor Integration**

The Beery Developmental Test of Visual-Motor Integration (VMI) consists of a developmental sequence of geometric forms that are copied with paper and pencil (Beery, 1997). Beery notes that some children who exhibit well-developed separate

visual and motor skills are unable to integrate the two sets of skills. Beery originally developed the VMI in 1967 as separate measures of visual-motor integration, the ability to co-ordinate visual and motor functioning, and as a reflection of developmental age differences in visual-motor integration. The test is suitable for individuals between the ages of 3 years 0 months to adulthood.

A total of 103 children or adolescents, 15.7% of the total clientele for the 10-year period ( $N = 647$ ) were assessed by means of the VMI. Of these, two were younger than 5 years of age and two were aged between 15 – 19 years 11 months old. The other 99 were between the ages of 5 – 14 years 11 months. The relative ages and frequencies for the 10-year period are summarised in Table A-20 (See Appendix A).

### **3.8 Tests of Visual Perception**

Visual perception can be described as the capacity of the brain to recognise and to differentiate amongst incoming visual stimuli and to interpret them accurately in the light of previous stored visual information. Visual perception can be measured by means of the three informal MacMillan Subtests that are used to assess letter matching, letter recognition and letter reproduction. The MacMillan Subtests are used at the CGC (Bidoli, 1999) but were not recorded separately amongst the variables.

### **3.9 Tests of Auditory Perception**

The tests of auditory perception that are currently used at the CGC include the Rosner Test of Auditory Analysis Skills, the WPPSI Sentence Memory test and the Wepman Auditory Discrimination Test (ADT), which was originally published by Wepman in 1958 and revised and standardised in the 1980s. The test consists of 40 word pairs that have been matched for length, phonetic category and familiarity and is used as a measure of the child's ability to hear spoken language accurately (Sattler, 1992).

A total of 27 children or 4.2% of the total population were tested by means of the ADT in the 1990s. Of these, 70.4% ( $n = 19$ ) were aged between 5 – 9 years 11 months and 29.6% ( $n = 8$ ) were aged between 10 – 14 years 11 months. The results are summarised in Table A-21 (See Appendix A).

### **3.10 Specified Scholastic Assessment Tests**

Ninety-six children (14.8% of the total population) underwent some form of specific scholastic assessment for identified problematic areas during the 10-year period. The four categories represented by the Scholastic variable include language, reading, spelling and mathematics. The individual diagnostic assessment tests used by the CGC are listed sequentially in Table 3-10.

Prior to 1996 the tests were used in the differential diagnosis of the DSM-III-R categories of Academic Skills Disorders and Language and Speech Disorders, and from 1996 onwards the tests were used in the differential diagnosis of the equivalent DSM-IV categories of Learning Disorders and Communication Disorders.

**Table 3-10:**

#### **Scholastic Assessment Tests**

**a) Tests of Language Assessment**

**1) Tests of auditory recall**

**2) Tests of auditory sequencing**

The Merrill-Palmer / Griffiths sentences, WPPSI sentences, Individual Scale for General Scholastic Aptitude (ISGSA) sentences and SSAIS story tests are used to test auditory recall and auditory sequencing.

**3) Tests of syntactic organisation**

ITPA grammatic closure subtest.

**b) Tests of Reading Assessment**

Newlands Education Support Centre Diagnostic Reading Test (NESC)

Schonell Graded Word Reading Test

MacMillan Group Reading Test

Daniels and Diack Graded Test of Reading Experience

*Continued*

c) **Tests of Spelling Assessment**

Guelph Diagnostic Spelling Test

Schonell Spelling Test

Ice Spelling Test

d) **Tests of Mathematics Assessment**

Ballard One Minute Addition and Subtraction

Schonell – Test 5

UCT Arithmetic Problems

Young Group Mathematics Test

**3.10.1 The Individual Scale for General Scholastic Aptitude**

The ISGSA, which is used in the assessment of language and mental handicap and has replaced the old South African OSAIS, was first used at the CGC in 1999. Two children in the 10 – 14 year 11 month-old category were assessed by means of the ISGSA. This accounts for 0.3% of all cases seen in the 1990s.

**3.11 Multimodal Assessment of Behavioural Problems**

The Conners' Rating Scales (CRS) for the multimodal assessment of behavioural problems were released in 1989 and re-released in 1997 in revised format (CRS-R).

The CRS-R was first used at the CGC in 1998. Of the seven children who were tested, six were seen in 1998 and one in 1999. The age distribution and relative frequencies are summarised in Table 3-11.

**Table 3-11**

**Two-Way Frequency Table: CRS-R by Age Category**

Test	AGE CATEGORY			Row
	0-<5	5-<10	10-<15	Total: <u>N</u>
CRS-R	1	4	2	7
Row %	14.3%	57.1%	28.6%	

The CRS-R was designed for use with children and adolescents aged from 3 – 17 years. The new self-report scales are suitable for completion by 12 – 17 year-olds. As the test combines reports from teachers, caregivers and self-reports from adolescents, it directly address the need for multimodal assessment in the diagnosis and treatment of youths with behavioural problems (Conners, 1997).

### **3.11.1 Multifaceted Assessment**

Because the various sub-scales of the CRS-R help assess the child in a variety of areas, the CRS-R is useful not only in assessing ADHD, but also conduct problems, cognitive problems, family problems, emotional problems, anger control problems, and anxiety problems. Conners (1997) states that the ability of the CRS-R to assess these other facets is crucial given that ADHD is frequently comorbid with these problems, particularly anxiety problems and conduct problems.

## **3.12 Projective Tests of Personality and Emotional Adjustment**

### **3.12.1 Projective Techniques**

Frank (1939, 1948) introduced the term “projective method.” The projective hypothesis is also widely attributed to Frank (Gregory, 1996). The hypothesis is rooted in psychoanalytic theory and is based on an understanding and interpretation of the unconscious processes that are at work in an individual. Frank (1939, cited in Gregory, 1996, p. 511) states:

When we scrutinize the actual procedures that may be called projective methods we find a variety of techniques and materials being employed for the same general purpose, to obtain from the subject, “what he cannot or will not say,” frequently because he does not know himself and is not aware what he is revealing about himself through his projections.

### **3.12.2 The DAP-SPED**

The role of the DAP in the intellectual assessment of children aged from 3 – 15 years 11 months has been discussed previously (Section 3.6.2). However, because of the long-standing recognition of the projective value of children’s human figure drawings (e.g., Koppitz, 1968; Richter, Griesel & Wortley, 1989; Rudenberg, Jansen & Fridjohn, 1998), the DAP has also been tested and rated as a reliable index of

emotional adjustment and personality characteristics. The DAP-SPED (Screening Procedure for Emotional Disturbance) is used for scoring purposes (Naglieri, 1988).

As previously reported, the relative frequencies and age distribution of the 241 clients who underwent either the Goodenough-Harris Drawing or the DAP test are summarised in Table 3-9. Unfortunately, due to an oversight during the data collection process, no distinction was made between the various purposes for which the test was originally administered during the 1990s.

### **3.12.3 The Thematic Apperception Test (TAT)**

Murray (1943) devised the TAT as a projective test of personality that reveals the predominant underlying drives, emotions, feelings, conflicts and defensive processes of a given individual. The test consists of a series of thirty black and white pictures of various themes and subjects, with one additional blank card. The examinee is instructed to make up a story for each picture and the combined scores from all the cards are used to form a composite portrait of his or her unconscious processes. The TAT is most suitable for use with adults and adolescents from the age of 11 years onwards.

### **3.12.4 The Children's Apperception Test (CAT)**

Bellak (1949) developed the CAT as a projective test that assists in the understanding of the dominant figures and drives in the lives of children aged between 3 – 10 years 11 months. The test is similar to the TAT but uses ten sequential pictures of animals in various situations as the basis for the stories. Bellak (1971) states that although the CAT originated from the TAT, it neither competes with, nor substitutes for it.

A total of 194 ( $n = 194$ ) or 30.0% of the total population were tested using either the TAT or the CAT during the 10-year period. The numbers and relative age distribution of the clients are summarised in Table 3-12.

### **3.12.5 The Kinetic Family Drawing (KFD)**

This is a projective drawing test in which the client is asked to draw a family portrait. Koppitz (1968) discusses the clinical significance of the family portrait as a reflection of a child's attitude towards family members. As such, the size, placement of figures,

exaggerations, omissions, additions and substitutions shown in the picture are all pertinent factors that contribute towards the formulation of the differential diagnosis.

A total of 192 ( $n = 192$ ) children and adolescents, 29.7% of the total clientele, were assessed using the KFD. The numbers and relative age distribution of the clients are summarised in Table 3-12.

### **3.12.6 The Bene-Anthony Family Relations Test**

The Bene-Anthony Family Relations Test is a projective test that is used in the assessment of a client's significant family relationships. A total of 108 children, 16.7% of the total clientele, were assessed by means of the test.

The annual distribution shows that the test was used consistently throughout the 10-year period, with an observed overall increase in frequency from 1994 onwards. The annual distribution is recorded in Table A-22 in Appendix A. The numbers and age distribution of the children to whom the tests were administered are summarised in Table 3-12.

### **3.13 Observation of Free Play**

Very young children are infrequently interviewed or tested in a formal way but much clinically valuable information can be derived through observing preschool children in a free play setting.

Although free play is usually reserved for children under the age of 5 years, Sattler (1992) notes that a short spell of play can be useful in observing children between the ages of 5 – 11 who are suspected of being hyperactive, retarded, low-functioning. It is also useful for children who have problems with aggression, or a dislike of the board games that are sometimes used to relax children in this age group prior to the actual interview. A total of 42 children or 7.8% of the overall clientele were observed in a free play situation. The numbers and age distribution of the children who were assessed are summarised in Table 3-12.

**Table 3-12**

**Two-Way Frequency Table: Projective Test by Age Category: 1990 – 1999**

<u>Projective Test Used</u>	<u>AGE CATEGORY</u>					<u>Row Total: N</u>
	<u>0-&lt;5</u>	<u>5-&lt;10</u>	<u>10-&lt;15</u>	<u>15-&lt;20</u>	<u>20-&lt;30</u>	
<b>TAT / CAT</b>	3	116	61	13	1	194
Row %	1.6%	59.8%	31.4%	6.7%	0.5%	
<b>Bene-Anthony</b>	0	77	29	2	0	108
Row %	0.0%	71.2%	26.9%	1.9%	0.0%	
<b>KFD</b>	2	121	60	8	1	192
Row %	1.0%	63.0%	31.3%	4.2%	0.5%	
<b>Free Play</b>	8	29	5	0	0	42
Row %	19.5%	69.1%	11.9%	0.0%	0.0%	

### **3.14 The DSM Differential Diagnosis**

The DSM-III-R (1987) diagnostic system was in use at the CGC during the first half of the 1990s. The DSM-IV was released in 1994 and was introduced at the CGC in 1996. Clients were therefore diagnosed according to DSM-III-R criteria from 1990 – 1995 and according to DSM-IV criteria from 1996 onwards.

CGC clients were diagnosed on all five DSM axes in the case files but for analytical purposes a total of 70 possible diagnostic categories from Axes I – IV were initially selected for inclusion in the Primary and Secondary Diagnosis variables. Where multiple conditions were diagnosed on Axis I or II the condition that was deemed by the clinician to be the primary focus of attention was recorded as the Primary Diagnosis. Where applicable, other conditions on Axes I – IV were recorded as Secondary Diagnoses. At this stage of the analysis the diagnoses were recorded specifically, even where only one instance of a specified condition, e.g., Bipolar Disorder, Schizophreniform Disorder, presented during the whole of the 10-year period.

Although of considerable diagnostic interest, this practice proved unwieldy for analytical purposes and the 70 categories were collapsed into 28 broad categories that were analysed in greater detail. Table 3-15 shows the full range of primary diagnoses

(updated to DSM-IV criteria) that were recorded for the 10-year period. The assessments for school readiness ( $n = 14$ ) and giftedness ( $n = 8$ ) are also included at the end of Table 3-13 as the primary reasons for consultation.

**Table 3-13**

**Primary Clinical Diagnoses: 1990 – 1999**

DSM DIAGNOSIS	<u>n</u>	% of <u>N</u>
<b>Mental Retardation (Coded on Axis II)</b>		
Mild Mental Retardation	20	3.1%
Moderate Mental Retardation	2	0.3%
Borderline Intellectual Functioning	20	3.1%
<b>Learning Disorders</b>		
Specified Learning Disorders	35	5.4%
<b>Motor Skills Disorder</b>		
Developmental Coordination Disorder	3	0.5%
<b>Communication Disorders</b>		
Expressive Language Disorder	4	0.6%
Mixed Receptive-Expressive Lang. Disorder	4	0.6%
Phonological Disorder	1	0.2%
Stuttering	5	0.8%
<b>Developmental Disorders</b>		
Specific Developmental Disorder NOS	2	0.3%
Slight Developmental Delay	4	0.6%
<b>Attention-Deficit and Disruptive Behaviour Disorders</b>		
ADHD Combined Type	8	1.2%
ADHD Inattentive Type	13	2.0%
ADHD Hyperactive Impulsive Type	5	0.8%
ADHD NOS	20	3.1%
Conduct Disorder	9	1.4%
Oppositional Defiant Disorder	11	1.7%
Disruptive Behaviour Disorder NOS	1	0.2%
<b>Elimination Disorders</b>		
Enuresis/All Types	30	4.6%
<b>Other Disorders of Infancy, Childhood or Adolescence</b>		
Separation Anxiety Disorder	18	2.8%

Reactive Attachment Disorder	1	0.1%
<b>Alcohol-Related Disorders</b>		
Alcohol Dependence	1	0.1%
<b>Schizophrenia and Other Psychotic Disorders</b>		
Schizophreniform Disorder	1	0.1%
<b>Depressive Disorders</b>		
Major Depressive Disorder	24	3.7%
Dysthymic Disorder	30	4.6%
Depressive Disorder NOS	9	1.4%
<b>Bipolar Disorders</b>		
Cyclothymic Disorder	1	0.2%
<b>Anxiety Disorders</b>		
Panic Disorder without Agoraphobia	2	0.3%
Specific Phobia	3	0.5%
Social Anxiety Disorder (Social Phobia)	2	0.3%
Obsessive-Compulsive Disorder	2	0.3%
Posttraumatic Stress Disorder	3	0.5%
Anxiety Disorder NOS	1	0.2%
Generalised Anxiety Disorder	7	1.1%
<b>Somatoform Disorders</b>		
Undifferentiated Somatoform Disorder	1	0.1%
<b>Gender Identity Disorders</b>		
Gender Identity Disorder in Children	1	0.1%
<b>Sleep Disorders</b>		
Nightmare Disorder	2	0.3%
<b>Adjustment Disorders</b>		
Adjustment Disorder with Depressed Mood	21	3.2%
<b>Personality Disorders (Coded on Axis II)</b>		
Specified Personality Disorder	4	0.6%
Personality Disorder Traits	2	0.3%
<b>Relational Problems</b>		
Parent-Child Relational Problem	93	14.4%
Marital Problem	27	4.2%
Partner Relational Problem	7	1.1%
Sibling Relational Problem	2	0.3%

Relational Problem NOS	11	1.7%
<b>Problems Related to Abuse or Neglect</b>		
Physical Abuse of Child	1	0.1%
Sexual Abuse of Child	4	0.6%
Physical Abuse of Adult	3	0.5%
Sexual Abuse of Adult	4	0.6%
<b>Additional Conditions That May be a Focus of Clinical Attention</b>		
Child or Adolescent Antisocial Behaviour	13	2.0%
Bereavement	13	2.0%
Academic Problem	35	5.4%
Religious or Spiritual Problem	1	0.2%
Acculturation Problem	5	0.8%
Phase of Life Problem	4	0.6%
Other Specified Family Circumstances	12	1.9%
<b>Additional Codes</b>		
Unspecified Mental Disorder (nonpsychotic)	1	0.2%
No Diagnosis or Condition on Axis I	38	5.9%
Diagnosis Deferred on Axis I	2	0.3%
No Diagnosis or Condition on Axis II	1	0.2%
<b>Conditions on Axes III and IV</b>		
Specified Medical Condition: Axis III	13	2.0%
Psychosocial/Environmental Problems: Axis IV	2	0.3%

#### **Additional Primary Reasons for Consultation: 1990 – 1999**

<b>Specified Assessments Undertaken in the 1990s</b>		
School Readiness	14	2.0%
Giftedness	8	1.2%
<b>TOTAL: N</b>	<b>647</b>	

It is important to note that although each specific diagnosis was made in complete accordance with the prevailing DSM criteria, Table 3-15 is specific to the clientele who were seen at the CGC during the 1990s, and is not intended as a full representation of either DSM diagnostic system. Where a disorder has been omitted from a particular category, this indicates that the condition was not seen at the CGC.

The full range of secondary diagnoses for the CGC clientele of the 90s is recorded in Table A-23 (See Appendix A).

### **3.14.1 Selection and Composition of the Five Most Frequent Diagnoses**

It was decided, in the interests of conciseness, to limit the discussion to the data for the five most frequently diagnosed disorders for the overall period. In order of prevalence these were Relational Problems (RP), ( $n = 150$ ), Learning Disorders (LD), ( $n = 70$ ), Depressive Disorders (DD), ( $n = 63$ ), ADHD, ( $n = 47$ ) and Mental Retardation (MR), ( $n = 41$ ). The 371 clients who were diagnosed with these five disorders accounted for 57.4% of the total clientele. The annual distribution for the five disorders is summarised in Table A-24 (See Appendix A).

The composition of each of the five diagnoses may be determined from Table 3-15. For example, in this study Relational Problems are limited to Parent-Child Relational Problems, Marital Problems (DSM-III-R), Partner Relational Problems (DSM-IV), Sibling Relational Problems and Relational Problems Not Otherwise Specified (NOS). As previously indicated, Learning Disorders replace the Academic Skills Disorders of the DSM-III-R classification system. It should also be noted that the Mental Retardation categorisation is not strictly according to DSM criteria, as Borderline Intellectual Functioning has been included with Mild and Moderate Mental Retardation for analytical convenience. The single case of Cyclothymic Disorder was included with the Depressive Disorders for the same reason.

### **3.14.2 Gender Distribution for the Five Most Frequent Diagnoses**

The gender distribution for each of the five main DSM diagnoses is summarised in Table 3-14. The ratio of males to females was approximately 3:1 in both the ADHD and Learning Disorders categories (74.5% and 71.4% respectively), whereas the ratios were reversed in the Depressive Disorders (60.3% females and 39.7% males). Although males predominated slightly in both the Relational Problems and the Mental Retardation categories (56.7% and 53.7% respectively), the male to female ratio was more evenly distributed for these categories.

**Table 3-14****Two-Way Frequency Table: Gender by DSM Diagnosis: 1990 – 1999**

<b>GENDER &amp; %</b>	<b>DSM DIAGNOSIS*</b>					<b>Row</b>
	<b>ADHD</b>	<b>LD</b>	<b>RP</b>	<b>MR</b>	<b>DD</b>	<b>Total: <u>N</u></b>
<b>Male</b>	35	50	85	22	25	217
<b>% Total</b>	74.5%	71.4%	56.7%	53.7%	39.7%	
<b>Female</b>	12	20	65	19	38	154
<b>% Total</b>	25.5%	28.6%	43.3%	46.3%	60.3%	
<b>Total: <u>N</u></b>	47	70	150	41	63	371

\* **ADHD** = Attention Deficit Hyperactivity Disorder, **LD** = Learning Disorder, **RP** = Relational Problem, **MR** = Mental Retardation, **DD** = Depressive Disorder,

Log-linear analysis revealed the poor fit of the model (Model = Gender DSM Diagnosis) and the DSM Diagnosis variable and Gender variables were found to be dependent: L-R  $\chi^2$  (4, N = 371) = 19.49,  $p = .0006$ . Analysis of the standardised residuals confirmed that males were over-represented in both the Learning Disorders and ADHD categories, and under-represented in the Depressive Disorders. Females were over-represented in the Depressive Disorders and under-represented in the ADHD and Learning Disorder categories. The full results of the analysis of the standardised residuals are summarised in Table A-25 (Appendix A).

### **3.14.3 Age Distribution for the Five Most Frequent Diagnoses**

The age distribution for each of the five categories is summarised in Table A-26 (See Appendix A). The 47 children with ADHD were all under 15 years of age, and of the 70 clients with Learning Disorders, all but one was under the age of 20. Three of the 41 clients who were categorised under the Mental Retardation variable were over 20 years of age. The full age range (0 – > 40 years of age) was represented in the Relational Problems and the Depressive Disorders categories.

