THERAPY AT THE UCT CHILD GUIDANCE CLINIC: AN INVESTIGATION INTO THE PRACTICE, UTILITY AND APPLICABILITY OF INDIVIDUAL PSYCHOTHERAPY IN THE LOCAL CONTEXT

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A minor dissertation submitted in partial fulfillment of the requirements for the award of the degree of Master of Arts in Psychology (Clinical) in the Department of Psychology, University of Cape Town

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2010

TABLE OF CONTENTS

ABSTRACT

Individual psychotherapeutic interventions conducted at the UCT Child Guidance Clinic between 2000 and 2009 were investigated with a view to offering informed conclusions on the current nature of clinical practice at the Clinic. Assuming an ecodevelopmental perspective with regards to mental health that explicitly acknowledges the potential impact of social context on individuals' lives the present research's focus centres on the role of socio-economic class and sex differences specifically on work at the Clinic. The broader influence of shifting political, historical and pedagogical contexts on such work is also explored. The 156 individual case files that make up the sample were reviewed and a broad range of clinical information was collated including data on clients' demographics, their presenting difficulties, the case formulations and intervention strategies employed as well as on clients' apparent clinical outcomes. In line with the descriptive and exploratory nature of the research design statistical analysis began with broad pivot table analyses and was followed by more focused Chi-squared analyses with key variables. Results indicated that the Clinic has shifted to working predominantly with socio-economically poorer classes over the past decade and that clients' social class had little or more likely no effect on clinical outcomes. Indeed the majority of clients in the sample were accorded positive outcomes upon termination despite a significant proportion of female clients specifically reporting histories of childhood sexual abuse and other trauma. Trainee clinicians at the Clinic appear to manage well, achieving generally positive clinical results over relatively short time frames despite their clinical inexperience and clients' often severe presenting difficulties. This attests both to the quality of the work being done at the UCT Child Guidance Clinic as well as to the power of individual work more generally to unlock individual potential in the local context.

DECLARATION

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

Signature: | Signed by candidate | Date: _____

ACKNOWLEDGEMENTS

CHAPTER ONE
INTRODUCTION

The conscience of the community will awake and remind it that the poor man should have just as much right to assistance for his mind as he now has to the life-saving help offered by surgery; and that the neuroses threaten public health no less than tuberculosis and can be left as little as the latter to the impotent care of individual members of the community.

(Freud, 1919, p. 166)

The present research aims to provide a clear picture of individual psychotherapeutic work done at the UCT Child Guidance Clinic (CGC) over the past decade. In so doing a broad assortment of information on the nature of clinical practice at the CGC will be offered together with an investigation into the applicability and utility of such work both at the CGC as well as by extension in the local Western Cape and South African context. In this endeavour, an overarching goal is also to scrutinize and offer some informed conclusions on whether individual work has the power to unlock individual potential no matter where or with whom it may be.

A detailed investigation of individual psychotherapy client records at the CGC was undertaken in order to identify the types of clients and presenting problems that are seen at the Clinic, the formulations that are used to conceptualise clients and the interventions embarked upon. Such analyses will, it is hoped, yield more information about the relevant interpersonal and professional issues that doing individual psychotherapy in the Western Cape and other similarly socio-economically complex contexts brings up. It seems likely that contextual factors relating to both clients and clinicians at the CGC will have at least some influence on psychotherapeutic interventions and clinical outcomes. Research is, however, needed in order to better elucidate the ways such factors may affect local psychotherapeutic encounters.

The CGC may be said to be a somewhat unusual example of individual psychotherapeutic practice, at least in so far as it is unlike the many private practice settings in which individual work is done locally. The accommodating sliding scale policy towards payment for sessions

present at the Clinic for example explicitly acknowledges the difficulty some CGC clients might have in paying normal medical aid and private practice rates (Melvill, 2000). Whether this increased affordability for poorer clients has a measurable impact on who is seen at the Clinic remains to be seen but it is this arguably quite unique and inclusive policy towards a variety of socio-economic classes that makes the Clinic an interesting subject of research in our local context. The CGC thus potentially affords the present research with an especially pertinent setting in which to investigate the practice, utility and applicability of individual psychotherapy in the complex local context more broadly.

Social development is the focus of both considerable resources and academic and professional expertise in South Africa (Seekings & Nattrass, 2005). Such a focus is obviously appropriate and crucial given the dire socio-economic position of the majority of this country's people. However, while public debate and protest rages on in particular about housing, municipal service delivery and infrastructure development less public attention appears to be given to the more personal, individual and broadly psychological needs of disadvantaged communities. While infrastructural development, education and job creation are undeniably priorities for social development in South Africa the potential for individual psychotherapeutic practice specifically to also assist in social development appears to remain largely unarticulated.