Log-linear analysis using the model (Age Category DSM Diagnosis) proved to be a poor fit and revealed that the Age Category and the DSM Diagnosis variables were dependent: L-R  $\chi^2$  (24, N = 371) = 106.24,  $p < 0.00001$ . Analysis of the standardised

residuals showed that Relational Problems were over-represented in the 0 – 4 year 11 month old category, ADHD was over-represented in the 5 – 9 year 11 month old category and Learning Disorders (LD) were over-represented in the 10 – 14 year 11 month old category. Depressive Disorders were over-represented in all of the age categories from 15 – 40 years and over, with the numbers peaking in the 20 – 30 year old age group and then falling off slightly in the 30 – 39 years and above 40 age categories (See Table A-27; Appendix A).

### 3.14.4 Racial Analysis of the Five Most Frequent Diagnoses

The racial analysis for each of the five diagnoses is summarised in Table 3-15.

**Table 3-15**

**Two-Way Frequency Table: Client Race by DSM Diagnosis: 1990 – 1999**

Client Race	DSM DIAGNOSIS *					Row
	RP	LD	DD	ADHD	MR	Total: <u>n</u>
African	10	6	7	2	3	28
Coloured	73	45	32	21	34	205
White	54	17	22	18	3	114
<b>Total: <u>N</u></b>	137	68	61	41	40	347

\* **RP** = Relational Problem, **LD** = Learning Disorder, **DD** = Depressive Disorder, **ADHD** = Attention Deficit Hyperactivity Disorder, **MR** = Mental Retardation.

Log-linear analysis using the model (Client-Race DSM Diagnosis) was a poor fit:  $L-R\chi^2(8, N = 347) = 24.70, p = .0038$ , and the two variables were found to be dependent. Analysis of the standardised residuals revealed that the Coloured population was over-represented in the Mental Retardation category, whereas Whites were over-represented in the ADHD category and under-represented in both the Mental Retardation and Learning Disorders categories. The full results of the analysis are recorded in Table A-28 (Appendix A).

### 3.14.5 Social Class Analysis of the Five Most Frequent Diagnoses

Log-linear analysis using the model (Class DSM Diagnosis) showed that the Social Class and DSM Diagnosis variables were not dependent:  $L-R\chi^2(20, N = 356) = 30.08, p = .0686$ . The social class breakdown for each of the five diagnoses is summarised in Table A-29 (Appendix A).

### 3.15 Treatment Options Used by the CGC

#### 3.15.1 Referrals

After the initial assessment process a total of 77 clients or 11.9% of the total population were referred elsewhere for treatment during the 10-year period. The annual referral figures ranged from a minimum of 7.5% ( $n = 3$ ) in 1999, to a maximum of 22.4%, ( $n = 14$ ) in 1998, ( $M = 12.2\%$ ;  $SD = 5.08$ ). The annual referral figures are summarised in Table A-30 (See Appendix A).

#### 3.15.2 Other Treatment Options

The treatment options used for the remaining 570 clients included individual assessment, therapy for the mother, therapy for both parents, marital therapy, family therapy, individual therapy and a behavioural treatment program. Of these seven options, assessment, 29.8%, individual therapy, 25.8%, and family therapy, 25.3%, were most frequently employed. The overall breakdown for the seven modalities is summarised in Table 3-16. The annual breakdown for each treatment option is recorded in Table A-31 (See Appendix A).

**Table 3-16**

**Frequency Table – Treatment Options: 1990 – 1999**

Total	TREATMENT OPTIONS							N
	Assess	Parents	Mother	Family	Therapy	Marital	Behaviour	
<u>n</u>	170	71	24	144	147	5	9	570
<u>%</u>	29.8%	12.5%	4.2%	25.3%	25.8%	0.8%	1.6%	

### **3.16 Duration of treatment**

More than two thirds (69.5%) of the total clientele ( $n = 448$ ) received treatment lasting between 1 – 9 sessions. A further 23.6% ( $n = 152$ ) were seen for between 10 – 19 sessions, 4.8% ( $n = 31$ ) for between 20 – 29 sessions and the remaining 2.1% ( $n = 14$ ) received relatively long-term therapy that lasted for 30 – 50 sessions. Of those receiving long-term therapy lasting for 30 sessions or more, two were diagnosed with ADHD, seven were being treated for a Depressive Disorder and five were receiving treatment for the difficulties associated with Relational Problems. The overall breakdown of the number of sessions is recorded in Table A-32 (Appendix A).

### **3.17 Client Dropout**

A total of 103 clients comprising 15.9% of the total population dropped out during the 10-year period. The annual dropout percentages ranged from a minimum of 6.9% ( $n = 4$ ) in 1994 to a maximum of 25.0% ( $n = 10$ ) in 1999 ( $M = 15.9\%$ ;  $SD = 5.28$ ). The annual dropout figures and percentages are recorded in Table A-33 (See Appendix A).

#### **3.17.1 Possible Factors in Client Dropout**

Of the 103 dropouts, 55.4% ( $n = 57$ ) were Coloured, 29.1% ( $n = 30$ ) were White, 8.7% ( $n = 9$ ) were African and 6.8% ( $n = 7$ ) were categorised as Unknown. The main factors that have been linked to clients dropping out of treatment can be broadly categorised as a) client factors, b) client / therapist factors and c) therapist factors (Seruya, 1997).

##### **3.17.1.1 Client Factors**

###### **3.17.1.1.1 Differential Diagnosis**

The differential diagnoses of the 103 clients who dropped out of treatment are summarised in Table A-34 (See Appendix A). Log-linear analysis using the model (Diagnosis Dropout) showed that in this cohort the two variables were independent:  $L-R\chi^2 (25, N = 625) = 33.87, p = .1107$ .

### 3.17.1.1.2 Social Class

Strupp, Schacht, Henry and Binder (1992) report that low SES, Borderline Personality Disorder and a lack of psychological sophistication are among the client factors that have been related to client dropout. Log-linear analysis using the model (Social Class Dropout) showed that the Social Class and Dropout variables were not dependent:  $L-R \chi^2 (5, N = 625) = 1.85, p = .8698$ . The social class breakdown of the clients who dropped out of treatment is shown in Table A-35 (See Appendix A).

### 3.17.1.2 Therapist / Client Factors

#### 3.17.1.2.1 Racial Differences

Following the omission of the Unknown categories from both Race variables, the relationship between the race of clients who dropped out of treatment and the race of the intern who was treating the client was investigated. The subtable for the remaining 96 clients who dropped out of treatment is shown in Table 3-17.

**Table 3-17**

**Subtable within Dropout Variable of Clients Dropping Out of Treatment**

Client Race	INTERN RACE			Row
	African	Coloured	White	Totals: <u>n</u>
<b>African</b>	6	0	3	9
Row %	66.7%	0.0%	33.3%	
<b>Coloured</b>	14	9	34	57
Row %	24.6%	15.8%	59.6%	
<b>White</b>	4	1	25	30
Row %	13.3%	3.3%	83.4%	
<b>Total: <u>N</u></b>	24	10	62	96

Log-linear analysis using the model (Race-Intern Race-Client) indicated that the two variables were dependent:  $L-R \chi^2 (12, N = 600) = 57.99, p < 0.00001$ . The results of the analysis of the standardised residuals in the subtable for clients who dropped out of treatment are summarised in Table A-36 (See Appendix A).

The most significant findings of the analysis of the standardised residuals are that African and Coloured clients who dropped out of treatment were over-represented when the intern was African, whereas when the intern was Coloured, Africans and Whites were under-represented. When the intern was White, African clients who dropped out were under-represented.

### **3.18 Treatment Outcomes**

The Outcome variable was subdivided into six categories: Worse, Unchanged, Improved, Recovery, Maintained, and Ongoing. The overall distribution of the different outcomes during the 10-year period is summarised in Table 3-18.

**Table 3-18**

**Summary Frequency Table – Treatment Outcome: 1990 – 1999**

Totals & %	TREATMENT OUTCOME *						Total: N
	W	U	I	R	M	O	
<u>n</u>	4	278	233	12	6	22	555
Row %	0.6%	43.0%	36.0%	1.9%	0.9%	3.4%	

\* **Treatment Outcome:** W = Worse, U = Unchanged, I = Improved, R = Recovery, M = Maintained, O = Ongoing.

#### **3.18.1 Additional Referrals**

A total of 92 clients were referred elsewhere for treatment. Of these, 77 were referred after the clinical assessment and 15 received some form of treatment prior to referral.

### **3.19 Relationship between Treatment and Outcome**

The overall breakdown of the relationship between the treatment given and the treatment outcome is summarised in Table 3-19. The majority of clients showed some benefit from treatment, with only four being rated as worse during the 10-year period. Of these, three had been in individual therapy and one family in therapy had deteriorated during treatment. Of the 271 clients who were rated as unchanged, 133 (49.1%) had come for assessment only and had not required any further treatment.

As could be anticipated, log-linear analysis using the model (Treatment Outcome) revealed that the Treatment Offered variable and the Treatment Outcome variable were dependent:  $LR\chi^2(30, N=548) = 145.28, p < 0.00001$ .

**Table 3-19**

**Two-Way Frequency Table: Treatment by Outcome: 1990 – 1999**

Treatment Offered	TREATMENT OUTCOME *						Total: <u>N</u>
	W	U	I	R	M	O	
Assess	0	133	31	0	0	1	165
Row %	0.0%	80.6%	18.8%	0.0%	0.0%	0.6%	
Therapy	3	37	79	5	2	18	144
Row %	2.1%	25.7%	54.9%	3.5%	1.4%	12.5%	
Family	1	48	79	4	2	2	136
Row %	0.7%	35.3%	58.1%	2.9%	1.8%	1.5%	
Parents	0	36	27	2	1	0	66
Row %	0.0%	54.6%	40.9%	3.0%	1.5%	0.0%	
Mother	0	13	8	1	0	1	23
Row %	0.0%	56.5%	34.8%	4.4%	0.0%	4.4%	
Behaviour	0	2	7	0	0	0	9
Row %	0.0%	22.2%	77.8%	0.0%	0.0%	0.0%	
Marital	0	2	2	0	1	0	5
Row %	0.0%	40.0%	40.0%	0.0%	20.0%	0.0%	
<b>Total: <u>N</u></b>	<b>4</b>	<b>271</b>	<b>233</b>	<b>12</b>	<b>6</b>	<b>22</b>	<b>548</b>

\* Treatment Outcome: W = Worse, U = Unchanged, I = Improved, R = Recovery, M = Maintained, O = Ongoing.

Analysis of the standardised residuals showed that the Assessment treatment category was significantly over-represented in the Unchanged Outcome category. As these clients did not receive further treatment, this could be expected. Individual therapy was significantly over-represented in the Ongoing Outcome category and under-represented in the Unchanged Outcome category. Marital therapy was over-

represented in the Recovery outcome category. The full results of the analysis are summarised in Table A-37 (See Appendix A).

### **3.20 Chapter Summary**

#### **3.20.1 Individual Statistics**

Clients were classified according to gender, age group, racial classification, social class, presenting problem and referring agent. The annual descriptive statistics were calculated for each of these variables and compared over the 10-year period. In view of the well documented correlation between race and social class which is a legacy of the apartheid era, the relationship between these two variables was analysed in more detail to see if there had been any noticeable shifts in the post-apartheid era. The relationship between gender and the presenting problem and clinical diagnosis was also investigated and found to be significant.

#### **3.20.2 Assessment Process**

The assessment process was described in detail, and the annual and overall descriptive statistics were calculated for each of the Class C diagnostic tests that are most commonly used by the CGC. Shifting trends in the use of tests and the introduction of new tests were observed and noted. A link was made between the test results and the formulation of the differential diagnosis on the five axes of the DSM classification system.

#### **3.20.3 The DSM Diagnosis**

Although clients were diagnosed on all five DSM axes in the case files, in this study they were classified in terms of the Primary and Secondary Diagnoses. The original 70 variables had to be collapsed into 28 categories for the analysis. Of these, the five most commonly diagnosed broad categories of mental disorders were selected and described in relationship to the client variables of gender, age, race and SES.

#### **3.20.4 Treatment Options**

The statistics for seven different treatment options were calculated and described. These included the option of referral. The average duration of treatment as measured by the number of sessions attended was calculated, and the annual client dropout rate

was recorded. Possible reasons for dropout were examined quantitatively in terms of a number of specific client and client/therapist factors.

### **3.20.5      Treatment Outcomes**

Treatment outcomes were rated in terms of seven possible outcomes. Not unexpectedly, treatment and outcome were positively correlated. These and other findings of statistical or clinical interest will be discussed in Chapter 5.

University of Cape Town

## Chapter 4

### Interviews with Past and Present Staff Members of the CGC

#### Chapter Outline

<b>4.1</b>	<b>Introduction</b>	<b>88</b>
<b>4.2</b>	<b>Main Findings from the Interviews</b>	<b>88</b>
<b>4.2.1</b>	<b>Period of Association with the CGC</b>	<b>88</b>
<b>4.2.2</b>	<b>Responses to the 1980s “Crisis” in Psychology</b>	<b>89</b>
<b>4.2.2.1</b>	<b>Political Background to the Crisis</b>	<b>89</b>
<b>4.2.2.2</b>	<b>Response in Psychological Circles to the Crisis</b>	<b>89</b>
<b>4.2.2.3</b>	<b>Individual and Institutional Responses to the Crisis</b>	<b>90</b>
<b>4.2.3</b>	<b>CGC Shift to a More Progressive Psychology</b>	<b>91</b>
<b>4.2.3.1</b>	<b>Extreme Responses to Prevailing Conditions</b>	<b>91</b>
<b>4.2.3.2</b>	<b>Shifts in Clientele</b>	<b>91</b>
<b>4.2.3.3</b>	<b>Revision of the Maudsley</b>	<b>92</b>
<b>4.2.3.4</b>	<b>Introduction of Community-Based Work</b>	<b>93</b>
<b>4.2.4</b>	<b>Shifts in Training and Treatments at the CGC</b>	<b>93</b>
<b>4.2.4.1</b>	<b>Establishing a Theoretical Framework for Community Psychology</b>	<b>93</b>
<b>4.2.4.2</b>	<b>Redefining the Scope of Training in Clinical Psychology</b>	<b>94</b>
<b>4.2.4.2.1</b>	<i>Support Component</i>	<b>95</b>
<b>4.2.4.2.2</b>	<i>Consultation and Training Component</i>	<b>95</b>
<b>4.2.4.3</b>	<b>Further Modifications to the Intern Training Programme</b>	<b>96</b>
<b>4.2.5</b>	<b>Under-representation of African Clientele</b>	<b>97</b>
<b>4.2.5.1</b>	<b>Access</b>	<b>97</b>
<b>4.2.5.2</b>	<b>Cost</b>	<b>98</b>
<b>4.2.5.3</b>	<b>Language Difficulties</b>	<b>99</b>
<b>4.2.5.3.1</b>	<i>Selection of Clinical Trainees</i>	<b>99</b>
<b>4.2.5.4</b>	<b>Resource Shortages</b>	<b>100</b>
<b>4.2.5.4.1</b>	<i>Referral</i>	<b>100</b>

4.2.5.5	Failure to Advertise	101
4.2.5.6	Other Cultural Considerations	101
4.2.6	Further Modifications to the Maudsley?	103
4.2.6.1	Cultural Limitations of the Maudsley	103
4.2.6.2	The Maudsley as a Training Instrument	103
4.2.6.3	The Maudsley as an Initial Screening Device	104
4.2.7	The Future of Clinical Psychology in South Africa	105
4.2.7.1	Interviewee Perceptions of the Future of Clinical Psychology	105
4.2.7.1.1	<i>Standardisation of Clinical Training</i>	105
4.2.7.1.2	<i>Potential Undesirable Effects of Professionalisation</i>	106
4.2.7.1.2.1	<i>Increased Costs for Therapists</i>	106
4.2.7.1.2.2	<i>Consequences of Over-Professionalisation</i>	106
4.2.7.1.2.3	<i>Polarisation within the Profession</i>	107
4.2.7.2	Interviewee Hopes for the Future of Clinical Psychology	107
4.2.7.2.1	<i>Increasing the Range of Services</i>	107
4.2.7.2.2	<i>Possible Community Service Component</i>	108
4.2.7.2.3	<i>Mental Health Services in Remote Areas</i>	109
4.2.7.2.4	<i>South African Solutions for South African Psychology</i>	109
4.2.7.2.5	<i>Addressing the Problems of HIV/AIDS</i>	111
4.2.8	Interviewees' Additional Comments and Insights	111
4.2.8.1	Increasing Complexity of Cases seen at the CGC	111
4.2.8.2	Average Duration of Treatment at the CGC	112
4.2.8.3	Additional Cultural Considerations	112
4.3	Concluding Comments	113

## **Chapter 4**

### **Interviews with Past and Present Staff Members of the CGC**

#### **4.1 Introduction**

In this part of the study eight past and present members of the CGC staff (A - H) were interviewed using a semi-structured questionnaire interview format. All eight have served as members of the CGC staff during the 1990s and three were still based at the CGC when the interviews were conducted. Details pertaining to the selection of interviewees and use of the semi-structured questionnaire are recorded in Chapter 2. A copy of the semi-structured questionnaire is contained in Appendix B.

As previously described, the interviews were conducted between May and August 2000. Each interview lasted from 45 minutes to an hour and seven of the interviews were recorded and later transcribed and thematically analysed using the coding system described by Miles and Huberman (1994, p. 57). The eighth interview was not recorded at the request of the interviewee but written notes were compiled during the interview. These were later thematically analysed.

#### **4.2 Main Findings from the Interviews**

In this part of the discussion the findings will be dealt with systematically in the same order that the questions were asked. Additional findings of interest that were not directly related to the questionnaire but that arose spontaneously during the course of the interview will be discussed in a separate section at the end of the chapter.

##### **4.2.1 Period of Association with the CGC**

All of the interviewees received a part or all of their postgraduate training in psychology at UCT. Of the eight, two completed their postgraduate studies at UCT in the 1970s, three

completed their masters training in clinical psychology during the 1980s and three completed their studies in clinical psychology at the CGC in the 1990s.

All eight have served in various capacities as members of staff at the CGC for periods that range from a maximum of over twenty-five years to a minimum of six years. Some of the interviewees have rotated between the main campus and the clinic during their time as members of staff and one staff member left Cape Town to work at another university before returning to work at the CGC during the mid 1990s. Two of the interviewees are no longer members of staff and are currently self-employed in the private sector.

## **4.2.2 Responses to the 1980s “Crisis” in Psychology**

### **4.2.2.1 Political Background to the Crisis**

The crisis in black education and the sociopolitical upheaval in South Africa during the 1970s – 1990s have been described in Chapter 1 and will not be repeated here.

### **4.2.2.2 Response in Psychological Circles to the Crisis**

The political upheaval of the 1980s precipitated a completely different type of “crisis” in psychological circles. As a result, the more progressive, often white, middle-class South African psychologists were forced to reconsider the relevance of the prevailing westernised neutral, apolitical model of clinical psychology, in the light of the needs of clients who had been physically and psychologically tortured for their political activities.

B stated:

There was a sense of a very powerful social movement sweeping the country, there was a sense that, in some ways, those who previously had been *resources*, in some ways were now needs - and those who had been *needs* were now resources. And it became clear that the people we were working with were certainly not presenting themselves as helpless and dependent victims. They were people who were *strong mentally* and were *strongly associated with political movements* - and it was a matter of whether they were prepared to make use of psychological resources at all - and the only circumstances in which they were prepared to make use of psychological resources, as it were, was through people who were politically acceptable to them. And (*pause*) the *power relations within*

*psychology* became very salient and very visible. People were very wary of being (*pause*) *disempowered* by psychology, potentially, and rendered less than they were. And in the course of this (*pause*) complicated negotiation between psychologists who were trying to be helpful (*pause*) and who felt identified with 'the struggle' rather than with the State (*pause*) and who needed in a sense to be able to do this work, needed acceptance and needed credibility, and in the course of this many of the basic assumptions about our work became changed.

As described in the literature review, the crisis in psychological circles of the 1980s and its effects on traditional psychology have been well documented (See Section 1.1.3).

#### **4.2.2.3 Individual and Institutional Responses to the Crisis**

All of the respondents reported having experienced the effects of the crisis in psychology, whether directly or indirectly. For example, although not yet involved in psychological circles, G's senior secondary school education was severely disrupted by the political chaos of the mid-1980s, sometimes for as long as a month at a time.

The crisis in psychology has had a central broadening effect on A's career development. A stated that his interest in language issues, community work and the wider application of resources had arisen in response to the particular problems and challenges posed by the crisis. F noted that the crisis in psychology had caused him to think more deeply about the relevance of psychology in a country whose political stability was as yet undetermined, and that the crisis had fuelled his interest in community psychology.

However, whereas three of the interviewees stated that their student political activities had naturally paved the way for their later extracurricular engagement with the crisis in psychology, D reports that until 1985 there was nothing in CGC practice that actually addressed the political crisis. As a result of attending meetings hosted by campus-based activist organisations, D started an extracurricular CGC-based forum in 1985 to discuss the ways in which concerned psychologists could respond to the needs of clients and their family members who had been brutalised or traumatised because of their political affiliations.