This may be due to the elitist and expensive associations that individual work continues to have for many of us, including policy makers. That it does still occupy a relatively elitist position in South Africa and abroad is undeniable; a fact underlined by the inaccessibility to individual work that many potential clients are likely to face due to its high service fees. That individual psychotherapy is available at more affordable rates in some public health care settings and community clinics including the UCT CGC stands as an important example of the potential for psychotherapy to help a greater range of individuals than just those who can afford private practice rates. Unfortunately, such professional resources in the state sector are widely recognised as being insufficient to address the tremendous needs of the South African population as a whole (Freeman & Pillay, 1997; Gibson, 2000).

Changing social and political contexts have arguably exerted considerable influence on South African psychotherapy over the past few decades especially. The present research then sets

out to ascertain the extent to which current calls for urgent social development and transformation in this country are being heard at the CGC, taken as it is in the present research as an example of individual psychotherapeutic practice in the larger local context. Furthermore, the nature and utility of the individual work being done by trainee clinicians in the context of the Clinic will be investigated with a view to offering conclusions on the applicability and potential of psychotherapy both at the CGC and in the local context more broadly.

LITERATURE REVIEW

The following chapter offers an overview of literature and thinking that is directly relevant to the present research. As such, an attempt is made first to present the current situation within which clinical psychology finds itself in South Africa, along with a discussion of pertinent issues this position brings up. Before continuing, the theoretical stance taken by the author is described. Following this is an account of the history and workings of the UCT CGC and subsequently, of other similar community clinics as well. Focus is then given to literature pertaining to the pedagogical context of the Clinic as well as to the role of case formulations in training clinical psychologists. The literature review concludes with a discussion of psychotherapeutic evaluation.

Mental Health and Psychotherapy in the South African Context

The Social, Economic and Racial Context of South African Psychotherapy

It is important to consider psychotherapy clients' societal contexts in South Africa because of the significant economic inequality and past political oppression borne by African, Coloured and Indian race groups in this country. Indeed Long (2002) writes, "psychoanalysis can only be used effectively in community settings when it explicitly recognises socio-political influences and includes these in the object-worlds of our clients" (p. 113). Added to this, according to Pillay and Peterson (1996) mental health care in South Africa has historically been directed towards the needs of the White and wealthy population, while being both beyond the reach of and supposedly inappropriate for the majority of South Africa's population. Clearly then, for a complete and accurate picture of individual psychotherapy at the UCT CGC to be offered in the present research, it needs to be properly contextualised within the relevant social, economic and political spheres it has occupied and continues to occupy.

Although in many ways an obvious observation to make, it remains important to appreciate that a person's socio-economic, cultural and political position has the potential to influence their lives pervasively, including their mental health. An appreciation of the impact of such macrosystemetic factors on individual and societal wellbeing has given rise to the burgeoning field of social development studies (Haynes, 2008). Psychological research has played a part in the growth of this field in part through articulating the interplay between human developmental trajectories and the social context. Louw, Donald and Dawes (2000) for

example write with regards to social development that "practical interventions will be strengthened if they build on existing knowledge of children's development" (p. 244). Acknowledging the potentially powerful impact of social and historical context on communities and individuals' development goes some way to acknowledging the playing fields of life are not fair and in so doing provides a more comprehensive conception of individual psychology and mental health.

Vygotsky (1978) also wrote on the subject of social context and human development and argued that a person's level of functioning generally will depend to a large degree on the kinds of opportunities and upbringing we receive in our lives. The opportunity to have a good quality education for example is arguably for the most part dependent on the socio-economic class of one's family. The fact then that the quality of one's education plays a critical role in our future employment or career prospects underlines the key and pervasive influence of socio-economic class. For Vygotsky, the influence of such socio-economic contexts is crucially important to bring to bear in psychological conceptualisation of the development and workings of higher mental functions (Wertsch, 1985). By extension, the influence of contextual factors would arguably also need to be considered in assessment or debate on the mentally distressed individual where mental functioning has to some extent gone awry. By drawing on such social developmental and contextual perspectives in the present research, an attempt is made to acknowledge the potential influence of relevant socio-economic, historical and political contexts on individual psychotherapy at the CGC.

In a similar vein, Maslow (1970) famously characterised human motives as a hierarchy of needs, arranged by fundamental priority, culminating in the need for self-actualisation. Such a model is pertinent to the South African context where contextual factors including poverty, violence, HIV/AIDS and unemployment relate to the basic physiological and security needs of the population and according to Maslow, would need to be adequately dealt with in order for people generally to progress towards prosperity, mental health and self-actualisation. Such views of mental health properly ground it in the very difficult social reality within which individual psychotherapy in South Africa operates.