Although the forum was open to staff, students and interested colleagues, it was kept quite separate from the clinical training programme at the CGC. The forum was later succeeded by the CGC-based Western Cape branch of OASSSA (Organisation for Appropriate Social Services in South Africa) that had been pioneered by psychologists from the Witwatersrand region.

### **4.2.3 CGC Shift to a More Progressive Psychology**

#### **4.2.3.1 Extreme Responses to Prevailing Conditions**

It was generally conceded that the politically turbulent conditions of the 1980s had necessitated extraordinary measures in response to extraordinary challenges and that these responses would not necessarily be helpful under other circumstances. A stated:

I think what also happened was that time led us to an extreme reaction to what we had been doing. I think we were very conservative about certain issues and jumped to the other extreme - and now we're more in the middle. [...] I found myself sort of running around and doing things that I wasn't particularly good at doing and that weren't particularly helpful. But it seemed necessary in order to show that I was (*pause*) politically in the right place. I think it was a necessary development but I don't think it's what I should be doing as a psychologist. So it's been influential, but a lot of what we did then I don't think I would do again.

B noted that there was a "bending of the rules" in response to the crisis of the 1980s that allowed psychologists sometimes to share meals with their political activist clients and to adopt a more flexible stance about sessions that lasted "anything between 10 minutes to 3 hours." For the clients who could only be seen once, it became important then

[...] Not to open things up but strengthen people in a sense by helping them to deal with intense trauma-related anxieties. You needed to do a kind of trauma reduction thing, rather than take away people's defenses and hence leave them vulnerable in a situation of ongoing trauma within the country.

#### **4.2.3.2 Shifts in Clientele**

Hay (1990) has documented how until 1971 only white children from predominantly middle-class backgrounds were seen at the CGC. The racial composition of the clientele

began to shift during the mid-70s when the CGC began an informal move towards desegregation. The clinic became fully desegregated during the politically turbulent 80s. E observed that on returning to work at the clinic in the mid-90s:

It seemed that the people we were seeing were *poorer* than the people that I had seen when I was a student - and seemed to have a *combination of poverty* and some kind of *social problems*; alcoholism, violence and rape cases and so on, and largely that there were very few white people referred here. That was my impression, although I don't know how accurate it was.

The political changes in the nation brought about changes in educational policy. D states:

What really affected us was the geographic changes and closure of school clinics, so that that meant the people we were seeing were different, which meant that a lot of the day-to-day crisis was *being responsive to the people we were seeing*, just as much as the crisis was about thinking consciously about policy.

#### 4.2.3.3 Revision of the Maudsley

D notes that becoming responsive to a different kind of clientele also sensitised clinic staff to the inherent biomedical and cultural assumptions of the original Maudsley history-taking interview format that Dowdall had introduced at the clinic in 1977. Many of the new clients had come from extremely chaotic dysfunctional family backgrounds and had been severely traumatised for their sociopolitical convictions. B states:

And there was concern that if we continued to work from a very westernised and even Maudsley-based and psychiatric diagnostic model we risked not only alienating the people that we worked with, but pathologising the trauma that they were sustaining in a principled movement.

As has been mentioned in Chapter 1, a modified version of the Maudsley was informally reworked at the clinic during 1986. It included questions about the social history of caretaking nexus and the religious and political affiliations of the client and it also made provision for the index patient to be seen within his or her family context during the first interview. The updated version of the Maudsley was introduced formally in 1987 and is still in use today at the CGC.

#### **4.2.3.4 Introduction of Community-Based Work**

Prior to 1986 the CGC adhered largely to a psychodynamically-oriented multi-disciplinary team model that focused chiefly on the therapeutic needs of individuals, families and children and reflected international trends in clinical practice (Smit, 1997). A second major shift in CGC policy and training occurred in 1986 when community work was incorporated into the clinical training programme.

C reports that by the early 90s the training in broader community issues had been completely integrated into the clinical programme and accounted for fully 35% of the syllabus. H's class in 1990 was the first to have a practical community component. At that stage the community programme was coordinated by Ray Lazarus, who had a particular interest in the field of mental handicap, and H notes that Lazarus exercised great care in not taking on projects that "we couldn't fulfil or meet expectations." C reports that in 1990 the community projects were carefully structured interventions that included individual assessments for mentally handicapped patients and usually some type of evaluative support component for the family members of clients.

When F began his clinical training in 1994 each student was involved in a single community project during the year. F notes that "during the 90s there was a development and a refinement of what a model of community psychology can be." One development was that the students of the latter part of the 90s were each involved in two community projects. Additional refinements and developments are discussed in the following section.

#### **4.2.4 Shifts in Training and Treatments at the CGC**

##### **4.2.4.1 Establishing a Theoretical Framework for Community Psychology**

The current community component of the clinical intern training differs considerably from its beginnings in 1986. On returning to the CGC in the mid-90s, E found that "community work was integrated and it hadn't been there at all." Lazarus left the clinic at the end of 1993, leaving behind "a set of community links and a really, really good network that was

in place” but E reports returning “with quite strong feelings about developing some kind of psychodynamic approach to community psychology.” Whereas in E’s early stages of community involvement:

My community work had been a whole sort of process of just *reacting* and *not thinking very theoretically* about anything through [...] we found that we had to get some sort of *theoretical framework* together to guide us in the work - and it felt like *psychodynamic theory* was the most grounded. [...] That’s what I brought back here, and what has been set up. From my perspective I felt it was a very *good* system (in place at the CGC) but not a very strong *theoretically grounded* system of working. All the procedures were in place but what wasn’t in place was, “*Well why do we do it like this and what’s the underlying theory behind it?*” so really I saw that as my contribution to try and ground it in theory.

#### 4.2.4.2 Redefining the Scope of Training in Clinical Psychology

Although CGC trainees do receive a basic training in psychotherapy, F stated that the CGC is not primarily concerned with turning out psychotherapists. Because there is a shortage of resources in the mental health field, there is a perceived need to move away from a one-on-one tertiary model of treatment. The scope of work undertaken by clinical psychologists has broadened considerably over the past decade to include work with groups and organisations - and clinically trained professionals therefore need to acquire skills in the areas of management, supervision and consultancy.

The aim of the CGC is to equip trainees with an effective arsenal of skills that will be transferable across a multiplicity of settings. F states:

We feel it’s important that students come out of the course having some theory and practical experience around what that actually means. And basically what that does is that it helps students integrate and think about theory and the kind of skills they need to develop. So I think some of the refinement that I’ve been talking about is also in being more clear that that’s what we’re doing. That there’s a commonality between the kind of options for intervention. So, in some senses, we’ve had to specify that this name *community* psychology is a bit of a misnomer, because it in some senses clouds the issue. I mean, some people regard community psychology as being quite different from clinical psychology, *whereas our model is that it’s integrated.*

The current CGC model of community psychology comprises two main components, namely support and consultation and training. Much of the in-service training of interns is acquired within these contexts. F observes that:

The kind of thinking and understanding about how people (*pause*) function, what people need, and how they respond to difficulties, that has emerged out of more intensive individual work, is very much applicable to organisational work and vice versa. But there are things that you understand about a person *in context* that illuminate individual work. So that's the kind of integration you get.

#### **4.2.4.2.1 Support Component**

F notes that group skills are learned within the context of providing support for people who might otherwise not have access to such support. The CGC currently facilitates support groups that include a single parents group, a student health group, a disability group, and a number of support groups within organisations. As funding is limited, and the university is primarily a training institution and not a service provider, respondent A emphasises the fact that all such in-service work has to be undertaken within the constraints of the current training requirements of the clinic.

F observes that one of the major refinements of present community psychology theory and practice lies in the area of support. An initial response to the “overwhelming” challenges of community work included attempts to empower community leadership through the “giving away” of psychology to communities. However, F likens this to a “one-shot injection of skills training and support” which did not succeed in the long term because of the extremely difficult nature of the work. The 90s model recognises the fact that just as professional psychologists seek out supervision for the more challenging aspects of their work, so community workers need the containment of ongoing support in the unrelenting nature of the work they are called upon to do.

#### **4.2.4.2.2 Consultation and Training Component**

F states that one of the chief aims in consultation and training work with organisations is to develop and enhance organisational capacity, with the long-term goal of leaving behind

viable, sustainable interventions which will not only survive but hopefully thrive after the CGC has moved on. F notes that this is achieved partly through the provision of empathic insight-oriented support for group members and also through specific task-related input and training for the identified leadership within the organisation.

#### **4.2.4.3 Further Modifications to the Intern Training Programme**

A noted that as a further response to the need for psychologists to diversify and offer a wider range of skills, there have been a number of modifications in the intern training programme at the CGC in recent years.

Firstly, A emphasises the need for available resources to be efficiently distributed and notes the possibility that many individual referrals may reflect broader community concerns. For example, on the day that A was interviewed there had been 40 potential referrals for remedial teaching from a certain school. He explained that whereas the CGC lacks the resources to see 40 children individually, an alternative approach would be to spread the existing resources through working with the school concerned. A also reiterated F's point that consultation work with people and organisations outside of the clinic should be seen as a continuity and not "just a tacked on community component."

Thirdly, A notes the need to think beyond the realms of psychology when dealing with potential clients. In essence, this means referring clients elsewhere more frequently. It also means working more widely with non-professionals, people in communities and community-based organisations and continuing, as in the past, to work with schools; "which is not particularly progressive if you look internationally at the history of clinical psychology, but it was unusual in our context." A added:

The other thing that I hope that we do, and I'm not sure whether we're successful, is that we give some sense that people's emotional problems and the solutions for them don't necessarily lie within the realm of the psychologist at all, and that one needs to think about other resources and other pressures on people - and that there are emotional consequences for political and economic arrangements. I think we do try and give students a broad sense of that. We

teach mental health policy, which years ago would never have been taught, for example.

Although A was open to correction, he expressed the belief that the CGC had begun to think about such issues “quite a long time before a number of other universities.” Whereas other universities include community programmes and projects and consultations in their curriculum, A had the impression that the CGC model was “more integrated into all the training - into everything that we do - than in other places. [...] And certainly in some places they don’t do any community work at all.”

#### **4.2.5 Under-representation of African Clientele**

There was general consensus amongst the interviewees that the under-representation of African clientele at the CGC is part of a complex, multi-faceted problem which cannot be resolved overnight by means of simplistic solutions. Whereas several respondents indicated that it would be relatively easy to increase the numbers of African clients attending the clinic quite rapidly via advertising, or by encouraging referrals through the existing contacts with community resources, this would nevertheless be both irresponsible and unethical. A noted that although the self-image of the CGC might temporarily be enhanced by such a move, it would also have the negative effect of raising client expectations that the CGC did not have the capacity to fulfil.

Respondents cited four broad underlying factors that they believe have contributed to the low numbers of African clientele seen at the CGC in the 90s. They include the issues of access, costs, language difficulties and the clinic’s limited fiscal and personnel resources. Each of the issues will be considered separately in the following sections.

##### **4.2.5.1 Access**

As part of the legacy of separate development, the residential areas allocated to “Blacks” are situated on the outskirts of the city. Smit (1997) argues that despite the desegregation policies of the clinic, the location of the CGC in a formerly white upper middle-class area therefore militates against an increase in African clientele. E observed that the lower

numbers of African clients were primarily due a geographical problem that was also being experienced by other local facilities. She stated that the Red Cross Child and Family Unit had also reported seeing relatively low numbers of African clients.

A raised the important concern that it is very difficult for the clinic to provide services in a context where there are very few other service groups. It was not considered ethical, for example, to undertake an assessment with the prior knowledge that it would not be possible to refer a client for help on the basis of the assessment. A remedial group was started on an experimental basis at the CGC in 2000 but is now full - and there are no other comparable facilities in the area for clients who lack the necessary finances. Both A and C spoke of the ongoing need to provide on-site support for existing community facilities in traditionally African residential areas like Khayelitsha. Empilweni is one such community project where the CGC has been involved with community health workers for a number of years.

#### **4.2.5.2 Cost**

The issue of cost is closely related to the issue of access. Despite the fact that the clinic is relatively accessible via public transport and that there are sliding scales for economically disadvantaged clients, mental health care is an expensive commodity that is far beyond the reach of many who might conceivably benefit greatly from it. D observes that “a lot of families who are struggling in terms of their basic needs are going to find that psychology is low down on their list of priorities.” This factor also links with a key finding of the study that the majority of African clientele to date are those with professional backgrounds and higher SES.

For those clients who can afford the fees, A observes that there are additional hidden costs that may militate against African clients making more use of the clinic. They include having to take regular time off work for therapeutic sessions and the funding of childcare for their other children.

For G, the spectre of cost looms so large that it outweighs almost all other considerations in rendering psychological services inaccessible to Africans. However, he notes that although high costs may be an overt factor in the low numbers of African clientele, there are also underlying cultural issues to be considered. He states:

And there's a whole variety of ways in which people get help - especially black people - through extended families. So there are mechanisms like being sent to your aunt or to your uncle who will talk to you, or going to them - you know, actively seeking their intervention when there are some difficulties. So it's mainly the black people who have got medical aids, for instance, who are now actively using the service. The people who do not have medical aid get referred to psychologists, or they take on that kind of opportunity to be seen by psychologists, *almost as a last resort*, usually.

#### **4.2.5.3 Language Difficulties**

A and E ascribed language difficulties to the need for senior staff with expertise in an indigenous language, and the requisite three years of registration that would permit them to supervise clinical trainees. There is also a need for trainees who can "converse comfortably" with African clients in their mother tongue. However, G observed that although the knowledge of an indigenous language is a prerequisite in the selection of candidates for clinical training, at this stage the language issue

[...] Almost fades away once people have been taken into the course. [...] So if that could be taken seriously, then obviously one would try to get more black clients on whom these trainees would actually practise and (*pause*). I think that that would be quite useful at this stage.

##### **4.2.5.3.1 Selection of Clinical Trainees**

Nevertheless, one way in which the language problems are being addressed is via the selection of more African trainees. This move reflects the overall shift in university policy away from its historically white roots, and is in keeping with the aims of UCT's mission statement, one of which seeks to "address the challenges facing our society." However, as D noted, there is "something very awkward about the idea that you need to train black

clinicians to deal with the entire black community because there's something very racist about that.”

Although he reports that the Professional Board for Psychology has ruled that within the next four years applicants are to be selected on a quota basis, A informed me that at present the CGC does not use a quota system for the selection of clinical trainees. However, two of the criteria that do influence selection are fluency in an indigenous language and the applicant's potential to contribute to previously under-resourced areas. “And that would often tend to favour people who don't look the same as the candidates we were choosing maybe 20 years ago.” Most of the successful applicants from all racial backgrounds have “quite considerable prior experience in other fields.”

#### **4.2.5.4 Resource Shortages**

The issue of a lack of supervision for work in African languages has been discussed but there are other resource deficits that limit what the CGC is able to offer. The clinic attempts to maximise its resources through consultation and training work with outside organisations, but in view of the fact that the university is primarily an institution geared to training and research, university fiscal policy does not support substantial funding for extension services work. A stated:

And what's been a major issue for us in the clinic is that when we had a lot of outside funding we expanded services quite a lot - and now we have to make every service that we provide, *work* in terms of training. And we just have to say when people say there aren't enough services, “Well that's not our job.” And it isn't actually our job. But - it's very hard to ignore. There's obviously a huge level of need.

##### **4.2.5.4.1 Referral**

A stated that part of the solution to the problem of overtaxed psychological resources lies both in networking with schools and other community-based organisations, and in referring more widely, so as to optimise the distribution of the available professional

resources. He observed that mental health policy had been incorporated into the clinical training curriculum with the broad objective of giving students some sense of the fact that:

People's emotional problems and the solutions for them don't necessarily lie within the realm of the psychologist at all, and that one needs to think about other resources and other pressures on people - and that there are emotional consequences for political and economic arrangements.

However, as A noted, "[This] is not particularly progressive if you look internationally at the history of clinical psychology, but it was unusual in our context."

#### **4.2.5.5 Failure to Advertise**

An additional outcome of the resource shortage is that the clinic does not advertise its services at all, which means that there are large sectors of the population, including potential African clientele, who are simply unaware of the clinic's existence. As A observed:

[...] And if you're going to do any form of advertising then you've got to be prepared to take the consequences - and I think we *are* afraid of being overwhelmed. But it does mean that the people who use the clinic will be - the client pool will tend to repeat itself because people hear by word of mouth, or a particular school gets to know us. And it expands sort of gradually - as it has sort of changed over the years. But if you don't actively go out and seek a particular form of clientele it's very hard for people to find out about it.

#### **4.2.5.6 Other Cultural Considerations**

Whilst the more obvious issues of access, costs, language, resources and advertising are extremely pertinent to the discussion, most of the respondents noted that there are additional factors that militate against the use of psychological services by Africans. D observed that, with the exception of school-related referrals,

Some of it is about perceptions - meaning that the kind of work that we do is so embedded in a white, western, middle-class set of assumptions about family life (*pause*) that I don't think that we're necessarily perceived as offering what's important.

As previously discussed, the issue of other help-seeking practices in African culture was raised when considering the effects of cost in limiting African client numbers. When asked whether he thought that the removal of some of the more obvious obstacles would make psychology a more sought after commodity in African culture, G responded:

(Pause.) Probably. Even if that doesn't happen then we would be able to see properly what is the problem, because at the moment the difficulty around financial accessibility of the service (pause) you know (pause) it's so *huge* that it obliterates all ... most other things, that if it were to be removed one would be able to look at other things which militate against people using the service. I don't think there is a guarantee, it's just that we are all aware of lots of difficulties that people have (pause) in the townships in particular. And people are developing strategies to deal with those things while psychology is not accessible, so psychology would be challenged and have some competition when it got to a stage when the field is levelled and it competes with other ways of intervening.

G also stated that, in view of the fact that clinical training is conducted according to a westernised, predominantly *English* model, it would be simplistic to believe that the problem would be addressed simply by having more black psychologists. He expressed the strong belief that in the training "we need to have more black clients so that we can be aware of their issues, and to look at them more carefully, and to *adjust*," and noted that after being trained according to a westernised model where he was "dealing mainly with either coloured people, or white people," he had had to make an active adjustment in order to deal with African clients. He states:

I mean *I* had to adjust (pause) and I actively took on that responsibility for myself to actually get used to seeing black people. (Pause.) Because I'm being trained in English, the concepts and all these kinds of things, they are in English - and to actually translate *those* into an African language is quite (pause) it takes some getting used to. [...] We need to have more black psychologists, but in the training we need to have more black clients so that we can be aware of their issues, and to look at them more carefully, and to adjust. And we need to have courses. I don't know what courses those would be, but courses that would specifically be geared at raising people's (pause) or training people to work in South African contexts.

However, G stated that he felt it would be naive to imagine that the problem could be overcome by simply increasing the number of black psychologists. He stated:

There are South African ways and there are *black* South African ways - so we need to engage people at both those levels. (*Pause.*) So just increasing the number of psychologists that are black won't be enough.

#### **4.2.6 Further Modifications to the Maudsley?**

The Maudsley history-taking interview format was initially introduced at the CGC in 1977 by Dowdall and played an important role in the early struggles for accreditation of clinical psychology by the psychiatric profession. The CGC's updated version of 1987 was essentially not very different from the original Maudsley, apart from the fact that it contained additional questions about the index patient's religious and political affiliations and "social history of caretaking nexus".

##### **4.2.6.1 Cultural Limitations of the Maudsley**

However the Maudsley has been criticised in some quarters as not adequately reflecting the multicultural norms and values of the Western Cape population (e.g., Smit, 1997; S. Swartz, 1996b, 2000). D observed that the Maudsley is based on "a set of hypotheses which feed our universalist, middle-class, northern hemisphere assumptions about mental health" - assumptions that include westernised ideas about "healthy development, family life, bonding, attachment theory, toilet training, breastfeeding, transitional objects and play."

##### **4.2.6.2 The Maudsley as a Training Instrument**

Despite these salient concerns about the cultural insensitivities of the Maudsley, there was general consensus among the interviewees about its value as a training instrument for clinical psychologists. H spoke of "the need of students for a tightly structured interview format that will contain their anxieties." B reflected that:

The function of question lists in training is really to orient people towards areas that often play a very important role. Maudsley's a shortcut to quickly getting a thumbnail sketch which may be, to a greater or lesser extent, helpful in making sense of people's circumstances.

Both D and A acknowledged that for as long as South African psychology is part of the global fraternity, it will continue to be bound by its biomedical diagnostic systems and its psychiatric systems of knowledge. As D observed, "So long as we're tied into that system of diagnosis we have to have something like the Maudsley."