Seekings and Nattrass (2005) argue that "the primary basis of inequality shifted from race to class under Apartheid" (p. 236) and that according to their in-depth analysis of censuses

conducted in the 1990s class was positively associated with satisfaction with life, children's health and adult health, more so than race categorisations were. They go on to suggest that the significance of class in South African society has not been adequately explored "probably because of the understandable national obsession with race" (p. 270). The present research then, while still acknowledging the significance of race in this country attempts to further understanding of the influence socio-economic class specifically on mental health and psychotherapy.

Seekings and Nattrass further describe how following the end of Apartheid "interracial inequality continued to decline but intraracial inequality continued to grow" (p. 340). Interestingly Melvill (2000) also found intraracial economic disparity had increased in her study of the CGC client profiles in the 1980s and 1990s. For Seekings and Nattrass it has been the political focus on race to the exclusion of class in South Africa that has in part allowed social and economic inequality to continue. However, Wilson (2004) who writes on race and class in African American populations takes issue with such arguments that focus on socio-economic stratification while implying a declining significance of race in society. For Wilson race remains a stumbling block to development for many disadvantaged communities within which race more than any other demographic variable continues to be a defining characteristic.

In South Africa, race and socio-economic status have been and continue to be closely linked and appear in turn to be linked to the manifestation of psychological distress. The link between race and social class is well established in the local literature (Dawes & Donald, 1994; Maw, 1996; Melvill, 2000; S. Swartz, 2007) with Melvill (2000) going as far as to call it "incontrovertible" (p. 56). Indeed Melvill found that race and class were statistically very closely related in client populations at the CGC during the 1990s.

It can, however, still be argued that the broad and long-term effects of the Apartheid era's segregated under-development generally continue to be experienced today in the same communities initially targeted first and foremost according to their racial and cultural profile. Establishing whether these long-term effects of Apartheid, like pervasively low socio-economic status in certain communities for example still impact on mental health in these same South African communities has been an important first step towards providing

appropriate intervention strategies. Strebel and Msomi (1999) for example conclude from their extensive epidemiological study of Western Cape psychiatric patients that "the demographic profile of the sample reflects clearly the history of racial and gender inequalities in South Africa (as well as the specific socio-economic dynamics of the region), which might contribute to particular psychological vulnerabilities" (p. 59). The authors also found that significant differences remain with regard to psychiatric diagnosis and management across racial and gender categories. As S. Swartz (2007) has noted, "in South Africa relatively long-term therapies remain a middle-class, often white, luxury commodity" (p. 180). The extent to which such uneven patterns in clients' demographics, presenting problems, diagnoses and treatment continue today and are demonstrable in data from the past ten years at the CGC is a key aim of the present research.

In a similar articulation of the often implicit and negative influence of race categorisation and racism on mental health, Franklin-Jackson and Carter (2007) investigated the relationship between racial identity, mental health outcomes and reported stress in a sample of the African American population. The authors found that both participants' racial identity and level of perceived race-related stress had a significant negative impact on their mental health score. The authors concluded that "race-related stress influences mental health outcomes" (p. 20) and further contended that "a person's racial identity must be considered when understanding race-related stress and mental health" (p. 5). Thus, apart from larger structural forces that historically initiated and perpetuated structural inequality the subtle psychological impact of negative race-related identity formation also has to be factored into understandings of such historically marginalised population groupings' mental health.

It can also be argued then that the local historical context of psychiatry and its relation to politically and socially sanctioned racism is relevant to a discussion of psychotherapy in South Africa today. Any research into current socio-political and economic influences on mental health has to acknowledge the pervasiveness of historical social inequality seen in South Africa. Swartz and Ismail (2001) plotted the historical emergence of the Antisocial Personality Disorder diagnosis in the early twentieth century in South Africa and note that White men of the time in particular were far more likely to be diagnosed with 'psychopathic personality', the forebear of Antisocial Personality Disorder, than African or Coloured men were. This is, according to Swartz and Ismail because the category was used selectively on

the basis of race, with White men more likely to be seen as mentally ill and African and Coloured men more likely to be seen as criminals and thus directly incarcerated. Drawing from this example at least it can be said that race has clearly served a critically important role in informing the way clients have been conceptualised and treated from the very beginning of mental health work in South Africa.

While an acknowledgement of the direct influence of historically racist political structures on mental health in South Africa is essential to the present discussion, the influence of class is perhaps equally or even more important to articulate, given its pervasive and universal influence across and within all demographic groupings including those constituted primarily along racial grounds. It has for example been argued in the international literature that dysfunctional homes and inappropriate socialisation and parenting styles increase the likelihood of children from socio-economically deprived contexts becoming antisocial (Sutker, Bugg & West, 1993). Given the already reportedly close association between race and class in South Africa such findings are as relevant to an investigation of race differences in mental health as they are to a discussion of class differences. Supporting Sutker et al.'s argument Lahey et al. (1998) found that clients diagnosed with Antisocial Personality Disorder for the most part came from homes where discipline was inconsistent or abusive and in which parents themselves had antisocial traits. While such pathological individual and familial dynamics are difficult to identify as having political and social-economic origins such research arguably goes some way to identifying mechanisms whereby larger structural forces shape individual mental health.