E had previously described the Maudsley as being outdated. However, she admitted that apart from finding the language of the Maudsley "quite alienating", she hadn't "seriously thought of throwing it out of the window and starting again" because she was "too entrenched in that model." E also noted that if there were too radical a departure from the Maudsley there would be a loss of reciprocity with other mental health professionals.

#### **4.2.6.3 The Maudsley as an Initial Screening Device**

The interviewees voiced considerable flexibility concerning their use of the Maudsley as an initial screening device. D preferred to think of the initial interviews as "a way of garnering narrative - and to see what direction that took one in." A noted that "the real question is much more *what you make of it* - and if it's done in a very narrow way, no matter how much you change the format it's going to be too narrow." B added:

Now it's not to say that the format of the Maudsley is the only format you can use. People can tell their story in the way that they feel comfortable telling their story, and you can intercept with that in ways that meet that kind of discourse. It can be done in a hundred ways, and I don't think one has to rigidly stick to it, but the same principles are likely to apply. In other words, I don't think you have to take a Maudsley history to connect up to the *principles* on which the development of the Maudsley was based, or the *assumptions* on which it is based. You can move around it in a hundred ways and I've certainly seen various psychiatrists or psychologists [...] tackling these things in very different ways.

F described the Maudsley as “A way of organising a story - and then you work with that.” He added, “You’d also have to work very hard to understand that maybe there are questions that I’m not asking that need to be asked,” as the Maudsley interview format highlights certain issues but fails to address others.

#### **4.2.7 The Future of Clinical Psychology in South Africa**

One of the first interviewees (D) responded to this question with, “How *do* I see it, or how would I *like* to see it?” and proceeded to answer both questions. Following this lively encounter, I adjusted my interview schedule to include the second question and received some thought-provoking responses.

##### **4.2.7.1 Interviewee Perceptions of the Future of Clinical Psychology**

Interviewee perceptions of the future of clinical psychology in South Africa can be broadly categorised in terms of their concerns about the standardisation of training and the less desirable effects of the move towards professionalisation. They also concurred that even desirable shifts in policy do not occur overnight but take time to implement.

###### **4.2.7.1.1 Standardisation of Clinical Training**

It is envisaged that future graduates in clinical psychology will sit the standardised national examination of the Professional College of Psychology. Although A agreed in principle with the concept of standard setting, he expressed concern that this would have a narrowing effect on the South African clinical psychology training, as trainers would need to allocate potential training time to ensuring that their candidates were well prepared for the college exam. A was also concerned that the inclusion of certain modules like hypnotherapy in the national syllabus would mean that “some of the more innovative things will not be seen as central to the work of psychologists, and the pressure will then come down as well” to exclude them from the syllabus. He stated:

But I think all of those are going to lead to a marginalised South African product, and it very much depends on who’s calling the tune. And I don’t think that

organisations like ours and universities which have our particular approach, are in the majority.

#### **4.2.7.1.2 Potential Undesirable Effects of Professionalisation**

##### **4.2.7.1.2.1 Increased Costs for Therapists**

A, F and G all referred to some of the less desirable potential effects of professionalisation on the practice of psychology. While the die has been cast and the changes are already well under way, A spoke quite forcibly about the issue of continuing professional development (CPD):

I think a lot of effort is going into the consolidation of professional power in quite a destructive way, and not enough energy is going into the question of resources being distributed more equitably. So, for example, in terms of the new practice framework, people are supposed to now get points. Every year they have to now go and attend seminars on, for example, ethics, and pay other psychologists to tell them about ethics, *when I think the ethical issues are absolutely clear in South Africa, because I mean we have a profession which is reaching so few people.* I'd much rather see people get points from actually addressing the issue.

A noted that in order to offset the high costs of the requisite CPD, certain private practitioners would be forced to cut back on the amount of *pro bono* work they are now able to offer as a service to people who cannot pay for psychological treatment. He stated, "It just seems to me that it's going completely in the wrong direction. So I feel very negative about that."

##### **4.2.7.1.2.2 Consequences of Over-professionalisation**

There was consensus that the move towards professionalisation would benefit the profession by raising the level of accountability within it. However, F believes that the move is being partly driven by financial factors, and that with the swing of the pendulum in the opposite direction, there is the risk of *over*-professionalisation and a consequent narrowing of the options available to practitioners. For example, the recent widespread cutbacks in medical aid benefits may well force private practitioners into having to adapt to the limitations and challenges of managed health care. F notes that there is the inherent

danger that medical aid schemes will begin to predetermine the number of treatment sessions clients need and, as F observed, “There’s a whole lot of things that might be excluded and ignored and neglected - and people need more.”

#### **4.2.7.1.2.3 Polarisation within the Profession**

F also envisaged the probability that the drive towards professionalisation will have an increasingly polarising effect on the profession, with the greatest differences being evidenced between “very professionalised people and people who are working in public health settings.”

There was tacit acknowledgement among respondents of the link between the services of “very professionalised people” and access to finance. A stated that he fully endorses the necessity and value of many of the long-term intensive therapies. However, he noted that one undesirable partial outcome of the dearth of resources is that, “People are selling what they have to offer to people who can afford it, for as long as people can afford it.”

#### **4.2.7.2 Interviewee Hopes for the Future of Clinical Psychology**

##### **4.2.7.2.1 Increasing the Range of Services**

There was consensus among the interviewees that in view of the enormous nation-wide need for mental health services, psychology trainees need to be able to work effectively across diverse settings. A noted that the scope of clinical psychology as practised by UCT graduates has broadened considerably in the past decade. He stated:

I think that graduates from UCT are doing a much wider range of work when they qualify. A lot of them are doing things like working with organisations and training - things that they wouldn’t have done, you know, if you think about *my* generation. And I think we need more of that - but there are difficulties with resources in terms of state money and NGO money. But, if we keep chipping away, things will be done. I don’t think it’s such a terrible thing that one or two of our black students have gone into the corporate world. It also increases the image of what psychologists can do.

Respondents agreed that the current CGC model of community training serves the dual purpose of providing affordable psychological services to the wider community, while equipping trainees with a broad repertoire of skills that enables them to adapt to the challenges of work in different settings. However, they also reported that there are huge deficits in access to mental health care across the nation.

G expressed the desire for clinical psychologists to be “more accessible to black people, in particular.” He noted that in view of the westernised model of training,

Clinical psychologists run a risk of not getting adequate exposure to other cultures and therefore to a true South African kind of spectrum by remaining in predominantly white institutions. I think it would be useful to be placed in institutions where other cultures other than white culture are operative.

#### **4.2.7.2.2 Possible Community Service Component**

In view of the existing deficits and resource shortages, a number of interviewees mentioned the possibility of including a community service component as part of the clinical training. Notwithstanding his previous reservations about potential black resistance to psychology, G felt strongly about the direction such a component should take:

I would like to see clinical psychologists being prepared to go out there and work with black communities, because we all are aware of all these difficulties and problems that the previous order brought to South Africa. You know it's a LOT - it's a legacy that everyone needs to be involved in.

Interviewee A also raised the possibility of instituting some form of regular public service work for registered psychologists. He stated:

I think some amount of public service work should be requested or required of people, either in a lump, or if they want to maintain their registration, a couple of hours a week. If every psychologist in Cape Town was doing two hours of public interest work a week it wouldn't affect any of their incomes substantially and it might have quite a big impact on public health.

#### 4.2.7.2.3 Mental Health Services in Remote Areas

The lack of fiscal resources has been felt across the board by the health sector. Whereas many mental health posts in the public health sector have been frozen due to a lack of state assets, there are also posts in the more remote areas that remain unfilled. This has resulted in vast sectors of the population having no access to mental health care. A believes:

Ideally there should be *very* big incentive schemes to get psychologists into those areas of the country and into those sorts of work with Internet linking, good supervision, and so on. There are possibilities in that direction because there are *far* too many psychologists in Cape Town - and then *one* in Mpumalanga. And there are posts that they can't fill, and so you'd need to think very carefully about how can you attract people. You've got to pay them more, you've got to give them support, and so on. I think that things can be done (*pause*) in order to attract people to that sort of work.

#### 4.2.7.2.4 South African Solutions for South African Psychology

Whereas D believes that the growing trend towards globalisation will ultimately prevail in South African psychological circles, she raised the interesting prospect of forging stronger professional links with the rest of Africa. She stated:

Let me say it very specifically. (*Pause*.) I wish that South Africa, in particular, had better links with the rest of Africa and that we were *much* more active in meeting with and talking to academics and professionals from other African countries because (*pause*) I think that's the way forward. But we don't have those links, mostly. [...] Of course there are exceptions, but until we start (*pause*). I suppose when we travel, for example, instead of going to conferences in America, we should be going to conferences in Uganda and that sort of thing.

The recent publicity surrounding the South African State President's purported views on the relationship between HIV and AIDS has sparked off much controversy around the notion of "African solutions." Notwithstanding the adverse publicity around that specific issue, D has given the matter much thought and is in full agreement with the principle of seeking African solutions to African problems. She stated, "There's a lot of very interesting work that's going on (in the rest of Africa). Let's take Uganda as an example

around HIV and AIDS interventions - and psychologists can learn an enormous amount around that.”

D added:

Unfortunately South Africa in some senses, certainly around the white western psychology, is still regarded as racist. And we are regarded with quite a lot of suspicion by black academics and intellectuals from the rest of Africa. And until we change *that* we're going to continue to be deafened by northern hemisphere voices. And I suppose it's about having a forum, and not pre-judging what it is we're going to learn from that, whether it's about acknowledging that there *are* certain universal principles, or whether there are certain things that African contexts require uniquely, or what it is - whether we've got a lot in common with South America, or wherever, we're not going to know that unless we make those links. So it's about who you're mixing with. That's *really* what I feel.

D stated that South African psychology is locked into a system that is driven by “a whole set of quite urgent imperatives around what the market wants, what the training demands, what people themselves are asking for.” Although D does not believe that any major shifts in the system will occur during her own academic career, she stated that she believes that change will only be achieved by actively forging links with:

[...] Places that we feel we've got *economic*, first of all, and then, secondly, *racial, multicultural* affinities with. And I think that's about being very active and forging links with (*pause*) South America and India and the rest of Africa - and really resisting the allure of Britain and America.

Although such major changes may only be achieved by future generations, G observed:

And I feel that, for psychology to be adequately relevant for South Africa, we need to go out there and be part of that and *write* about those things and start talking about them in our meetings, and so on. *Not* continuously talk about transference and . . . [*laughter*]. That's too (*pause*) you know, that's a comfort zone. Those things have been talked about - quite a lot - and they're still problems. So let's go out there!

#### **4.2.7.2.5 Addressing the Problems of HIV/AIDS**

Interviewee A also raised the issue of the challenges brought about by the AIDS pandemic. He stated:

I think a *huge, huge* area which we should look at in our programme, but which we don't deal with basically, is HIV/AIDS, which is going to affect *everybody* in South Africa.

#### **4.2.8 Interviewees' Additional Comments and Insights**

Most interviewees felt that they had expressed their views fully and used the opportunity to add their further comments and insights to elaborate on what they had already said. However, there were three further points of interest that emerged in the concluding section of the interview. They will be considered separately in the following section.

##### **4.2.8.1 Increasing Complexity of Cases Seen at the CGC**

A expressed surprise that I had not enquired whether he thought that there had been any noticeable changes in the client profile of the 90s, as he sensed that there had been a dramatic increase in the severity and complexity of the problems being referred to the clinic. He observed that the types of problems he had dealt with as a student seemed "very mild in comparison to what the present students have to deal with," but didn't know whether his impression was accurate or not.

A also noted that the initial reaction had been one of shock, accompanied by the feeling that "these are not the sorts of people who should be being seen by psychologists - other people should be seeing them and should be dealing with them." However, he noted that after a period of taking one referral after another, "you just sort of get used to all these terrible, terrible stories."

It will be remembered that E made a similar observation about the apparently changed client profile on returning to the CGC in the mid-90s. The accuracy of these observations has been confirmed by the statistical analysis and will be amplified in Chapter 5.

#### 4.2.8.2 Average Duration of Treatment at the CGC

In the light of his previous references to the potential limitations of managed health care, F noted that the bulk of the work undertaken at the clinic is relatively short-term but that he believed it to be “actually very good.” F made the interesting observation that “people will need to grapple more and more with the idea of, ‘What is an outcome? What is good enough to do, what sort of service to provide?’” He noted that unless psychologists who are engaged in organisational work are able to set very small goals for themselves, they often remain unaware of their own achievements, “whereas if you set these very grandiose goals it’s not going to work.”

F enquired whether the research had considered these factors and whether any correlation had emerged between the average length of treatment and the treatment outcome. These aspects will also be elaborated in Chapter 5.

#### 4.2.8.3 Additional Cultural Considerations

G highlighted the considerable differences that exist “within what the Nationalists came then to refer to as ‘the Black people’” and noted that “they (‘the Black people’) actually scorn at the reference of the whole group as Black.” Although G was not sure whether it would be possible for psychology to become truly non-racial, he believes that psychologists need to engage more openly with the issue. He stated:

So, I’m saying that we need to go back and actually to tease these groups apart and understand them in their different entities before we can actually clamp them all together again. [...] I know that we don’t talk about this much and it’s controversial. I don’t even know how valid it is. But a black patient would probably feel more understood - better understood in the long run (*pause*) by a black clinician. That’s why I was saying to you that I don’t know if it’s possible for psychology to become completely ‘racist-less.’ [...] And I’m saying, *in the long run*, because initially patients actively seek a person of a different race because it’s too close to home to actually talk to the person of the same race.

G went on to explain the cultural implications underpinning his statements concerning “the long run.” As the explanation came as somewhat of a revelation for someone with a “white, westernised, *English*” background in psychology and may well account for some of the findings of the statistical analysis, it will be developed further in Chapter 5.

### **4.3 Concluding Comments**

This was an informative, enjoyable part of the research in which respondents shared their views and experiences generously and freely. A number of respondents indicated that they had found the interview interesting and that they would be willing to give additional interviews if the research required it.

As the semi-structured interviewee format allowed for considerable flexibility with respect to the respondents’ particular fields of interest and expertise, the precise order and format of the questions was not always strictly adhered to. In some instances interviewees offered illuminating information about subjects that had not been included in the questionnaire. However, as each interview lasted for approximately an hour, some difficulty was experienced in selecting which information was essential to the present discussion, and what would have to be omitted in the interests of conciseness. In the final analysis, interviewee responses were coded and grouped systematically according to the original interview format, while attempting to make room for as much additional material as possible.

## Chapter 5

### Discussion of Principal Findings

#### Chapter Outline

<b>5.1</b>	<b>Introduction</b>	<b>116</b>
<b>5.2</b>	<b>Age Distribution of Clientele</b>	<b>116</b>
5.2.1	Age and Referring Agent	116
5.2.2	Age and the Five Main DSM Diagnoses	117
5.2.2.1	ADHD and Age	117
5.2.2.2	Mental Retardation and Age	117
5.2.2.3	Learning Disorders and Age	118
5.2.2.4	Depressive Disorders, Relational Problems and Age	118
<b>5.3</b>	<b>Gender Distribution of Clientele</b>	<b>119</b>
5.3.1	Relative Distribution of Males and Females	119
5.3.2	Gender and Presenting Problem	120
5.3.3	Gender and the Five Main DSM Diagnoses	121
5.3.3.1	ADHD and Gender	122
5.3.3.2	Learning Disorder and Gender	122
5.3.3.3	Mental Retardation and Gender	123
5.3.3.4	Relational Problems and Gender	123
5.3.3.5	Depressive Disorders and Gender	123
<b>5.4</b>	<b>Racial Distribution of Clientele</b>	<b>124</b>
5.4.1	Racial Distribution in Cape Metropolitan Area	124
5.4.2	Shifts in Racial Distribution at the CGC during the 1990s	124
5.4.3	Under-representation of African Clientele	125
5.4.3.1	Factors Associated with the Under-representation of Africans	125
5.4.3.1.1	<i>Language Difficulties</i>	126
5.4.3.1.2	<i>Cultural Preferences and Practices</i>	126
<b>5.5</b>	<b>The Link between SES and Psychiatric Illness</b>	<b>127</b>
<b>5.6</b>	<b>Additional Cultural Considerations</b>	<b>128</b>

5.6.1	Potential Areas of Cultural Bias	128
5.6.2	Cultural Aspects of the Maudsley Interview Format	128
5.7	Multiple Diagnoses	129
5.8	Treatment Offered	129
5.9	Duration of Treatment	130
5.10	Treatment Dropout	130
5.10.1	Factors Related to Dropout	131
5.10.1.1	Racial Status	131
5.10.1.2	Client Defenses	132
5.10.1.3	Therapist Defenses	133
5.11	Chapter Summary	133

University of Cape Town

## **Chapter 5**

### **Discussion of Principal Findings**

#### **5.1 Introduction**

In this chapter the principal findings from the statistical analysis that were recorded in Chapter 3 will first be discussed and, where applicable, these results will be compared and contrasted with international trends. In the second part of the discussion the statistical findings will be linked to the qualitative findings from the interviews that were discussed in Chapter 4. The material contained in this chapter will therefore be a blend of verifiable “facts” and the personal insights and perceptions of the eight interviewees.

#### **5.2 Age Distribution of Clientele**

##### **5.2.1 Age and Referring Agent**

Of the 644 clients whose ages were known, 86.9% were between the ages of 0 - 19 years 11 months and the remaining 13.1% were aged 20 years and over. Almost half (47.3%) of the total clientele were aged between 5 - 9 years 11 months. In the light of these findings it is not particularly surprising that in 62.9% of all cases mothers were documented as the primary referring agents. Verhulst and Koot (1992) report that referral to a child guidance clinic occurs more frequently in response to parental concerns than as a direct result of problematic behaviour. They also allege that the mothers of children who are referred are more prone to anxiety and depression, more easily upset by stress, and in general tend to cope less well with their children than mothers from the general population.

Smit (1997) reported that in contrast to only 2.5% in 1982, 12% of the index patients were over the age of 16 in 1992. The shift was attributed to the diversification of CGC practice to include adults and family members that occurred at the height of the political upheavals in the late 80s. The vast majority of the older clients were self-referrals. The trend was sustained throughout the 90s but the focus has remained predominantly on children of school-going age and youth.

## **5.2.2 Age and the Main DSM Diagnoses**

The DSM diagnostic criteria for Mental Retardation, Learning Disorders and ADHD are age-related. These statistics are therefore pertinent to the finding that the five most frequent diagnoses over the 10-year period were Relational Problems ( $\underline{n} = 150$ ), Learning Disorders ( $\underline{n} = 70$ ), Depressive Disorders ( $\underline{n} = 63$ ), ADHD ( $\underline{n} = 47$ ) and Mental Retardation ( $\underline{n} = 41$ ). The age distribution of all clients diagnosed with the five disorders is recorded in Table A-26 (See Appendix A).

### **5.2.2.1 ADHD and Age**

The DSM-IV estimates the prevalence of ADHD at 3% - 5% in children of school-going age. The DSM-IV cautions that the diagnosis of ADHD is particularly difficult to establish in children below the age of 4 - 5 years due to the fact that inattentiveness is so difficult to pinpoint in toddlers. Moreover, many of the normally active behaviours of very young children are difficult to differentiate from the symptoms of ADHD.

In the CGC cohort there was only one child below the age of 5 with ADHD. Of the remaining 46 children, 37 were in the 5 - 9 year 11 month-old group and nine were in the 10 - 14 years 11 month-old group. The 47 children with ADHD accounted for 8.4% of the total clientele below the age of 20 years ( $\underline{N} = 559$ ) in the 1990s.

### **5.2.2.2 Mental Retardation and Age**

The DSM-IV notes that the age and mode of onset of Mental Retardation are dependent on the etiology and severity of the condition, with the more severe types of retardation or those linked to a particular phenotype (e.g., Downs Syndrome) generally being diagnosable at an earlier stage of development. The onset of the disorder must however occur before the age of 18 years for the diagnosis of Mental Retardation to be made.

It was noted in Chapter 3 that there was some loss of specificity in the data because certain of the original DSM categories were collapsed for analytical purposes. The newly defined Mental Retardation category in this analysis included all the subtypes of Mental Retardation (i.e., an IQ of approximately 70 or below) and all clients diagnosed with Borderline Intellectual Functioning (IQ between 71 - 84). The loss of

specificity is also reflected in the age distribution of the clients (See Table A-26, Appendix A), although 92.7% of the 41 clients in this category were below 20 years of age.

### **5.2.2.3 Learning Disorders and Age**

Sattler (1992, p. 641) states that "Specific Learning Disability is a term used to refer to children who have difficulty mastering one or more basic scholastic skills, but who have adequate intelligence, maturational level and cultural background. The DSM-IV estimates the prevalence of Learning Disorders to range between 2% - 10% but notes that because many studies fail to differentiate between the various Learning Disorders (Reading, Mathematics, or Written Expression), it is difficult to determine the exact prevalence. According to DSM-IV estimates, approximately 5% of school-age children in the US are diagnosed with Learning Disorders.