Interestingly the risk factors that are associated with an increased likelihood of an individual being abused either physically or sexually includes poverty, as well as parents' poor working models of the self and self-other relationships (Engeland, Jacobvitz & Sroufe, 1988). Thus, coming from a socio-economically disadvantaged background and having poorly socialised or educated parents potentially increases the risk to children of having psychically devastating and abusive experiences that are likely to inflict damage to their later mental health. This again highlights the fundamental yet subtle influence of socio-economic context on mental or emotional development as well as the importance of this influence being properly acknowledged.

There is also growing evidence that low familial socio-economic status predicts later substance use disorders in adolescents (Kaplow, Curran & Dodge, 2002). Considering the widely held view that substance use has an adverse impact on mental health and general well-being such a finding may be said to both confirm that low socio-economic status impacts mental health negatively and suggest that any intervention aimed at reducing or stopping substance use would be beneficial to poorer individuals and their communities.

In a similar vein, Dishion, Capaldi and Yoerger (1999) found that socio-cultural disadvantage coupled with stress at the time of or near the time of birth was a significant risk factor for later substance abuse in those same children. Interestingly, however, Dishion et al. also found that pathological family dynamics and interaction patterns were better predictors of later substance abuse than purely socio-economic factors were. Nonetheless, the authors also acknowledge that the ecological and specifically socio-economic context may impact adversely on family interactions indirectly. Familial interactions that were found to be most predictive of later adolescent substance abuse and alcohol abuse included verbal or physical abuse and erratic disciplining. Supporting this latter assertion Kilpatrick et al. (2000) concluded from their large sample of adolescents that child maltreatment including sexual and physical abuse and neglect pose a significant risk for later substance use disorders. While poor parenting competency should not be automatically associated with lower socio-economic classes it appears that there is a complex association between later substance use, alcoholism, poor parenting or abusive parenting and low socio-economic status.

The degree to which such socially contextual perspectives have gained ground in both psychotherapeutic thinking generally and in psychotherapeutic practice is evidenced in a recent and extensive survey study that examined the relationship between clients' race and ethnicity, clinicians' social and professional characteristics and the diagnosis accorded (Hsieh, Kirk, Pottick & Tian, 2007). The authors found that the large majority of clinicians did not diagnose a mental disorder when they perceived the problem to be in part exacerbated by adverse environmental conditions. This suggests then that in clinical practice today clients' presentations may often be understood from a contextual or ecological perspective and also by implication that such a perspective is widely seen as the most appropriate.

The Influence of Sex and Gender

Quite apart from socio-economic status and race, gender also remains an especially value-laden social category that exerts influence in many spheres of people's lives. Hartung and Widiger (1998) for example note that "most of the mental disorders diagnosed within the DSM-IV do appear to have significant differential sex prevalence rates" (p. 271). Recently Wesely (2006) has argued that women are far more likely to experience "sexual, emotional, and physical violence; degradation; social exclusion; and economic vulnerability" than men are (p. 324). She goes on to say that women's unequal social position and their associated accumulated victimisations "set them up for social, emotional, and behavioural deficits" (p. 325). The present research then attempts to ascertain the extent to which this is true within the CGC sample and by extension; the local population it caters to.

However, it is crucial to note that feminist and post-structuralist viewpoints query the concept of distinct and mutually exclusive sex and gender categorisations (Butler, 1993, 1997; Fuss, 1989). Thus any so-called essential or actual sex or gender differences in relation to mental health that might exist are understood to be very difficult to disentangle from the influence of gender socialisation that both clients and clinicians have generally been exposed to.

Reviewing literature on sex differences with regards to DSM axis II diagnosis Widiger and Samuel (2005) found evidence of significant sex differences in diagnosis rates with more men presenting with antisocial traits and more women presenting with borderline traits for example. There is also considerable evidence that males are at greater risk of exhibiting substance abuse disorders than females are (Bray, Adams & Mc Queen, 2003). Establishing the reason for these apparent sex and gender differences has "been among the more difficult and heated diagnostic issues" in mental health research (Widiger & Samuel, 2005, p. 283). In addition to an actual biological or fundamental neuropsychological difference between the sexes, researchers have offered a number of alternate explanations for these gender differences, including allegations of sex-bias in the DSM diagnostic definitions and criteria, as well as gender-biased attitudes in clinicians. The present study aligns itself with the post-structuralist explanation exhorted by for example Butler (1997) and Fuss (1989) that clients themselves may internalise sex and gender norms present in society and that this may indirectly account for different sex prevalence rates. However, it is important to acknowledge that there is still little consensus in the literature on the underlying reasons for such sex

differences (Nolen-Hoeksema & Girgus, 1994). Any sex or gender differences potentially present in the CGC sample will have to be considered with all of the above perspectives in mind.