Whereas specific diagnoses were recorded in the CGC case files for every child with one or more specific Learning Disorders, the distinction between the various Learning Disorders was not retained when the data were computerised for analysis. The Learning Disorder category was also expanded in this study to include the DSM-IV diagnosis of Academic Problem. Of the total clientele below 30 years of age (N=607), 11.5% were categorised as having a Learning Disorder. However, not unexpectedly, 90.0% of all clients diagnosed with Learning Disorders were aged between 5 - 14 years 11 months (See Table A-26, Appendix A).

### **5.2.2.4 Depressive Disorders, Relational Problems and Age**

The relative age distributions for Depressive Disorders and Relational Problems are summarised in Table A-26. The DSM-IV reports a point prevalence of Major Depressive Disorder in community samples that ranges between 5% - 9% in women and 2% - 3% in men. The prevalence rates for the Depressive Disorders are however apparently independent of ethnic, socioeconomic or marital status.

Whereas the core symptoms of a Major Depressive Episode are similar in childhood and adolescence, the DSM-IV notes that there may be age-associated differences in the prominence of the characteristic symptoms. Whilst children commonly present with irritability, social withdrawal and somatic symptoms; adults and adolescents

### 5.3.2 Gender and Presenting Problem

Following a review of 38 international studies of psychiatric illness in children ( $N = 123,000$ ) that was not based on DSM-III diagnostic criteria, Verhulst and Koot (1992) report that whereas the effect of age on the prevalence of child problem behaviours was found to be ambiguous, gender effects on the prevalence of problem behaviours were far more consistent. They state (p. 130):

Girls tend to show more internalizing or emotional problems, whereas boys show more externalizing or disruptive behavior problems. Cross-cultural research employing the same methodology demonstrated that sex differences with regard to the type of problem behaviour were not artifacts of local cultural or semantic factors.

In this study the Presenting Problem variable was categorised very broadly in terms of School, Conduct, Somatic, Emotions and Habits. When the five categories were analysed by gender ( $N = 644$ ), males were shown to predominate with a male-to-female ratio of 2:1 in both the School and Conduct categories (67.2% and 65.3%, respectively). The ratios were reversed in the Emotions category, where females accounted for 67.4% of the referrals. The relationship between gender and presenting problem was found to be statistically significant:  $L-R\chi^2(4, N = 644) = 55.61, p < 0.00001$ . These findings are also clinically significant and concur with international trends (Smith & Rutter, 1995).

Smith and Rutter (1995, p. 770) state that there are “striking contrasts between the sexes in the development of psychosocial disorders.” For example, whereas eating disorders are comparatively rare in males (Steinhausen, 1994), crime, substance abuse and completed suicide are far more common in males than females, with crime accounting for the greatest differences between the genders. Although the vast majority of antisocial children do not engage in crime as adults, Smith and Rutter (1995) note that criminal behaviour in youth and adulthood is almost invariably preceded by one of the conduct disorders in childhood. Smith and Rutter report that the higher incidence of conduct disorders and crime in males is observable even in childhood, and suggest that this may be attributable to the fact that the predominantly male traits of aggression and impulsivity are also the common factors in criminal activity and completed suicide.

Conversely, with respect to the depressive disorders, the female-to-male ratio is 2:1. Smith and Rutter state (p. 770):

A large number of studies agree in showing that the rate of depressive disorders increases sharply during adolescence. The rates for girls and boys are about the same up to the age of 11, but thereafter the rate rises much more quickly among girls. As a result, adult rates of depressive disorders are about twice as high among females as among males. This broad pattern is found both among clinical samples and among samples of the general population. However, unlike the crime rate and the use of psychoactive drugs, the rate of depressive disorders does not decline after adolescence, but remains high in adult life.

Smith and Rutter (1995) state that data on suicidal behaviour derived from various cross-national population surveys and suicide treatment centres reveal that females are more likely than their male counterparts to engage in suicidal behaviours. This is in contrast to the higher rate of completed suicides reported in males. Smith and Rutter attribute the gender difference to the finding that the expressed or acknowledged emotion that is more characteristic of females than males is also the common denominator in depression and suicidal behaviour.

Notwithstanding the very small sample size ( $n = 5$ ), the predominance of males in the Habits category is also clinically significant. According to the DSM-IV, at the ages of 5, 10 and 18 years old, the prevalence of males with enuresis is 7%, 3% and 1%, respectively. The relative prevalence for females of the same age is 3%, 2% and < 1%, respectively. The DSM-IV also reports a higher incidence of males than females in the 1% of 5-year-olds who present with encopresis.

### **5.3.3 Gender and the Five Main DSM Diagnoses**

Some of the more striking gender differences in the development of psychosocial disorders (Smith & Rutter, 1995) were discussed in relation to the Presenting Problem variable, with particular reference to the higher incidence, even in childhood, of conduct disorders and crime among males. Males were also seen to account for 67.2% of the referrals related to school problems. In the light of these findings it could be anticipated that there would be a gender bias towards males in the prevalence of Learning Disorders, ADHD and Mental Retardation.

### **5.3.3.1 ADHD and Gender**

The gender differences were confirmed by the data (See Table 3-16). The DSM-IV reports that ADHD occurs far more frequently in males than in females, with male-to-female ratios ranging between 4:1 and 9:1, depending on the setting (general population or clinic). In the CGC cohort, 35 (74.5%) of the 47 cases of ADHD were male. The male-to-female ratio in this cohort is therefore 3:1.

In a pilot study of ADHD in over 2,000 North Sotho speaking primary school children in the Northern Province of South Africa, Meyer (1998) reports that “the usual differences of age and sex” (according to DSM-IV criteria) were found. Meyer concludes that these findings suggest that cultural variables do not affect the prevalence of ADHD. However, in a 5-year comparative study of psychopathology in 798 urban and rural/peri-urban children from Kwazulu Natal in South Africa, Pillay, Naidoo and Lockhat (1999) report a significantly higher prevalence of ADHD and other disruptive behaviour disorders in the urban cohort. (By contrast, more mental retardation was diagnosed in the rural cohort.) These findings are interpreted both in terms of the children’s life experiences and the availability of psychological facilities in the two settings.

### **5.3.3.2 Learning Disorder and Gender**

The male-to-female ratio for the 70 cases of Learning Disorder was also 3:1 (71.4% and 28.6%, respectively). Notwithstanding the alleged difficulties with establishing a prevalence rate for the different Learning Disorders, the DSM-IV reports that 60% - 80% of diagnosed Learning Disorder cases are male. However, the DSM-IV notes that referral sources may be biased towards the identification of males, as they more frequently engage in disruptive behaviours in association with Learning Disorders.

Maughan and Yule (1994, p. 654) have also drawn attention to the associations that exist between learning disabilities and emotional and behavioural problems. The associations are particularly evident in children with reading problems and Maughan and Yule note that “specific, IQ-discrepant reading difficulties have been particularly linked with disruptive behaviours.”

### **5.3.3.3 Mental Retardation and Gender**

The 41 cases in this cohort that were broadly categorised as Mental Retardation comprised 6.3% of the total clientele of the 90s. The DSM-IV reports an estimated prevalence rate of 1% for Mental Retardation (including non-referred populations), with a male-to-female ratio of 1.5:1. In the CGC cohort the male-to-female ratio was 1.2:1.

### **5.3.3.4 Relational Problems and Gender**

The ratio of males-to-females with Relational Problems in this cohort was 1.3:1 (56.7% and 43.3%, respectively). The comorbidity of Relational Problems with the other four main disorders has been alluded to in Section 5.2.1.4 with reference to age, but this aspect should also be considered in relation to the highly emotive familial aspects of disorders like ADHD, Mental Retardation and the Learning Disorders.

### **5.3.3.5 Depressive Disorders and Gender**

Smith and Rutter (1995) report that a range of cross-sectional population surveys that include the US, the UK, Europe, Korea and Puerto Rico confirm that there has been a definite increase in the prevalence of depressive disorders since the Second World War. The female-to-male ratio of 2:1 for the depressive disorders that was reported by Smith and Rutter (1995) concurs with DSM-IV statistics. This ratio was reflected by the CGC cohort in both the Presenting Problem category of Emotional Disorders (67.4% and 32.6%, respectively), and the DSM Diagnosis category of Depressive Disorders (60.3% and 39.7%, respectively).

The finding that “the rate of depressive disorders does not decline after adolescence, but remains high in adult life” (Smith & Rutter, 1995, p. 770) was also evidenced in the CGC cohort (See Table A-26, Appendix A). In this cohort ( $N = 63$ ) the Depressive Disorders peaked in the 20 - 29 year-old age group (28.6%) but were also evidenced in the 30 - 39 year-old group (7.9%) and the > 40 year-old group (9.5%). It is of course important to recall that the CGC figures are for referred clients, which may not reflect the underlying population distribution.

## 5.4 Racial Distribution of Clientele

In order to have a better idea of the relative racial distribution of the two populations concerned, the racial distribution of the CGC clientele of the 1990s is compared with that of the entire Cape Metropolitan Area during the mid-90s. It will be seen that the racial composition of the CGC clientele does not precisely reflect that of the Cape Metropolitan Area, especially with respect to African clients.

### 5.4.1 Racial Distribution in Cape Metropolitan Area

Although the most recent census figures for the Cape Metropolitan Area are not available, the figures obtained from the government Department of Statistics for the 1996 South African census revealed the following racial distribution for the region.

**Table 5-1**

**South African Census 1996: Population Weighted, Cape Metropolitan Area**

RACE	TOTAL: ( <u>n</u> )	% of <u>N</u>
African/Black	643,378	25.16%
Coloured	1,236,124	48.33%
Indian/Asian	37,873	1.48%
White	542,536	21.21%
Unspecified	97,545	3.81%
<b>TOTAL: (<u>N</u>)</b>	<b>2,557,456</b>	

### 5.4.2 Shifts in Racial Distribution at the CGC during the 1990s

Smit (1997) notes that desegregation led to dramatic shifts in the racial distribution of clients between 1982 and 1992. She reports that whereas the relative distribution for Africans, Coloureds and Whites was 1%, 21% and 78%, respectively in 1982, the percentages had shifted to 5%, 72% and 23%, respectively in 1992, with the most dramatic shifts occurring in the reversal of the Coloured-to-White ratios.

In the present study the Coloured population (n = 40) was found to account for 61.5% of the total clientele (N = 65) in 1992 (See Table 3-4). It should however be borne in mind that twenty consecutive files were found to be missing from the 1992 folders

when the data were computerised for the study. More significantly, the trends reported by Smit (1997) regarding the Coloured and White populations were sustained throughout the 90s: ( $\underline{M}$  = 52.3%; SD = 8.11, and  $\underline{M}$  = 29.6%; SD = 7.37, respectively).

### **5.4.3 Under-representation of African Clientele**

As reported in Chapter 3, Africans accounted for 9.1% of the total clientele in the 1990s, with the annual percentages of Africans ranging between a minimum of 0.0% in 1990 to a maximum of 27.6% in 1996 ( $\underline{M}$  = 10.3%; SD = 8.36). However, it was apparent from the interviews with CGC staff members that although it would be comparatively easy to swell the numbers of African clients quite rapidly by advertising, or by encouraging referrals from outlying community sources, the underlying issues were far more complex, and not simply about numbers. Some of the issues will be considered in the following section.

#### **5.4.3.1 Factors Associated with the Under-representation of Africans**

As reported in Chapter 4, the eight interviewees considered problems with access, costs, resources, language, and differences in cultural preferences and practice to be the main factors that can be ascribed to the under-representation of African clients at the CGC.

Lupwana, Simbayi and Elkonin's (1999) interview-based survey in the Black (African) suburbs and townships of Port Elizabeth (South Africa) lends support to these views. The survey was conducted in order to assess the randomly selected adult respondents' awareness, attitudes, practices and needs concerning psychological services. Whilst fewer than half of the 256 respondents were aware of psychology, Lupwana et al. report that those who were aware regarded psychology in a positive light and indicated that they would be willing to avail themselves of psychological services in the future. However, Lupwana et al. report that very few of the respondents or their families had actually used psychological services. The survey findings are discussed in terms of difficulties with access and the respondents' request for the introduction and marketing of community-based mental health services to the community. The findings are also discussed in terms of their broader

implications regarding the provision of mental health care to the Black population of South Africa.

#### **5.4.3.1.2 Language Difficulties**

The issue of clinicians being able to converse in an indigenous language needs to be taken more seriously in a country which boasts eleven official languages. However, as Swartz, Drennan and Crawford (1997) have noted, in South Africa the issues pertaining to language policy in mental health care are not obviously prioritised. Their recommendations concerning the implementation of “enabling basics” at national level (See Section 1.3.1.3) are important first steps towards facilitating the desired transition towards multilingualism in mental health provision.

#### **5.4.3.1.3 Cultural Preferences and Practices**

Paradoxically, and notwithstanding the possibility of initial client resistance, G also stated that in view of the overwhelming legacy of need in post-apartheid South Africa, he would like to see clinical psychology becoming more accessible to black people. He suggested that this could be implemented through a period of mandatory community service for trainee clinical psychologists in the same way that a community service component is required of medical practitioners. Nevertheless, G was careful to differentiate between the former model of community service, with its connotations of exposure to previously disadvantaged populations, and a model that permitted cross-cultural exposure. He stated:

There is no adequate exposure to these communities and to their *ways* of doing things and to the kinds of problems that we are actually encountering, you know. And I feel that, for psychology to be adequately relevant for South Africa, we need to go out there and be part of that and *write* about those things and start talking about them in our meetings, and so on.

As reported in Chapter 4, G emphasised that there are important distinctions between “South African ways and *black* South African ways - so we need to engage people at both those levels.” G is part of the growing body of psychologists who are calling for a more integrated approach towards an indigenised psychology (e.g., Bodibe & Sodi, 1997; Mashegoane, 1998; & Peltzer, 1998). Bakker (1999) calls for a specifically *South African* perspective to be adopted in psychology. Given the need for South

African psychology to retain its reciprocity with the global fraternity, this would appear to be an important challenge for future generations of South African psychologists to engage with.

### **5.5 The Link between SES and Psychiatric Illness**

The correlation between racialised identity and social class in South Africa was discussed in Chapter 3 (See Section 3.2.6). The correlation between low SES and psychiatric illness has been widely reported both in the international epidemiological literature (e.g., Gullotta, 1997; Rutter, 1987; Rutter, 1988; Rutter & Madge, 1976; Verhulst & Koot, 1992) and in South African studies (e.g., Dawes & Donald, 1994; Robertson, 1996; L. Swartz, Gibson & S. Swartz, 1990; L. Swartz & Levett, 1989). Following a review of 38 international epidemiological studies of childhood psychiatric illness, Verhulst and Koot (1992, p. 130) report that “children of lower SES showed somewhat more problem behaviors, especially externalizing problems.”

Whereas psychiatric illness cannot be attributed to low SES per se, these authors are in broad agreement that much mental illness is attributable to the effects of low SES. These include poverty, overcrowding, malnutrition, substance abuse, teenage pregnancies, child neglect and abuse, gangsterism, elevated crime rates, and escalating incidences of domestic and general violence. At first glance it is therefore somewhat surprising that the analysis of the relationship between social class and the main DSM diagnoses was found to be non-significant (See Section 3.14.5), as in South Africa many of these effects have been cast as direct consequences of the apartheid system. Smit (1997) also reported that no correlation was found between SES and the three main Presenting Problem categories (School, Conduct and Emotional Problems) in her comparative analysis of the 1982 and 1992 clientele.

However, both findings should be interpreted with caution as being peculiar to the CGC clinical population of the 90s, and not as representative of the general population. In the present study 488 (75.4%) of the total clientele ( $N = 647$ ) represented the upper and middle classes. Of the remaining 159, 3.4% ( $n = 22$ ) were categorised as Unknown, leaving only 137 (21.1%) in the lower SES bracket (See Table 3-5). Of the 137, 45.0% ( $n = 86$ ) were diagnosed with one of the five main

DSM diagnoses (See Table A-28). The factors that were discussed in relation to the under-representation of African clientele, particularly those of high costs and limited access, need to be considered when interpreting these findings.

## **5.6 Additional Cultural Considerations**

### **5.6.1 Potential Areas of Cultural Bias**

There has been extensive debate concerning the potential for cultural bias in the referral, assessment, diagnosis, attitudes towards treatment, duration of treatment and treatment of ethnic minority clients (e.g., Good, 1996; Mezzich, Kleinman, Fabrega & Parron, 1996; Miller & L. Swartz, 1992; Ridley, 1995; Sattler, 1992).

While the CGC certainly cannot purport to be free of all cultural bias, there is nevertheless a high level of awareness concerning the issue. Evidence of this is seen in the multicultural staff team at the clinic, the annual selection of interns (See Section 4.2.5.3.1), and the exposure of clinical trainees to a multicultural clientele. Where deemed appropriate, South African normed ( $n = 161$ ) and non-language tests of intelligence ( $n = 241$ ), were used in the 90s (Shuttleworth-Jordan, 1996). All test results are carefully screened in order to minimise cultural bias in interpretation. A number of writings on cultural issues have emanated from CGC staff and trainees (e.g., Kleintjes & L. Swartz, 1996; L. Swartz, 1989). There is also a high level of awareness concerning the potential for culture-bound syndromes in a multicultural clientele.

### **5.6.2 Cultural Aspects of the Maudsley Interview Format**

Some of the allegations concerning the westernised cultural assumptions inherent in the Maudsley history-taking interview format (S. Swartz, 1996b; S. Swartz, 2000) were discussed in Chapter 4. However, despite broad agreement regarding the potential cultural limitations of the Maudsley within a South African context, there was general consensus among the eight interviewees concerning the advantages of adhering to a standardised internationally recognised format, both for training and for clinical purposes. The interviewees concurred in their view of the Maudsley as a comprehensive initial screening device that allows clinical findings to be contextualised within the cultural frame of reference of the client.

## **5.7 Multiple Diagnoses**

Inspection of the CGC case files for the 90s reveals that a high proportion of the clientele was diagnosed with multiple conditions on both Axes I and II. The frequently occurring comorbidity of the five most frequent DSM diagnoses for the 90s with other psychiatric disorders has also been discussed (See Section 5.2.1.4).

The data for the Secondary Diagnosis variable was not analysed in detail but the full range of secondary diagnoses is recorded in Table A-23 (See Appendix A).

Inspection of Table A-23 reveals that when the Secondary Diagnosis variable categories are collapsed to match those of the Primary Diagnosis (See Section 3.14.1), Relational Problems ( $n = 71$ ) and Learning Disorders ( $n = 42$ ) account for 11.0% and 6.5% of the secondary diagnoses, respectively.

The international and South African epidemiological findings concerning the correlation between the effects of low SES and psychiatric illness were alluded to in Section 5.5. Seventy (10.8%) of the clients during the 1990s had specified medical problems that were coded as a focus of clinical concern on Axis III. However, perhaps the most significant finding for the Secondary Diagnosis variable is the fact that 37.7% ( $n = 244$ ) of the total clientele also experienced clinically significant psychosocial or environmental stressors in addition to their primary psychiatric and/or general health problems.

This fact, coupled with the fact that a high proportion of the clients were diagnosed with multiple disorders, may serve as a partial explanation for both A and E's perceptions regarding the increased severity and complexity of the cases seen during the 90s, relative to those seen in the 80s.

## **5.8 Treatment Offered**

As reported, the majority of clients showed some benefit from treatment, with only four being rated as worse during the 10-year period. Individual assessment, individual therapy and family therapy were the most frequently employed treatment options

(29.8%, 25.8% and 25.3%, respectively). As anticipated, the Treatment Offered and Treatment Outcome variables were found to be dependent.

The relatively high percentage of clients who were rated as Unchanged following treatment (43.0%) was ascribed to the high number of clients whose treatment was limited to assessment ( $n = 170$ ), and whose mental health status therefore remained unchanged. An analysis of the standardised residuals confirmed that the Assessment treatment category was over-represented in the Unchanged outcome category (See Table A-37).

The 36.0% of clients who were rated as Improved following treatment ( $n = 233$ ), represented the full range of treatment options (See Table 3-21). This finding underscores the importance of remaining flexible and selecting the most appropriate treatment for the client concerned.

## **5.9 Duration of Treatment**

Inspection of Table A-32 (Appendix A) reveals that 69.2% of the clientele ( $n = 448$ ) were seen for between 1 – 9 sessions. Of these 448, 37.9% ( $n = 170$ ) were only seen for assessment purposes. A further 23.5% ( $n = 152$ ) were seen for between 10 – 19 sessions. Two cases (0.3%) were missing, and the remaining 7.0% ( $n = 45$ ) received relatively longer-term treatment of 20 or more sessions.

Despite the relative brevity of most treatments, these findings are encouraging with respect to the potential efficacy of short-term treatment.

## **5.10 Treatment Dropout**

In a meta-analysis of 125 studies of psychotherapy dropout Wierzbicki and Pekarik (1993) found that dropout and racial minority status were significantly correlated, with minority clients tending to drop out of treatment more frequently than other clients. In this study 103 clients (15.9%) dropped out of treatment during the 10-year period. Of these, 55.4% were Coloured, 29.1% were White and 8.7% were African. The Unknown category (6.8%) was omitted from the analysis. The dropout ratios for the Coloured, White and African populations are equivalent to the racial distribution

ratios of the total clientele ( $M = 52.3\%$ ,  $29.6\%$  and  $10.3\%$ , respectively). The annual breakdown statistics are summarised in Table A-33 (See Appendix A).

### **5.10.1 Factors Related to Dropout**

As previously discussed (See Section 3.17), Seruya (1997) ascribes client dropout to three broad sets of factors, namely client variables, client/therapist variables and therapist variables. Beckham (1992) reports that establishing early levels of rapport between client and therapist is clearly related to clients deciding to remain in treatment. Sledge, Moras, Hartley and Levine (1990) report that client dropout rates may be reduced by setting a specific time limit on individual psychotherapy at the outset of treatment.

#### **5.10.1.2 Racial Status**

Whilst it is not possible to substantiate or negate claims of bias in a retrospective study of this nature, statistical analysis of the relationship between psychotherapy dropout, client race and intern race revealed a relationship of dependency between the two variables: ( $L-R\chi^2 (12, N = 600) = 57.99, p < 0.00001$ ).

One of the less expected findings of this study was that  $66.7\%$  ( $n = 6$ ) of the 9 Africans who dropped out of treatment were being treated by African interns. However, the small size of the African cohort ( $N = 59$ ) should be borne in mind when interpreting the clinical significance of these findings. An analysis of the standardised residuals confirmed that African dropouts were the most substantially over-represented when the treating intern was also African (See Table A-36).

Whilst these findings were somewhat surprising to someone with a Eurocentric cultural background, one can only speculate about which specific factors may have contributed to the outcome. Ridley (1995) suggests that both therapist insensitivity and the failure to establish a strong therapeutic alliance with minority clients may contribute to client dropout.

#### 5.10.1.2.1 Client Defenses

The commonly held assumption that clients feel better understood when treated by a therapist with a similar cultural background to their own (Ridley, 1995; D. W. Sue & D. Sue, 1990) does not always pertain. Interestingly, as alluded to in Chapter 4, G submitted the opposite viewpoint. He stated:

Initially (African) patients *actively seek a person of a different race* because it's too close to home to actually talk to the person of the same race [...] but in the long run such people would still have fared better if they had managed to overcome that fear of talking to the person of the same race. So it's almost like taking your baggage [...] and depositing it into someone who's as far away from you, culturally and otherwise, as possible. So, I don't know if that will help you adequately to deal with the things. There's an issue of integration here. If you talk to the person of the same race and the same culture, and that person still accepts you and continues to work with you, I think that could work, and the healing process would be much more profound than continuously splitting and leaving your things over there with another person who is not part of your environment (*pause*) part of your community.

A partial explanation for the active seeking out of a person “who's as far away from you culturally and otherwise, as possible” may lie in the predominant differences between collectivistic and individualistic cultures. Whereas Bodibe and Sodi (1997) maintain that emotional mutuality, a shared ‘we’ consciousness, a collective identity, group cohesiveness, evidenced by sharing, together with codes of common duty or responsibilities, are hallmarks of collectivistic ideology; self-responsibility, independence, individual initiative, personal autonomy and a right to privacy are prized in individualistic societies. Whilst there may be age, class and gender related differences, in addition to distinct differences between urban and rural populations, Bodibe and Sodi (1997, p. 187) state:

In terms of fundamental assumptions, individualist cultures are rooted in the primacy of individual reason and rationality whereas the deep assumption of collectivist orientations is that of “relatedness”; an emphasis on collective welfare.

Thus the client who has acted autonomously in reaching beyond cultural boundaries for treatment may not wish to risk the humiliation of empathic failure.

#### **5.10.1.2.2 Therapist Defenses**

Ridley (1995) contends that over-identification with clients, for example when therapist and client have culturally similar minority backgrounds, can be a defense which acts as a smokescreen that blinds the therapist to the real client issues, and may even ultimately lead to an unsuccessful therapeutic outcome. He maintains that over-identification by minority therapists with “the (White) oppressor” is another defense against the intense pain of being a minority that frequently manifests in the placing of unduly stringent expectations on minority clients to measure up to the standards of the majority. Such defensive behaviour on the part of the therapist could be misconstrued as a lack of empathy.

Strupp et al. (1992) contend that empathic failure, the omission of parts of the initial clinical interview, criticism of the client, and a lack of clear focus in the therapy may all contribute to client dropout. Whilst there is no overt evidence in the present study to either validate or refute any of the above factors, they should definitely be weighed up in the search for plausible explanations for the findings.

### **5.11 Chapter Summary**

In this chapter the principal findings of the statistical analysis were elaborated and where pertinent, the analytical findings were linked to the findings from the interviews with CGC staff.

The effects of age and gender were examined in relation to the Presenting Problem and DSM Diagnosis variables and in general the findings were found to concur with international trends. However, in view of the considerable under-representation of African clients, the CGC population is not reflective of the general population and, contrary to international findings, in this study the presenting problem and DSM diagnosis were found to be independent of SES. These findings were interpreted chiefly in terms of the high costs and limited access that determine the racial composition of the CGC population.

The types of treatment offered were discussed in relation to the duration and predominantly successful outcome of treatment. Possible reasons for client dropout were considered in relation to client, therapist and client/therapist variables.

In conclusion, it is suggested that the relatively high prevalence of psychosocial and environmental stressors in the lives of the CGC clientele of the 90s has contributed to the increasing complexity and severity of the caseload. As this area was not investigated in detail, further research is needed in order to substantiate these claims.

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## Chapter 6

### Concluding Comments

#### Chapter Outline

<b>6.1</b>	<b>Introduction</b>	<b>136</b>
<b>6.2</b>	<b>Strengths and Limitations of the Study</b>	<b>136</b>
<b>6.2.1</b>	<b>Strengths of the Study</b>	<b>136</b>
<b>6.2.1.1</b>	<b>Resources</b>	<b>136</b>
<b>6.2.1.2</b>	<b>Personnel</b>	<b>136</b>
<b>6.2.2</b>	<b>Limitations of the Study</b>	<b>137</b>
<b>6.2.2.1</b>	<b>Time Constraints</b>	<b>137</b>
<b>6.2.2.2</b>	<b>Lack of Specific Focus</b>	<b>137</b>
<b>6.2.2.3</b>	<b>The Need for a Computerised Database</b>	<b>137</b>
<b>6.2.2.4</b>	<b>Retrospective Insights Concerning the Project</b>	<b>138</b>
<b>6.3</b>	<b>Clinical Significance of the Findings</b>	<b>139</b>
<b>6.3.1</b>	<b>Significance of the Clinical Findings</b>	<b>139</b>
<b>6.3.1.1</b>	<b>Changes in Client Profile</b>	<b>139</b>
<b>6.3.1.2</b>	<b>Comparison with International Findings</b>	<b>139</b>
<b>6.3.1.3</b>	<b>SES and Psychiatric Illness</b>	<b>139</b>
<b>6.3.2</b>	<b>Significance of the Interview Findings</b>	<b>140</b>
<b>6.4</b>	<b>Possible Areas for Further Research</b>	<b>140</b>
<b>6.4.1</b>	<b>Responses to the HIV/AIDS Pandemic</b>	<b>141</b>
<b>6.4.2</b>	<b>Multicultural Issues</b>	<b>141</b>
<b>6.4.3</b>	<b>Further Areas for Research</b>	<b>141</b>
<b>6.5</b>	<b>Chapter Summary</b>	<b>142</b>

## **Chapter 6**

### **Concluding Comments**

#### **6.1 Introduction**

In this final chapter the strengths and limitations of the project will be deliberated from an evaluative perspective and the clinical significance of the findings will be reviewed.

Inevitably there are certain issues that have not been adequately addressed, others omitted, and there are doubtless significant questions that need to be pondered. Some of those that come to mind will be advanced as suggestions for further research.

#### **6.2 Strengths and Limitations of the Study**

##### **6.2.1 Strengths of the Study**

###### **6.2.1.1 Resources**

The greatest strength of this study undoubtedly lay in the abundance of resources that were put at my disposal for the duration of the research. I was granted unlimited access to the confidential case files that, with the exception of the 1990 batch that had already been archived, were conveniently located under one roof. I was also accorded the privilege of writing up the research at the CGC, where the data is housed. Both of these factors greatly facilitated the somewhat laborious task of data extraction and compilation.

###### **6.2.1.2 Personnel**

The second major strength of the study was found through my interviews with past and present CGC staff members. Without exception, the interviewees responded generously to my request for an hour of their time, and several offered me a second interview if it seemed necessary. It is difficult to do justice to the wealth of information that was gleaned through these times, and I came away with the realisation that a number of them had grappled with the prevailing issues of the day, frequently at considerable expense and inconvenience to themselves.

As leaders in their field, some have pioneered significant changes, and they remain at the cutting edge of their profession. More than half of the interviewees have published prolifically in the past and continue to do so. At the end of the day, I was left with the realisation that these are simply concerned, thinking individuals who are attempting to make a difference through their professional involvement - and that it had been an immense privilege to be privy to some of their insights.

## **6.2.2 Limitations of the Study**

### **6.2.2.1 Time Constraints**

For a range of reasons, my greatest constraint was that of time. The size and scope of the study have therefore been dictated by the need to complete the research in the allotted timespan. As a result, there are many potentially interesting issues that have been left unexplored and the finished product is merely an overview of some of the more significant shifts and trends that have occurred in the past decade.

### **6.2.2.2 Lack of Specific Focus**

The second limitation of this study arises from the first. Because of the sense of urgency that catapulted me into finding a research project as speedily as possible, I undertook to do this research without having predetermined precisely what its focal point would be. In essence, this meant that without a clear objective in mind, the original databases had to be as inclusive as possible so as to avoid having to return to the files in search of information which had unwittingly been omitted. This made the information gathering process far longer than necessary, as much of the available data was later omitted from the study.

### **6.2.2.3 The Need for a Computerised Database**

The third limitation of the study is closely linked to the first two. The data gathering process proved to be extremely time-consuming and laborious, as each individual file had to be carefully scrutinised for the relevant information. This was particularly onerous in the early stages of the project before the decision was taken to confine the study to those cases seen by interns. Much valuable time was wasted in searching for details that had not been written up by clinicians. The format of the clinician files was frequently inconsistent with that of the intern files - a factor that further complicated the search.

It is suggested that the CGC would benefit greatly by switching over to a readily accessible standardised computerised database that would be used by both clinic staff and students. Although there would undoubtedly be initial snags during the transition period, such a move would streamline the data storage and retrieval process, make it more uniform, and ultimately improve efficiency by freeing staff and students for other tasks. It would certainly facilitate future research projects by enabling researchers to selectively screen and retrieve the requisite data with relative ease.

#### **6.2.2.4 Retrospective Insights Concerning the Project**

With the benefits of hindsight, there are two principal areas that I would have approached differently. First and foremost, although I was content to regard the project as an exploratory study, I would have consulted more widely in advance with CGC personnel, so as to inform myself better regarding clinic practice and policies. With a more thorough preparation phase, I would doubtless have equipped myself better to focus my study more specifically.

Secondly, this would inevitably have led to the more selective screening and processing of data, thereby saving both my research assistant and myself the many valuable hours that were spent transferring unnecessary details from the files into the computerised database. I would also have eliminated some of the less relevant questions concerning the past from the semi-structured interview schedule. They would have been replaced with some of the more immediate issues of the present, as many more hours were spent in transcribing intriguing and informative details that were later eliminated from the study. Nevertheless, having made these observations, I do not regret having gained the experience that has allowed me to reach these conclusions. This project has been of considerable interest and I have learned a great deal in the process.

## **6.3 Clinical Significance of the Findings**

### **6.3.1 Significance of the Clinical Findings**

#### **6.3.1.1 Changes in Client Profile**

The diversification of clinic practice that began in the late 1980s led to an increase in the numbers of young adults and family members of clients who were treated at the clinic. However, despite the increase in older clients, almost half of the 90s clientele were aged between 5 - 9 years 11 months and 86.9% of them were below the age of 20 years.

Whereas Africans were generally under-represented throughout the 90s, the dramatic reversal of the Coloured-to-White ratio that Smit (1997) reported for the 1982 and 1992 clientele was sustained throughout the decade. In effect, the reversal meant that the predominantly White school-age clientele of the 70s and early 80s systematically gave way to a predominantly Coloured school-age clientele in the 90s. It will be of considerable interest to observe whether there are further dramatic shifts in the racial profile of the CGC during the next decade.

#### **6.3.1.2 Comparison with International Findings**

Verhulst and Koot (1992) report that a meta-analysis of 38 international studies on the effect of age on the prevalence of child problem behaviours yielded inconclusive findings. Given the need in this study to redefine certain DSM categories of disorders more broadly, it is significant that the age-related findings were largely consistent with the age-related DSM diagnostic criteria. The gender-related findings also concurred well with the reported international epidemiological trends (Smith & Rutter, 1995; Verhulst & Koot, 1992).

#### **6.3.1.3 SES and Psychiatric Illness**

The lack of correspondence between SES and psychiatric illness in the clinic population was attributed to the fact that the clinic population is not representative of the general population. This is ironic, given that the predominant factors deemed to be responsible for shaping the CGC client profile are high costs of access and limited access - both indicators of low SES. Nevertheless, it is clearly significant that 37.7% of the total clientele

experienced clinically significant psychosocial and environmental stressors of varying severity in addition to their psychological problems.

### **6.3.2 Significance of the Interview Findings**

The interviews with present and former staff members convinced me that the CGC has made an important contribution to the field of clinical psychology by keeping abreast with the times and remaining relevant in a changing South Africa. Some of the more significant changes include the introduction of the Maudsley in 1977, the “politically incorrect” move towards diversification during the turbulent 80s, the adaptation and introduction of a more culturally relevant version of the Maudsley in the late 80s, the changing profile of the clinical trainees and the introduction of community psychology in the early 90s.

As previously stated the CGC community psychology model of the latter 90s differed considerably from that of early 90s. Because resource shortages have altered the profile of the clinical psychologist, the latter community model has two main foci, namely support and consultation and training. CGC trainees are being equipped with a broad repertoire of skills that enables them to work effectively with individuals, families, groups and organisations across diverse settings. This is just one of the many ways in which imaginative solutions to the dilemma of insufficient resources are being implemented.

Beyond the immediate horizons of the CGC there is the considerable challenge of providing culturally relevant psychological services to an historically disadvantaged multicultural clientele. Notwithstanding the obstacles that hinder the search for African or *South* African solutions, (Bakker, 1999) it would appear that various staff members have pondered the matter deeply and have come up with some particularly creative alternatives. As these interviewees have considerable professional influence, there is good reason to believe that at least some of the envisioned changes will be implemented in the future.

### **6.4 Possible Areas for Further Research**

The major disadvantage of an analysis of this nature is the inevitable sacrifice of detail that occurs in the interests of analytical expediency. As almost every case file could be

construed as a potential research project, it becomes difficult to select among the many alternatives. However, after due consideration, I have highlighted the following issues.

#### **6.4.1 Responses to the HIV/AIDS Pandemic**

The staggering escalation of the HIV/AIDS pandemic has created a global crisis of a magnitude previously unknown to mankind. Following attendance at an HIV/AIDS workshop, Weir (personal communication, 14 October 2000) informed me that of the 34.3 million persons worldwide with positive HIV/AIDS status, 24 million (70%) are resident in sub-Saharan Africa. (By early December 2000 the global figure for positive HIV/AIDS status had reportedly escalated to 36 million persons.) To date, the disease has orphaned an estimated 13 million children. These alarming statistics call for radical intervention by virtually every sector of society. Clearly this is a field which provides almost unlimited scope for urgent further research in the psychological arena.

#### **6.4.2 Multicultural Issues**

In view of the multiple inequities that exist as a legacy of the previous regime, this is another enormous potential area for further research. The search for South African solutions to “African” problems may well initially best be conducted by those whose cultural origins are similar to those of the research population. As with the HIV/AIDS question, there is almost unlimited scope for further research in this area. However, in view of the lessons that have emerged through numerous crosscultural community developmental studies (e.g., Kelly & Van Vlaenderen, 1996; Melvill, 2000), this type of research needs to be conducted with the utmost sensitivity and respect. Other future research projects might examine trainee dynamics, with particular reference to crosscultural issues.

#### **6.4.3 Further Areas for Research**

As this study has provided such a broad overview of CGC practice and policies, there is substantial scope for further research in almost any direction. For example, a detailed cross-sectional study of all the cases seen at 2-year intervals during the 10-year period would determine whether there really had been an escalation in the severity and complexity of the types of problems that were seen at the CGC during the 90s.

Alternatively, a detailed case study of all those clients who were documented as having to contend with clinically significant psychosocial and environmental stressors in addition to their psychological problems would undoubtedly prove to be informative.

Looking ahead to the future, a follow-up study of all clients who drop out of treatment could be invaluable in helping to combat the problem. On a longer-term basis, the findings of the present study could be used to design and implement specific research projects with the objective of obtaining important long-term data on various aspects of the CGC clientele of the 2000s.

## **6.5 Chapter Summary**

The strengths and flaws of this research project were evaluated and the clinical significance of the findings was discussed. In conclusion, suggestions were made concerning other potentially interesting research projects.

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## APPENDIX A

### Tables Associated with Chapter 3

#### A.1 Tables Related to Referring Agent Variable

**Table A-1:**

**Two-Way Summary Table: Year by Referring Agent**

Year	REFERRING AGENT							Total:
	Father	Mother	Family	School	Doctor	Welfare	Self	<u>N</u>
1990	9	59	0	0	3	1	6	78
1991	16	61	5	5	13	0	8	108
1992	8	39	0	7	3	2	6	65
1993	8	52	3	7	4	0	7	81
1994	9	37	2	4	2	0	4	58
1995	4	42	3	4	3	2	5	63
1996	4	29	4	5	9	2	5	58
1997	5	28	2	2	2	0	8	47
1998	1	38	1	0	1	0	8	49
1999	3	22	4	2	6	0	3	40
<u>n</u>	67	407	24	36	46	7	60	647
<u>% N</u>	10.4%	62.9%	3.7%	5.6%	7.1%	1.1%	9.3%	

**A.2 Tables Related to Racial Classification Variable**

**Table A-2:**

**Log-linear Analysis: Standardised Residuals – Year by Racial Classification**

Year	RACIAL CLASSIFICATION			Total
	African	Coloured	White	
1990	-2.55054	.20067	1.16462	-1.18525
1991	-2.59632	.48699	.81363	-1.29571
1992	-1.28097	.43896	.14005	-.70195
1993	-.00083	.23421	-.30762	-.07424
1994	-.62270	.38955	-.16365	-.39680
1995	.81119	-.50791	.21376	.51705
1996	4.50750	-1.25486	-.87400	2.37863
1997	-.23484	.55901	-.60381	-.27964
1998	2.69085	.00986	-1.52014	1.18056
1999	1.41187	-.93260	.43598	.91525
<b>Total</b>	<b>2.13520</b>	<b>-.37612</b>	<b>-.70118</b>	<b>1.05789</b>

### A.3 Tables Related to Social Class Variable

**Table A-3:**

**Log-linear Analysis: Standardised Residuals – Year by Social Class**

Year	SOCIAL CLASS						Total
	P	SP	S	SS	US	UE	
1990	-2.11034	-.88725	1.05539	1.41712	.46143	-.26426	-.32792
1991	-.63155	-1.17815	.17312	2.17006	.97136	-1.26090	.24395
1992	1.67423	-.40641	.55756	-1.68767	-.66038	.06772	-.45494
1993	-.65724	1.34623	.65498	-1.20703	-1.47256	-.33335	-1.66897
1994	1.31468	3.24972	-2.86992	-.77318	-.50951	.24341	.65520
1995	1.01133	-.73652	-.31123	-.36905	1.14648	.27441	1.01542
1996	.75600	-.87538	-.15399	.45978	-.42890	.92304	.68054
1997	.82448	-.36984	-.15085	.09611	-.19304	-.01202	.19484
1998	-.52908	-.01236	.06158	-.47760	.60088	.81876	.46219
1999	-1.28370	.14182	.74450	-.38066	.04555	.22664	-.50585
<b>Total</b>	.36882	.27188	-.23885	-.75213	-.03870	.68345	.29447

P = Professional, SP = Semi-professional, S = Skilled, SS = Semi-skilled,  
 US = Unskilled, UE = Unemployed. (U = Unknown omitted).