Apart from questions around their seemingly racist heritage it has also been argued that psychiatric hospitals in the Western Cape have a long history of institutionalised sexism, evident in gender-biased diagnoses for example (Durrbaum, 1998). Such evidence of historical structural discrimination in the local context has to be brought to bear on the present discussion of potential sex differences in relation to mental health if a fair and balanced description of the situation here today is to be offered. Indeed it is arguably crucial to ascertain whether similar historically and socially embedded patterns continue to exist if progress is to be made in improving the social benefit of clinical practice.

Shelmerdine (2001) for example examined patient records at Valkenberg Hospital from the 1930s and found evidence of sex differences in diagnosis rates that suggests women were more likely to be given diagnoses relating to manic and depressive symptomotology while men were more likely to be given schizophrenia spectrum diagnoses. Shelmerdine contends that "these findings are probably explainable in terms of the prevailing stereotypes of women as more emotional than men, and of the fact that women were, through these stereotypes, socialized into being more emotional" (p. 11). This research highlights the apparently sexist early history of psychiatric practice in the Cape as well as more generally the apparently long-standing and far from neutral influence of prevailing social and political ideologies on local work with psychically distressed individuals.

Broadening the discussion to population groupings that have both race and sex related demographic characteristics which together potentially invite unique marginalisation in our society Spangenberg and Pieterse (1995) have identified the often-significant influence of poor socio-economic context on the mental health of black South African women specifically. They found that stress related to socio-economic factors, especially low incomes, had a stronger negative effect on African women's well-being than stressful events of a more personal nature generally had. It is perhaps true to say then that while Apartheid-era segregation policies have fallen away both socio-economic class and race continue to be salient factors affecting women's' mental well-being and future prospects. Added to this

recognition of the influence of the social and economic is an implicit acknowledgement of the importance of articulating the contributing influence of gender and sex difference to people's social and mental lives.

Local Perspectives and Debate

As much as gender and socio-economic status are arguably essential contextual factors to consider when looking at psychotherapeutic practice as a whole in South Africa, focus must also be given to the academic discourse that has arisen in response to the uniquely local challenges and dilemmas facing the psychotherapeutic profession today. Berg (2009) for example has written on the question of psychoanalytic theory in contemporary South Africa and advocates the need for an appraisal of the applicability of psychoanalytic theory to our specific context. Berg further argues that the practice of psychoanalysis is threatened by managed health care and biological psychiatry and as such open debate around its applicability here can only strengthen its legitimacy. She writes, "our colleagues rarely challenge the theoretical and technical underpinnings of psychoanalysis, even though when specifically asked in private, considerable doubt is expressed about the applicability of some of the notions of psychoanalysis in an African cultural setting" (p. 108).

Berg highlights a number of pertinent issues she sees as needing thought and debate, like for example; the universality of psyche, the question of understanding cultural difference in psychoanalytic theory and the role and meaning of tradition and culture in this country. In a similar vein Ngonyama ka Sigogo et al. describe their commitment to "the ideal of developing a truly South African community psychology" (p. 88). One that embodies "a reverence for theory and application and sometimes . . . what we believe to be a healthy irreverence for both" (p. 88). Even just that perspectives like Berg's and those of Ngonyama ka Sigogo et al. are coming up in academic discourse in this country is important to acknowledge in this discussion of the South African context of psychotherapy as they exemplify the more culturally inclusive and broadly contextual viewpoint apparently present in South African psychotherapeutic discourse today.

Likewise Lazarus and Kruger (2004) have written on the applicability of psychodynamic work with children in low-income South African communities specifically. For Lazarus and Kruger, "psychoanalysis holds that while we live in a social context, the social context also

lives in us, in powerful ways that need to be reckoned with" (p. 49) and as such the social context becomes an integral and important aspect of individual presentations. The authors also argue that the individual's natural internalisation of their social context is accounted for implicitly in a number of major theoretical perspectives, including for example attachment theory and object relations. For them "a depth psychology could provide a rich description of internal life and its reciprocal relationship to social context" and in so doing can also "provide tools for the therapist, the supervisor and the consultant to conceptualise and work with the complex feelings evoked by community child work" (p. 66). If psychoanalytic and psychodynamic theory can indeed be used to account for the impact of the social on individuals the utilization of such theory in case formulations would be important to explore in the present research which aims to examine this proposed influence of the social on individual psychotherapy generally. Moreover, the extent to which social class and context are considered in case management would also be useful to ascertain.

The degree to which 'mainstream' and Western psychotherapeutic theory and intervention strategies are applicable or acceptable in the South African context has been the subject of some debate locally. Kagee and Price (1994) for example have argued, "Euro American mainstream models of psychological intervention have limited value in the context of South African apartheid" (p. 91). Such models Kagee and Price contend are grounded in an individualist ideology that implicitly excludes the social, economic and political contexts from consideration as also exerting influence on behaviour. The authors underline the especially significant role Apartheid-era political and social oppression has had on individuals in South Africa and how this historical context continues to exert considerable influence on people's lives and their mental health. For Kagee and Price individual psychotherapy's focus on the intra-psychic falls short of the needs of the South African population. They conclude that alternative models of intervention are required that explicitly include and acknowledge the impact of social, economic and political histories and contexts on individuals lives. Considering this, the extent to which individually orientated psychotherapy has any utility to South African clients from previously disadvantaged populations or who are socio-economically poor would be important to ascertain.

Kagee (2006) further contends "if South African clinical psychology is to make itself relevant to the needs of contemporary society, it needs to abandon non-falsifiable theoretical tenets

and adhere more vigorously to the criteria of evidence when dispensing clinical services" (p. 233). It is this common critique of individual psychotherapy's evidence base that the present research attempts to address in part by providing some evidence of local clinical outcomes at the UCT CGC.

Theoretical Approach

This research will assume an ecodevelopmental perspective with regard to clients' distress, in which the importance of "multiple sources of simultaneous influence on a particular outcome" is generally emphasized (Duclos, Goodyear, Locke & Newcomb, 2007, p. 137). According to this model, CGC clients' mental distress can be understood as potentially arising from multiple influences. Such a perspective may also be said to be aligned with histories that embrace a contextualist approach to psychological practice, such as Hay's 1990 research on the CGC.

Dawes and Donald (2000) argue that "in South Africa, millions of children live in urban poverty environments that are powerful predictors of negative psychological outcomes" (p. 17). In keeping with this conception of the contextual underpinnings of psychological wellbeing Dawes and Donald propose that an ecological-transactional orientation helps to properly acknowledge the "central influence" of children's developmental contexts in "the formation of their psychological capacities" (p. 3).

Bronfenbrenner (1986) stressed the importance of context on human development, outlining how a person's character, their styles of interaction in their family as well as their social contexts generally, all interact to influence their psychological development and wellbeing. Added to this, is the notion of multiple, overlapping social systems constantly operating and exerting influence on the individual, including the microsystem of the family and the macrosystem of the country for example. Sameroff (1991) added to this ecological viewpoint by emphasizing the transactional nature of personal development in which the child's own developmental stage will also have an influence on the nature of their interaction with contextual or systemic factors. Thus while focus is given to the impact of social context on the individual this in no way suggests the developing individual is completely powerless to grapple with and negotiate their way out of such adversity. Indeed, it is arguable that it is precisely this individual potential that psychotherapy specifically can help to harness and

realise.

Nonetheless Peterson (1998) explains that a critical perspective towards psychology and mental health explicitly recognises the influence of the social structures that "pattern interpersonal relationships, shape social behaviour, generate social meanings and condition collective experience" (p. 8). The critical and post-structuralist theoretical viewpoint in psychology places the onus of psychological understanding and intervention on societal factors rather than on the individual's role alone. In fact Collins (2004) argues that the very notion of the individual as separate from society is a "social construct, specific to recent western culture" (p. 3). The focus that individual psychotherapeutic practice implicitly puts on the individual is understood by some such perspectives to neglect the crucially important influence of an individual's context on their mental health. Long and Zietkiewicz (2002), for example, argue that "in spite of a massive accumulation of data regarding culture and mental health, Western psychiatry has, for the large part, continued to ignore the articulation of socio-cultural factors in its theoretical and applied approaches to the problem" (p. 164). Thus by assuming an eco-developmental approach in the present research, elements of a critical and post-structuralist perspective on psychological distress and treatment will also be drawn upon. Moreover, the present research attempts to provide an account and investigation into any such social influence on mental health at the CGC as well as into the suitability of individual psychotherapy to address the apparently complex causes of clients' distress.

The UCT Child Guidance Clinic

The University of Cape Town's CGC operates within the unique and complex context of 21st century South Africa. Doing individual psychotherapy in this South African context can raise a number of issues for clinicians and clients alike around difference and identity, around efficacy and access to services and around race and gender, to name but a few. As these specific issues are arguably relevant to individual psychotherapy in the South African context, it seems likely they will also prove to be salient factors in psychotherapeutic work done at the CGC. It is hoped that by providing a history of the UCT CGC that contextualises it within a South African historical context a fuller appreciation of its place in South Africa today will be offered. In so doing, it is hoped that a fuller account of the position of individual psychotherapy in South Africa today will also be offered.