**Table A-4****Two-Way Summary Table: Social Class Subtable within RACE: African**

YEAR	SOCIAL CLASS							Total:
	P	SP	S	SS	US	UE	U	<u>N</u>
1990	0	0	0	0	0	0	0	0
1991	0	0	1	0	1	0	0	2
1992	2	0	0	0	1	0	0	3
1993	2	3	2	0	1	0	0	8
1994	0	3	0	0	1	0	0	4
1995	2	2	1	0	2	1	0	8
1996	5	1	4	2	2	1	1	16
1997	1	0	2	0	0	0	0	3
1998	1	1	1	1	1	1	3	9
1999	0	3	1	0	1	1	0	6
<u>N</u>	13	13	12	3	10	4	4	59

**Table A-5****Two-Way Summary Table: Social Class Subtable within RACE: Coloured**

YEAR	SOCIAL CLASS							Total:
	P	SP	S	SS	US	UE	U	<u>N</u>
1990	1	2	18	14	4	2	1	42
1991	6	7	26	16	7	2	1	65
1992	5	9	19	3	1	3	0	40
1993	3	15	22	6	0	1	1	48
1994	5	16	7	4	1	2	0	35
1995	2	5	11	6	2	2	4	32
1996	1	5	11	4	0	2	1	24
1997	1	4	11	5	1	2	0	24
1998	1	5	10	2	1	0	3	22
1999	0	2	9	3	1	1	0	16
<u>N</u>	25	70	144	63	18	17	11	348

P = Professional, SP = Semi-professional, S = Skilled, SS = Semi-skilled,  
 US = Unskilled, UE = Unemployed, U = Unknown.

**Table A-6****Two-Way Summary Table: Social Class Subtable within RACE: White**

YEAR	SOCIAL CLASS							Total:
	P	SP	S	SS	US	UE	U	<u>N</u>
1990	2	14	13	0	0	0	0	29
1991	5	14	15	5	0	0	1	40
1992	6	6	9	0	0	0	1	22
1993	3	9	11	0	0	2	0	25
1994	6	8	2	1	0	1	0	18
1995	6	5	8	0	0	0	2	21
1996	3	5	4	0	0	1	1	14
1997	5	2	2	1	0	0	0	10
1998	0	3	2	1	1	0	0	7
1999	2	5	5	1	0	0	0	13
<u>N</u>	38	71	71	9	1	4	5	199

**Table A-7****Two-Way Summary Table: Social Class Subtable within RACE: Unknown**

YEAR	SOCIAL CLASS							Total:
	P	SP	S	SS	US	UE	U	<u>N</u>
1990	0	0	5	0	1	1	0	7
1991	0	0	0	0	0	0	1	1
1992	0	0	0	0	0	0	0	0
1993	0	0	0	0	0	0	0	0
1994	0	1	0	0	0	0	0	1
1995	0	0	1	0	1	0	0	2
1996	0	0	2	2	0	0	0	4
1997	1	5	3	0	1	0	0	10
1998	2	2	4	0	0	2	1	11
1999	0	1	4	0	0	0	0	5
<u>N</u>	3	9	19	2	3	3	2	41

P = Professional, SP = Semi-professional, S = Skilled, SS = Semi-skilled,

US = Unskilled, UE = Unemployed, U = Unknown.

#### A.4 Tables of Standardised Residuals: Social Class by Race

**Table A-8**

**Standardised Residuals: Social Class by Race: 1990**

Social Class	RACE			Total
	African	Coloured	White	
P	-.72398	-1.77855	-.54544	-3.04797
SP	-1.25858	-2.51101	3.10985	-.65974
SS	-1.62060	.80294	1.34872	.53105
SS	-.71522	3.67844	-1.59903	1.36419
US	-.18226	1.02250	-.92227	-.08203
UE	-.11449	-.02374	-.84283	-.98106
<b>Total</b>	<b>-4.61514</b>	<b>1.19059</b>	<b>.54900</b>	<b>-2.87555</b>

**Table A-9**

**Standardised Residuals: Social Class by Race: 1991**

Social Class	RACE			Total
	African	Coloured	White	
P	-1.02916	-.63449	.18398	-1.47968
SP	-1.62891	-2.02684	1.64533	-2.01042
SS	-1.60312	.92286	.53760	-.14266
SS	-1.01952	2.87758	.20992	2.06798
US	.58700	1.72969	-1.24917	1.06752
UE	-.37806	-.60729	-1.16063	-2.14599
<b>Total</b>	<b>-5.07177</b>	<b>2.26150</b>	<b>.16703</b>	<b>-2.64324</b>

P = Professional, SP = Semi-professional, S = Skilled, SS = Semi-skilled,

US = Unskilled, UE = Unemployed. (U = Unknown omitted.)

**Table A-10**

**Standardised Residuals: Social Class by Race: 1992**

Social Class	RACE			Total
	African	Coloured	White	
P	1.13744	.071423	1.79757	3.00643
SP	-1.18478	-.129592	.18407	-1.13029
SS	-1.53690	1.410360	.28562	.15908
SS	-.65317	-.773343	-1.51595	-2.94246
US	1.16767	-.672170	-.85629	-.36079
UE	-.05853	.754186	-.77845	-.08280
Total	-1.12826	.660865	-.88343	-1.35082

**Table A-11**

**Standardised Residuals: Social Class by Race: 1993**

Social Class	RACE			Total
	African	Coloured	White	
P	.809483	-1.17801	-.23587	-.60439
SP	.419872	.98415	.78342	2.18745
SS	-.752511	1.25095	.29008	.78852
SS	-.810987	.02647	-1.72916	-2.51368
US	.904086	-1.49146	-1.02459	-1.61196
UE	-.199300	-.80376	.57151	-.43155
Total	.370644	-1.21166	-1.34461	-2.18562

P = Professional, SP = Semi-professional, S = Skilled, SS = Semi-skilled,

US = Unskilled, UE = Unemployed. (U = Unknown omitted.)

**Table A-12**  
**Standardised Residuals: Social Class by Race: 1994**

Social Class	RACE			Total
	African	Coloured	White	
P	-.58389	.30805	2.07248	1.79663
SP	.98953	2.51996	1.29692	4.80641
SS	-1.43354	-1.48742	-1.90458	-4.82554
SS	-.57545	-.12382	-.82729	-1.52657
US	1.30598	-.54495	-.77402	-.01298
UE	.01277	.26084	.18102	.45463
Total	-.28460	.93266	.04453	.69259

**Table A-13**  
**Standardised Residuals: Social Class by Race: 1995**

Social Class	RACE			Total
	African	Coloured	White	
P	1.361150	-1.00674	2.15741	2.51182
SP	.344168	-1.08113	.08609	-.65088
SS	-.813554	-.26610	.32958	-.75008
SS	-.552026	.87136	-1.38274	-1.06341
US	2.730572	.15856	-.74931	2.13983
UE	1.483691	.30969	-.67386	1.11952
Total	4.554001	-1.01437	-.23282	3.30681

P = Professional, SP = Semi-professional, S = Skilled, SS = Semi-skilled,

US = Unskilled, UE = Unemployed. (U = Unknown omitted.)

**Table A-14**  
**Standardised Residuals: Social Class by Race: 1996**

Social Class	RACE			Total
	African	Coloured	White	
P	4.44986	-1.37771	.50345	3.575600
SP	-.28113	-.92634	.23754	-.969936
SS	1.09480	-.04717	-.98109	.066531
SS	1.49227	.07838	-1.31963	.251026
US	2.86684	-1.11271	-.69804	1.056094
UE	1.57689	.41240	.29832	2.287615
<b>Total</b>	11.19952	-2.97315	-1.95945	6.266930

**Table A-15**  
**Standardised Residuals: Social Class by Race: 1997**

Social Class	RACE			Total
	African	Coloured	White	
P	.817528	-1.01542	2.40716	2.20926
SP	-.786699	-.69771	-.67141	-2.15582
SS	.298401	.85613	-1.26572	-.11120
SS	-.307752	1.19289	-.37158	.51356
US	.201320	-.09842	-.49407	-.39118
UE	.269649	.84096	-.42322	.68739
<b>Total</b>	.492447	1.07843	-.81885	.75202

P = Professional, SP = Semi-professional, S = Skilled, SS = Semi-skilled,

US = Unskilled, UE = Unemployed. (U = Unknown omitted.)

**Table A-16**  
**Standardised Residuals: Social Class by Race: 1998**

Social Class	RACE			Total
	African	Coloured	White	
P	.967536	-.864460	-.98263	-.879551
SP	.186008	-.027435	.05619	.214760
SS	-.254357	.896823	-1.07174	-.429272
SS	.982102	-.269223	-.22958	.483301
US	2.010196	.042535	.65477	2.707496
UE	2.163543	-.711973	-.33894	1.112631
<b>Total</b>	<b>6.055028</b>	<b>-.933733</b>	<b>-1.91193</b>	<b>3.209364</b>

**Table A-17**  
**Standardised Residuals: Social Class by Race: 1999**

Social Class	RACE			Total
	African	Coloured	White	
P	-.283622	-1.51439	.383541	-1.41447
SP	1.799950	-1.42073	.971637	1.35086
SS	-.341487	.32436	.122811	.10569
SS	-.275658	.17927	-.316607	-.41299
US	1.899542	-.04396	-.460896	1.39469
UE	2.049473	.07279	-.390510	1.73175
<b>Total</b>	<b>4.848198</b>	<b>-2.40265</b>	<b>.309975</b>	<b>2.75552</b>

P = Professional, SP = Semi-professional, S = Skilled, SS = Semi-skilled,

US = Unskilled, UE = Unemployed. (U = Unknown omitted.)

## A.5 Tables Related to Presenting Problem

**Table A-18: Three-Way Table: Year by Gender by Presenting Problem**

<u>Year</u>	<u>Gender</u>	<u>PRESENTING PROBLEM</u>					<u>n</u>
		<u>School</u>	<u>Conduct</u>	<u>Somatic</u>	<u>Emotion</u>	<u>Habits</u>	
<b>1990</b>	Males	33	12	0	7	2	54
	Females	15	2	0	7	0	24
	<b>Total: n</b>	48	14	0	14	2	78
<b>1991</b>	Males	28	25	1	12	2	68
	Females	15	10	1	14	0	40
	<b>Total: n</b>	43	35	2	26	2	108
<b>1992</b>	Males	21	13	0	1	0	35
	Females	10	10	1	9	0	30
	<b>Total: n</b>	31	23	1	10	0	65
<b>1993</b>	Males	27	15	1	6	0	49
	Females	12	9	0	11	0	32
	<b>Total: n</b>	39	24	1	17	0	81
<b>1994</b>	Males	21	8	1	2	0	32
	Females	11	6	0	9	0	26
	<b>Total: n</b>	32	14	1	11	0	58
<b>1995</b>	Males	25	12	0	2	0	39
	Females	7	5	0	12	0	24
	<b>Total: n</b>	32	17	0	14	0	63
<b>1996</b>	Males	12	12	0	6	0	30
	Females	9	7	1	11	0	28
	<b>Total: n</b>	21	19	1	17	0	58
<b>1997</b>	Males	14	10	0	2	0	26
	Females	6	4	0	8	0	18
	<b>Total: n</b>	20	14	0	10	0	44
<b>1998</b>	Males	12	11	0	2	0	25
	Females	7	7	0	10	0	24
	<b>Total: n</b>	19	18	0	12	0	49
<b>1999</b>	Males	4	10	0	7	1	22
	Females	4	8	0	6	0	18
	<b>Total: n</b>	8	18	0	13	1	40
	<b>N</b>	293	196	6	144	5	644

## A.6 Tables Related to Diagnostic Tests

**Table A-19**

**Summary Frequency Table - BGT by Age Category: 1990 – 1999**

<u>Test</u>	<u>AGE CATEGORY</u>				<u>Row</u>
	<u>0-&lt;5</u>	<u>5-&lt;10</u>	<u>10-&lt;15</u>	<u>15-&lt;20</u>	<u>Total: N</u>
BGT	0	50	35	4	89
Row %	0.0%	56.2%	39.3%	4.5%	

**Table A-20**

**Summary Frequency Table – VMI by Age Category: 1990 – 1999**

<u>Test</u>	<u>AGE CATEGORY</u>				<u>Row</u>
	<u>0-&lt;5</u>	<u>5-&lt;10</u>	<u>10-&lt;15</u>	<u>15-&lt;20</u>	<u>Total: N</u>
VMI	2	77	22	2	103
Row %	1.9%	74.8%	21.4%	1.9%	

**Table A-21**

**Summary Frequency Table – ADT by Age Category: 1990 – 1999**

<u>Test</u>	<u>AGE CATEGORY</u>				<u>Row</u>
	<u>0-&lt;5</u>	<u>5-&lt;10</u>	<u>10-&lt;15</u>	<u>15-&lt;20</u>	<u>Total: N</u>
ADT	0	19	8	0	27
Row %	0.0%	70.4%	29.6%	0.0%	

**Table A - 22****Summary Frequency Table: Bene-Anthony by Year**

Year	<u>n</u>	% of <u>N</u>	Clientele: <u>N</u>
1990	7	8.9%	78
1991	5	4.6%	108
1992	15	23.1%	65
1993	3	3.7%	81
1994	11	18.9%	58
1995	15	23.8%	63
1996	15	23.8%	58
1997	10	21.3%	47
1998	17	34.7%	49
1999	10	25.0%	40
<b>Total: <u>N</u></b>	108		647

**A.7 Data Related to DSM Diagnosis****Table A - 23****Secondary DSM Diagnoses: 1990 - 1999**

DSM DIAGNOSIS	<u>n</u>	% of <u>N</u>
<b>Mental Retardation (Coded on Axis II)</b>		
Mild Mental Retardation	2	0.3%
Moderate Mental Retardation	1	0.2%
Borderline Intellectual Functioning	13	2.0%
<b>Learning Disorders</b>		
Specified Learning Disorders	20	3.1%
<b>Communication Disorders</b>		
Expressive Language Disorder	1	0.2%
Stuttering	4	0.6%
<b>Attention-Deficit and Disruptive Behaviour Disorders</b>		
ADHD Combined Type	8	1.2%
ADHD Inattentive Type	2	0.3%

Oppositional Defiant Disorder	5	0.8%
<b>Elimination Disorders</b>		
Enuresis/All Types	9	1.4%
Encopresis	1	0.2%
<b>Other Disorders of Infancy, Childhood or Adolescence</b>		
Separation Anxiety Disorder	7	1.1%
<b>Cannabis-Related Disorders</b>		
Cannabis Dependence	2	0.3%
<b>Depressive Disorders</b>		
Major Depressive Disorder	2	0.3%
Dysthymic Disorder	7	1.1%
Depressive Disorder NOS	3	0.5%
<b>Anxiety Disorders</b>		
Panic Disorder without Agoraphobia	2	0.3%
Posttraumatic Stress Disorder	1	0.2%
Generalised Anxiety Disorder	4	0.6%
<b>Somatoform Disorders</b>		
Undifferentiated Somatoform Disorder	1	0.2%
<b>Gender Identity Disorders</b>		
Gender Identity Disorder in Children	1	0.2%
<b>Sleep Disorders</b>		
Nightmare Disorder	2	0.3%
<b>Adjustment Disorders</b>		
Adjustment Disorder with Depressed Mood	6	0.9%
<b>Personality Disorders (Coded on Axis II)</b>		
Specified Personality Disorder	3	0.5%
Personality Disorder Traits	21	3.2%
<b>Relational Problems</b>		
Parent-Child Relational Problem	50	7.7%
Marital Problem	6	0.9%
Sibling Relational Problem	9	1.4%
Relational Problem NOS	6	0.9%
<b>Problems Related to Abuse or Neglect</b>		
Neglect of Child	1	0.2%
Physical Abuse of Adult	2	0.3%
Sexual Abuse of Adult	1	0.2%
<b>Additional Conditions That May be a Focus of Clinical Attention</b>		

Child or Adolescent Antisocial Behaviour	6	0.9%
Bereavement	1	0.2%
Academic Problem	22	3.4%
Religious or Spiritual Problem	1	0.2%
Phase of Life Problem	5	0.8%
Other Specified Family Circumstances	6	0.9%
<b>Additional Codes</b>		
No Diagnosis or Condition on Axis II	70	10.8%
Diagnosis Deferred on Axis II	1	0.2%
<b>Conditions on Axes III and IV</b>		
Specified Medical Condition: Axis III	70	10.8%
Psychosocial/Environmental Problems: Axis IV	244	37.7%
No Secondary Diagnosis	18	2.8%
<b>TOTAL: N</b>	647	

**Table A – 24**

**Two-Way Table: Observed Frequencies of Five Most Frequent DSM Diagnoses**

2-Way Summary Table: Observed Frequencies Year x DSM Diagnosis						
YEAR	DSM DIAGNOSIS*					Row
	R P	L D	DD	ADHD	M R	Total: <u>N</u>
1990	17	15	5	3	4	44
1991	28	9	9	8	5	59
1992	13	7	2	3	10	35
1993	22	12	5	3	10	52
1994	14	4	8	6	4	36
1995	12	10	9	3	2	36
1996	8	4	6	2	3	23
1997	13	2	7	5	0	27
1998	14	6	5	8	2	35
1999	9	1	7	6	1	24
<b>Total: <u>N</u></b>	150	70	63	47	41	371

\*RP = Relational Problem, LD = Learning Disorder, DD = Depressive Disorder, ADHD = Attention Deficit Hyperactivity Disorder, MR = Mental Retardation.

**Table A-25****Standardised Residuals: DSM Diagnosis by Gender: 1990 - 1999**

*DSM Diagnosis	GENDER		Total
	Male	Female	
MR	-.40767	.48280	.075131
LD	1.40600	-1.66512	-.259120
ADHD	1.41281	-1.67318	-.260374
DD	-1.94059	2.29823	.357642
RP	-.28228	.33430	.052022
Total	.18827	-.22297	-.034699

**Table A-26****Two-Way Frequency Table: Age Group by DSM Diagnosis: 1990 – 1999**

I) Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence								
DSM*	AGE CATEGORY							Total: N
	0-<5	5-<10	10-<15	15-<20	20-<30	30-<40	>40	
ADHD	1	37	9	0	0	0	0	47
Row %	2.1%	78.7%	19.2%	0.0%	0.0%	0.0%	0.0%	
LD	1	28	35	5	1	0	0	70
Row %	1.4%	40.0%	50.0%	7.2%	1.4%	0.0%	0.0%	
MR	0	19	14	5	1	2	0	41
Row %	0.0%	46.3%	34.2%	12.2%	2.4%	4.9%	0.0%	
II) Relational Problems and Depressive Disorders								
DSM*	0-<5	5-<10	10-<15	15-<20	20-<30	30-<40	>40	N
RP	16	73	37	11	6	4	3	150
Row %	10.7%	48.7%	24.7%	7.3%	4.0%	2.7%	2.0%	
DD	1	13	12	8	18	5	6	63
Row %	1.6%	20.6%	19.1%	12.7%	28.6%	7.9%	9.5%	
<b>N</b>	19	170	107	29	26	11	9	371

\*RP = Relational Problem, LD = Learning Disorder, DD = Depressive Disorder, ADHD = Attention Deficit Hyperactivity Disorder, MR = Mental Retardation.

**Table A-27****Standardised Residuals: DSM Diagnosis by Age Category: 1990 – 1999**

*DSM	AGE CATEGORY							Total
	0-<5	5-<10	10-<15	15-<20	20-<30	30-<40	>40	
<b>MR</b>	-1.25068	-.05820	.55273	.99599	-.97658	.76691	-.71206	-.68188
<b>LD</b>	-1.27308	-.72385	<b>3.24811</b>	-.18821	-1.67606	-1.28528	-1.13604	-3.03441
<b>ADHD</b>	-.77448	<b>3.18403</b>	-1.25468	-1.77642	-1.66497	-.94725	-.81369	-4.04746
<b>DD</b>	-1.13647	-2.94946	-1.44207	<b>1.33852</b>	<b>6.16724</b>	<b>2.09796</b>	<b>3.22984</b>	7.30556
<b>RP</b>	<b>2.74657</b>	.64727	-.87638	-.26813	<b>-1.41867</b>	-.36110	-.48966	-.02011
<b>Total</b>	-1.68812	.09978	.22770	.10175	.43096	.27125	.07839	-.47829

**Table A-28****Standardised Residuals: DSM Diagnosis by RACE: 1990 – 1999**

Standardised Residuals: DSM Diagnosis by RACE: 1990 - 1999				
*DSM DIAGNOSIS	RACE			Total
	African	Coloured	White	
<b>MR</b>	-.037322	2.071321	-2.74526	-.711257
<b>LD</b>	.212836	.755624	-1.11734	-.148885
<b>ADHD</b>	-.604827	-.676990	1.21297	-.068847
<b>DD</b>	.915395	-.675089	.43259	.672892
<b>RP</b>	-.410224	-.840579	1.33172	.080919
<b>Total</b>	.075858	.634286	-.88532	-.175178

\* **MR** = Mental Retardation, **LD** = Learning Disorder, **ADHD** = Attention Deficit Hyperactivity Disorder, **DD** = Depressive Disorder, **RP** = Relational Problem.