The social, economic, historical, political and cultural context of Cape Town South Africa could be said to imbue the psychotherapeutic work that is done at the CGC with a specifically local flavour. The Western Cape is subject to a number of especially insidious social ills, including most notably violence and child sexual abuse (van den Berg, 2000). These long-standing contextual and societal factors are considered likely to influence the mental health of Western Cape communities (Evans & L. Swartz, 2000; Long, 2002; L. Swartz, 1998). The present research sets out to use the CGC sample as a microcosm of its larger Western Cape and South African context and in so doing investigates both how individual work operates within its local context as well as whether this multi-layered social context exerts a discernable influence on mental health.

This research follows on from three previous archival studies of the UCT CGC by Hay (1990), Smit (1997) and Melvill (2000). By providing an update on individual work at the CGC the present research also aims to take stock of the position, utility and applicability of individual work more generally today, both at the Clinic and in its larger national context.

Hay (1990) undertook a critical historical analysis of the clinic from its inception in 1935 until its struggles with Apartheid segregation policies in the 1970's. Such an analysis provides clear evidence of the Clinic's ethically questionable past practices and the discernable impact of Apartheid era policies on its own policies and psychotherapeutic work. Hay reports the CGC was originally established as an educational centre for 'European children' in 1935 and that its establishment had been largely as a result of the preceding International Child Guidance Movement which had began in the 1920s (Hay, 1990). Rose (1985) explains that the development of the Child Guidance Movement had in turn been influenced by the eugenicist ideology that had been prevalent at the beginning of the twentieth century and which had seen fit to categorise and remove 'feeble-minded' persons from society. Rose goes on to note that this eugenicist strategy eventually gave way to Neo-Hygiene and later Mental Hygiene Movements in 1910 that prioritised preventative mental healthcare in families. Thus even from its earliest inception it can be said that the CGC was the product of the ideological and social contexts of its time. This is most clear in the fact that the CGC's ambit of operations only included White children for many years despite the needs of children from other race groups who assumedly would also have potentially benefitted from its input (Hay, 1990). Despite ostensibly offering neutral and professional psychological assistance to clients

in its past, it is arguable that the CGC more truthfully propagated the implicit yet racist and elitist notion that only European or White children could benefit from psychotherapeutic input. It is important to stress, however, that segregationist policies were common in South Africa for most of the twentieth century and that CGC policy was simply in-step with a larger political and social context.

Indeed the CGC fell under the jurisdiction of Apartheid-era Cape Education Department up until and during the 1970s and as such complied with the racially segregated policy of the State at that time (Hay, 1990). According to Hay, although a formal policy of desegregation had been adopted at the Clinic in the 1980's the Clinic had been moving toward desegregation since the early 1970's. Prior to this, "racial segregation was implemented on both a formal and informal level" (1990, p. 13) and both the Clinic's link to the Cape Education Department as well as its situation in a White middle class area perpetuated the racial disparity in its client population. For Hay this is evidence of "the extent to which the practice of psychology [at the CGC] was influenced by the wider social context" (p. 13). The present study then attempts to ascertain the extent to which the CGC's current social, geographical and political context continues to have an effect on the work done at the Clinic.

Smit (1997) focuses on the effects of the political upheavals of the 1970s and 1980s in South Africa on the psychological practice of the Clinic during those years. He explains the State of Emergency declared in South Africa in 1985 instigated a crisis in psychological circles where the traditionally politically-neutral position of the psychologist was challenged by the desperate political and social position of the majority of the South African population. The reality was that the psychological profession as a whole in South Africa had generally focused exclusively on work with middle-class White South Africans prior to this and throughout the Apartheid era (Swartz, Dowdall & Swartz, 1986). According to S. Swartz and Gibson (2001) "the myths of neutrality within academia and the helping professions were being strongly challenged" and "there was clear recognition in these times that the traditional consulting room practices of clinical psychology were not reaching the large numbers of people who were affected psychologically by the war in the streets" (p. 38).