**Table A-29****Two-Way Frequency Table– Social Class by DSM Diagnosis: 1990 – 1999**

Social Class	DSM DIAGNOSIS					Row
	MR	LD	ADHD	DD	RP	Totals: <u>N</u>
<b>P</b>	0	6	9	7	16	38
Row %	0.0%	15.8%	23.7%	18.4%	42.1%	
<b>SP</b>	10	18	14	7	46	95
Row %	10.5%	19.0%	14.7%	7.4%	48.4%	
<b>S</b>	14	31	15	28	49	137
Row %	10.2%	22.6%	11.0%	20.4%	35.8%	
<b>SS</b>	5	7	5	9	19	45
Row %	11.1%	15.6%	11.1%	20.0%	42.2%	
<b>US</b>	7	3	1	4	7	22
Row %	31.8%	13.6%	4.6%	18.2%	31.8%	
<b>UE</b>	3	2	2	5	7	19
Row %	15.8%	10.5%	10.5%	26.3%	36.8%	
<b>Total: <u>N</u></b>	39	67	46	60	144	356

**Social Class:** P = Professional, SP = Semi-professional, S = Skilled,

SS = Semi-skilled, US = Unskilled, UE = Unemployed, U = Unknown.

## A.8 Tables Related to Treatment Options

### A.8.1 Referrals

**Table A-30**

**Two-Way Frequency Table: Referral by Year**

<u>Year</u>	<u>Referred</u>	<u>% of N</u>	<u>N</u>
1990	6	7.7%	78
1991	8	7.4%	108
1992	6	9.2%	65
1993	14	17.2%	81
1994	7	12.1%	58
1995	7	11.1%	63
1996	10	17.2%	58
1997	5	10.6%	47
1998	11	22.4%	49
1999	3	7.5%	40
<u>N</u>	77	11.9%	647

## A.8.2 Other Treatment Options

**Table A-31**

**Two-Way Frequency Table: Year by Treatment Option: 1990 – 1999**

Year & %	TREATMENT OPTION							Total N
	Assess	Parents	Mother	Family	Therapy	Marital	CBT*	
1990	30	12	3	11	14	0	2	72
Row %	41.7%	16.7%	4.2%	15.3%	19.4%	0.0%	2.8%	
1991	20	19	3	29	24	1	4	100
Row %	20.0%	19.0%	3.0%	29.0%	24.0%	1.0%	4.0%	
1992	20	12	4	11	10	1	1	59
Row %	33.9%	20.3%	6.8%	18.6%	16.9%	1.7%	1.7%	
1993	17	10	5	22	11	1	1	67
Row %	25.4%	14.9%	7.5%	32.8%	16.4%	1.5%	1.5%	
1994	11	5	4	18	12	1	0	51
Row %	21.6%	9.8%	7.8%	35.3%	23.5%	1.9%	0.0%	
1995	22	5	2	16	11	0	0	56
Row %	39.3%	8.9%	3.6%	28.6%	19.6%	0.0%	0.0%	
1996	13	3	2	14	16	0	0	48
Row %	27.1%	6.3%	4.2%	29.2%	33.3%	0.0%	0.0%	
1997	11	1	1	10	19	0	0	42
Row %	26.2%	2.4%	2.4%	23.8%	45.2%	0.0%	0.0%	
1998	14	1	0	8	14	0	1	38
Row %	36.8%	2.6%	0.0%	21.1%	36.8%	0.0%	2.6%	
1999	12	3	0	5	16	1	0	37
Row %	32.4%	8.1%	0.0%	13.5%	43.2%	2.7%	0.0%	
<b>N</b>	170	71	24	144	147	5	9	570

\* CBT = Cognitive Behavioural Training.

## A.9 Tables Related to Duration of Treatment

**Table A-32**

**Number of Client Sessions: 1990 – 1999**

No. of Sessions	Count	Cumul. Count	% of all Cases	Cumul. % of All
1-9	448	448	69.2%	69.2%
10-19	152	600	23.5%	92.7%
20-29	31	631	4.8%	97.5%
30-39	9	640	1.4%	98.9%
40-49	5	645	0.8%	99.7%
Missing	2	647	0.3%	100.0%

## A.10 Tables Related to Dropout Figures

**Table A-33**

**Two-Way Frequency Table: Dropout by Year**

Year	Dropout: <u>n</u>	% of <u>N</u>	Clients: <u>N</u>
1990	9	11.5%	78
1991	20	18.5%	108
1992	10	15.4%	65
1993	16	19.8%	81
1994	4	6.9%	58
1995	10	15.9%	63
1996	12	20.7%	58
1997	6	12.8%	47
1998	6	12.2%	49
1999	10	25.0%	40
<b>Total <u>N</u></b>	103	15.9%	647

**Table A-34****Two-Way Table: DSM Diagnosis by Dropout**

DSM Diagnosis	Dropout: <u>n</u>
Mental Retardation	2
Learning Disorder	9
Communication Disorder	1
ADHD	8
Disruptive Behaviour Disorders	10
Elimination Disorders	3
Separation Anxiety Disorder	3
Schizophreniform Disorder	1
Depressive Disorders	4
Anxiety Disorders	4
Sleep Disorder	1
Adjustment Disorder	3
Relational Problem	26
Abuse or Neglect	3
Specified Family Circumstances	9
No / Deferred Diagnosis on Axis I or II	12
Specified Medical Condition on Axis III	3
School Readiness Assessment	1
<b>TOTAL: <u>N</u></b>	<b>103</b>

**Table A-35****Two-Way Frequency Table: Social Class by Dropout Rate: 1990 – 1999**

Dropout	SOCIAL CLASS						<u>N</u>
	P	SP	S	SS	US	UE	
<u>n</u>	13	24	39	15	4	6	101
Row %	12.9%	23.8%	38.6%	14.8%	4.0%	5.9%	

**Social Class:** P = Professional, SP = Semi-professional, S = Skilled, SS = Semi-skilled, US = Unskilled, UE = Unemployed. (U = Unknown omitted).

**Table A-36****Standardised Residuals: Intern Race by Dropout Client Race**

Intern Race	Race of Clients Dropping Out of Treatment			Total
	African	Coloured	White	
African	3.59556	1.509688	-.47863	4.62662
Coloured	-.85881	.222433	-1.59249	-2.22887
White	-1.29580	-.666901	.68348	-1.27922
Total	1.44095	1.065220	-1.38764	1.11853

**A.11 Tables Related to Treatment Outcome****Table A-37****Standardised Residuals: Outcome by Treatment Offered: 1990 - 1999**

Out- come	Treatment Options						Total
	Assess	Parents	Mother	Family	Therapy	Marital	
W	-1.1089	-.3942	.30308	-.18677	1.2158	1.25982	1.08880
U	5.6814	.4832	.22547	-2.35203	-4.04653	-.711675	-.720006
I	-4.52061	-.16298	-.669653	2.95688	2.45222	-.435079	-.379214
M	-1.89196	.47085	.955846	.39113	.77466	.613071	1.31358
R	-1.34411	.36472	.123261	.16951	.08096	3.81254	3.20688
O	-2.19972	-1.47569	.308290	-1.49686	4.63366	.235194	.004873
Total	-5.38383	-.71412	1.24630	-.51814	5.11084	4.77387	4.51493

**Outcome:** W = Worse, U = Unchanged, I = Improved, M = Maintained,  
R = Recovery, 0 = Ongoing.

## APPENDIX B

### INTERVIEW SCHEDULE FOR CGC STAFF MEMBERS

1. Please outline your personal involvement with the CGC over the years e.g., as student, lecturer, senior lecturer, director, etc.
2. The “crisis” in psychology which occurred during the 80s seems to have been experienced predominantly by the younger, more progressive psychologists of the time. What was your experience of, and response to the crisis? How has this affected the way you work now?
3. During this period the CGC is documented as having shifted from a conservative to a more progressive position. How, in your experience, has this affected subsequent CGC policy and training procedures?
4. Treatment trends have shifted over the years e.g., the emphasis on behavioural programmes in the 80s. What effect has the shift towards the community had on the training and treatments you offer?
5. A comparison of the client distribution in 1982 and 1992 showed that Africans were significantly under-represented in both years. In the past decade the percentage of African clients has ranged from 0% in 1990 to a maximum of 27.6% in 1997. How do you feel that the imbalance can most effectively be redressed?
6. The revised Maudsley which includes the “social history of caretaking nexus” and political affiliations of the client was formally introduced to the CGC in 1987 but there is still some speculation about its suitability for the client population seen in the Western Cape. How do you feel the document could be modified to meet these needs?
7. How do you see the future of clinical psychology in South Africa?
8. Do you have any other comments / insights to offer?

## APPENDIX C

### THE CLINICAL HISTORY AND MENTAL STATE EXAMINATION (ADULTS)

#### MAUDSLEY FORMAT

The headings and sequence should be followed, where possible, for the sake of uniformity and completeness. Facts and evidence should be stated in detail (even though negative) rather than abbreviated using technical terms. Subjective impressions and historical detail should not be mixed. If the history is taken from relatives or friends, the source should be noted. Do not collate into one the accounts taken from several informants.

#### COMPLAINTS OR REASONS FOR PRESENTATION NOW

A detailed, coherent, chronological account of the problem(s) from the earliest time change was noticed. Let the person tell his/her own story as far as possible. If there are several problem areas, each should be elicited in the same, orderly, way. Be sure to include information about previous treatment or consultations - dates and whom consulted.

#### FAMILY HISTORY

**Father and Mother:** Note date of marriage, and ages at the time. Ages now, names, occupations, health. If illness is present, date this. If dead, give the date, age at time and cause. Whereabouts at present? Personality?

**Siblings:** List in order of birth, with given names, ages, marital status, occupation, personality, health. Include any miscarriages or stillbirths plus dates in the list.

**Home Atmosphere:** Salient happenings between parents, siblings, during the client's early years. Emotional relationships within the family? Note here the periods when other persons lived with the family and details about such persons.

**Social Position and General Efficiency of Family:** Communication skills, class, position, financial details, stresses?

**Familial Diseases:** Physical or mental handicaps, congenital diseases, epilepsy, alcoholism, etc., including details of 'nervous breakdowns'.

## **PERSONAL HISTORY**

**Pregnancy & Birth:** Planned birth? Date and place born. Mother's condition during pregnancy. Full term? Normal delivery? Breast/bottle fed?

**Early Development:** Delicate/robust baby? Problems in infancy (e.g., crying, feeding, sleeping)? Early health? Milestones - teething, talking, walking, toilet training – ages. Primary caregiver?

**Neurotic Symptoms in Childhood:** Sleepwalking, night terrors, tantrums, bed-wetting, soiling, thumb-sucking, nail-biting, food fads, stammering, mannerisms, fear states, 'model' child?

**Health During Childhood:** Note ages - infections, accidents, hospitalisations.

**Schooling:** Nursery school/creche? Age began primary school? Age leaving school and standard achieved? Details of special abilities and failures or problems. Hobbies, sports, interests. Peer relations.

**Menstrual History:** Age of menarche, own reactions and those of family? Regularity? Problems? Date of last period?

**Sexual Inclinations & Practice:** Where first information obtained, in what form. First sexual feelings. Masturbation - age commenced, frequency, attitudes (own and parents). Sexual fantasies. Prudery. Homosexual encounters or history. Heterosexual relationships (apart from marriage).

**Occupations:** Since leaving school, in chronological order, giving wages, dates, reasons for change. Satisfaction in work? Present economic circumstances. Ambitions.

**Marital history:** Length of courtship and acquaintance. Spouse's age, occupation, personality, previous marital history and children. Compatibility? Mode and frequency of sexual relating. Sexual satisfaction? Impotence/frigidity? Contraceptive measures - past and present, with dates.

**Children:** In birth order, listing names, date of birth, personality, problem areas considered significant. Also list miscarriages and stillbirths, giving dates.

**Habits:** Use of alcohol, tobacco, drugs - specify amounts per day or week, at present and in the past.

**Previous Mental Illness:** (Or psychological problems). A detailed account is required - dates, symptoms, duration. If treated, where and by whom, giving dates.

**Medical history:** Illnesses, accidents, operations. List chronologically and in detail, with dates.

### **PERSONALITY BEFORE PRESENT ILLNESS/PROBLEMS**

Do not be content with a few adjectives or epithets. Aim at a quite full picture of the person and their lifestyle, using the following as a guide. Sources other than the patient/client may be used.

**Social relations:** Family, friends, groups, work and colleagues, leader or a follower?

Socially active or not. Aggressive, submissive, easy to adapt, etc.

**Intellectual activities:** Books - preferences, plays, movies - noting preferences.

Memory, observation, judgement, critical faculties.

**Mood:** Cheerful, despondent, anxious, worrying, optimistic, self-confident, satisfied, stable or fluctuating (if the latter: with or without reason?), controlled, demonstrative, etc.

**Character:** Shy, sensitive, timid, suspicious, resentful, quarrelsome, irritable, impulsive, jealous, selfish, self-centred, reserved, self-conscious, fussy, strict, rigid, critical of others.

**Standards:** Moral, religious, social, economic, practical. Attitude towards self and others, attitude to body. Interests and ambitions.

**Energy:** Plentiful, sustained or fitful output, easily fatigued, etc.

**Fantasy life:** Frequency and content of daydreams. Recurring dreams. Access to own dream material.

**Habits:** Eating fads, regularity. Sleeping habits. Regular excretion, or problems?

### **PSYCHIATRIC STATE**

**General Behaviour:** Give a description as complete, accurate and lifelike as possible, of what you observe in the patient's behaviour, especially anything abnormal. If the patient does not speak, the description of his/her mental state may be limited to a careful report of his/her behaviour.

**The following points may be considered, though not exclusively:**

1. Does the patient look ill?
2. Is he/she in touch with his/her surroundings in general and in particular?
3. Relationship to other patients, to the nurse, to the doctor who examines and treats him/her?
4. Response to various requirements and situations? Gestures, grimaces or other motor expressions? Tics, mannerisms?
5. Much or little activity? Is it constant, abrupt, or fitful? Spontaneous or provoked? Free or constrained? Slow, stereotyped, hesitant, or fidgety?
6. Tenseness, scratching or rubbing? Do movements and attitudes have an evident purpose or meaning?
7. Do real or hallucinatory perceptions seem to modify behaviour?
8. Eating, sleep habits, cleanliness in general?
9. Way of spending the day?

**Talk:** Concern with the patient's utterances rather than the content. Does he/she say much or little, talk spontaneously, or only in answer, slow or fast, hesitantly or promptly, to the point or wide of it, coherently, discursively, loosely, with interruptions, sudden silences, changes of topic, comments on happenings and things at hand, appropriately, using strange words or syntax, rhymes, puns? How does the form of his/her talk vary with its subject?

**Sample of Talk:** Conversation should be recorded with your remarks on left side of page, and patient's on right. It should be representative of the form of the talk, responses to questioning and main preoccupation of the patient. Its length will depend on its individual significance.

**Mood:** The patient's appearance may be described as far as it is indicative of his/her mood. His/her answers to, "How do you feel in yourself?" "What is your mood?" "How about your spirits?" or some similar inquiry should be recorded. Observe the constancy

of the mood, the influences that change it, and the appropriateness of the patient's apparent emotional state to what he/she says.

Moods include such states as depression, anxiety, irritability, suspicion, fear, worry, restlessness, bewilderment, etc.

**Delusions and Misinterpretations:** The patient's attitude to the various people and things in the environment. These matters may be complicated or concealed and may need inquiry.

Does he/she misinterpret what happens, give it special or false meaning, or is he/she doubtful about it? Does he/she think anyone pays special attention to him/her, treats him/her in a special way, persecutes or influences him/her bodily, or mentally, in ordinary or scientific or preternatural ways? Laughs at him/her? Admires him/her? Tries to kill, harm, or annoy him/her? Does he/she depreciate him/herself in any regard, his/her morals, possessions, or health? Has he/she grandiose beliefs?

**Hallucinations and other Disorders of Perception:** These may be auditory, visual, olfactory, gustatory, tactile, or visceral. The source, vividness, reality, manner of reception, content, and all other circumstances of the experience are important, the content, especially if auditory or visual, must be reported in detail.

**Compulsive Phenomena or Obsessional Thoughts, Impulses, or Acts:** Are they felt to be without, or part of the patient's own mind? Does their insistence distress him/her? Does he/she recognise their inappropriateness? What is their relation to his/her emotional state? Does he/she repeat actions, such as washing unnecessarily to reassure him/herself?

**Orientation:** Record the patient's answers to questions about his/her own name and identity, the place where he/she is, the time of day, and the date.

**Memory:** This may be tested by comparing the patient's account of his/her life with that given by others, or examining his/her account for gaps or inconsistencies. Do not merely record the conclusion reached but give the evidence first, in full, and describe at appropriate length such facts of behaviour as seem to indicate whether he/she was attending, trying his/her hardest, being distracted by other stimuli, etc. Inquire especially about recent events such as those of admission and happenings in the ward. Where there is selective impairment of memory for special incidents, periods, recent or remote happenings, this should be recorded in detail, and the patient's attitude towards his/her forgetfulness and the things forgotten specially investigated.

**Memory Tests:** Record the patient's success or failure in grasping, retaining, and being able to recall spontaneously or on demand three or five minutes later a number, a name and address, or other data. Give the patient the "Cowboy" or "Donkey and Salt" to read and ask him/her to repeat it in his/her own words: record his/her repetition of the story verbatim if possible, and say whether he/she sees the point of it. See how many items of the Logical Memory Test he/she can repeat immediately, and how many after an interval of five minutes. Give him/her digits to repeat forwards, and then others to repeat backwards, and record how many he/she can repeat immediately after being told to him/her.

**Attention and Concentration:** Is attention easily aroused? To test concentration, ask him/her to tell the days or months in reverse order, or to do simple arithmetic problems requiring "carrying over" (112-25), subtraction of serial sevens from 100 (give answers and time taken).

**General Information:** Test for general information and grasp should be varied according to the patient's educational level and his/her experience and interests. The following are useful questions:

1. Name of the State President and his immediate predecessors?
2. Six large cities in South Africa?

3. Capitals of France, Germany, Italy, Spain, Scotland?
4. Date of beginning and end of the last war?

**Intelligence:** Try to assess the patient's intelligence, using what you know of his/her background, his/her general knowledge and his/her ability to reason. I.Q. tests can be done later.

**Insight:** What is the patient's attitude to his/her present state? Distinguish between "course" and insight, i.e., just knowing that his/her distressing feelings or experiences are due to illness, and the more discriminate type of insight which shows a deeper understanding of what the symptoms are about, knowledge of conflicts and underlying fears, etc.

Does he/she regard it as an illness, as "mental" or "nervous", as needing treatment? Is he/she aware of mistakes made spontaneously or in response to tests? How does he/she regard them and other details of his/her condition? How does he/she regard previous experiences, mental illnesses, etc?

**Judgement:** What is his/her attitude towards social, financial, domestic, ethical problems? Is his/her judgement good? What does he/she propose to do when he/she has left the hospital?

### **FORMULATION OF CASE**

Following the history taking and the mental state examination, all significant available data are summarised and collated in order to reach a rational understanding of what is happening – i.e., to form a working hypothesis upon which further decisions can be based. Aim at concise relevance so that the salient features are easily grasped.

**Identifying Data:** Name, age, sex, occupation, social class, and marital state.

**Manner of Presentation Now:** Briefly summarise problems/symptoms and duration, and previous treatment if any, and note by whom referred.

**Highlights of the History and Examination:** In a few sentences, and in the same order as elicited, summarise the salient features of the history and mental state examination, noting etiological factors (hereditary and congenital possibilities, early and later environmental influences, personality structure and characteristic reaction patterns to common stresses, ego defenses, physical illnesses).

**Psychodynamic (Or other Theoretical) Understanding of Problem:**

**Differential Diagnosis:**

**Working Plans:**

**1. Immediate Management / Further Investigations:**

**2. Long Term:**

- Client/patient - therapy, medical
- Social - family and vocational

(Take account of person's strengths and weaknesses and also those of his/her environmental, social and occupational context and of treatment facilities.)

**Prognosis:** (Note reasons.)

*Modified from UCT Department of Psychiatry outline  
1982*