This political instability of the 1980s led to the eventual acknowledgement of the need for a more progressive psychology in South Africa generally (Ngonyama ka Sigogo et al., 2004) as

well as leading more specifically to the growth of community psychology perspectives at the CGC (Smit, 1997; L. Swartz, Gibson & S. Swartz, 1990). Such shifts in ideology included for example CGC clinical staff being "expected to formulate and conceptualise all clinical work within the context of community work and challenges" (Gibson & S. Swartz, 1996, p. 6). Smit (1997) also notes the CGC "became actively involved in forging a new community-conscious identity" at this time (p. 8). Indeed, according to Smit "this allowed a much broader, community-orientated definition to emerge, moving away from its roots in the traditional guidance movement" (p. 8). It appears then that while the political and social context of the CGC has historically played a key role in influencing which patients were seen at the Clinic it has also at times exerted considerable influence over how they and their presenting problems were conceptualised. This shift to a more socially and politically conscious conceptualisation of clients' mental distress is important to position within the larger socio-political changes that were occurring in South Africa in the 1980s and in so doing highlight again the significant impact of the social context broadly on the practice of psychotherapy in this country.

Smit (1997) compared client files from the CGC from the years 1982 and 1992 and found an increased number of clients over the age of 16 being seen and far more Coloured clients being seen in the 1990s than in the 1980s. He also found the percentage of Clinic patients that were White dropped from 78% in 1982 to 23% in 1992 and that the percentage of patients that were Coloured rose from 21% in 1982 to 72% in 1992. The percentage of patients that were African rose marginally from 1% in 1982 to 5% in 1992. Furthermore, Smit found evidence of a strong correlation between race and social class in his analysis, and given that Whites were by far the majority of patients seen prior to 1992, he contends "the shift towards community-orientation or community-representation should be interpreted as a movement towards the low socio-economic groups and other racial groups" (p. 50).

In her study of client profiles at the CGC from 1990 to 1999 Melvill (2000) also identifies a discernable shift away from the typically White middle-class clientele who were seen prior to the mid-1980s. Substantiating Smit's claims Melvill found that although there was considerable variability throughout the 1990's in terms of which social classes were seen, there was an increased proportion of clients from the middle and lower middle classes than in the preceding decades.

Melvill (2000) also found that more males were generally seen at the clinic than females were. In addition, more male clients generally were diagnosed with conduct problems, ADHD and relational problems than female clients were and more female patients were diagnosed with mood disorders than male clients were. As already discussed, the meaning of any such sex differences in diagnosis always needs to be considered very carefully. While these apparent differences are to some extent in line with questionable early twentieth century diagnostic patterns at Valkenberg Hospital as reported by Shelmerdine as well as with some contemporary international literature, the reasons behind such patterns persisting remain unclear.

Melvill notes that the trend Smit first noticed of more young adults and adult family members of patients being seen from the late 1980s, continued well into the 1990s. However, according to Melvill the vast majority of clients (86.9%) seen during the 1990s were still below the age of 20, as had generally been the case from the time of the clinic's inception. It is unsurprising then that during the 1990s 62.9% of all referrals were from mothers of clients (Melvill, 2000).

The degree to which the Clinic has had a scholastic or individual psychotherapeutic focus has also vacillated over the years. Hay writes that "the high percentage of school referrals in the first years helps to substantiate the hypothesis that ... psychology was initially ensconced in education" (p. 18). She goes on to explain though that from 1957 individual psychotherapy began to be offered at the Clinic and that "this was in line with the growth of clinical psychology at the end of the 1950s" internationally (p. 39). Interestingly, however, the Clinic's traditional role in intervening primarily with scholastic presenting problems resurfaced and was maintained throughout the 1990s. Melvill found scholastic assessment accounted for the majority of treated cases (29.8%) over the 1990s while individual psychotherapy and family therapy accounted for 25.8% and 25.3% of interventions respectively. The total number of individual psychotherapy cases taken on during these ten years including those categorised by Melvill as individual behavioural interventions was 156 or 27.4% of the total number of treated cases.

Both Smit (1997) and Melvill (2000) found in their research that the overwhelmingly White population of school-age clients that had been seen prior to the diversification of clinical

practice in the 1980s began to give way to a predominantly Coloured population of school-age clients in the 1990s. This picture appeared to continue throughout the 1990s, with an average of 52.3% of the clinic's population being Coloured and an average of 29.6% being White over the 1990 to 1999 period. African clients accounted for an average of 9.1% of the CGC client population during the 1990s. Melvill (2000) goes on to comment that "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" (p. 139). She explains that semi-structured interviews conducted with CGC staff members brought to light a number of possible reasons for this under-representation of African clients including access to the clinic, costs, language issues as well as differences in cultural practices. There was, however, a gradual increase in the number of African clients seen over the 1990s (Melvill, 2000). Despite such shifts, however, Melvill concludes that "beyond the immediate horizons of the CGC there is the considerable challenge of providing culturally relevant psychological services to an historically disadvantaged multicultural clientele" (p. 140). The extent to which the CGC has risen to this challenge is assessed in the present research.

Psychotherapy in Similar Contexts

As the present research deals specifically with the psychotherapeutic work done in a clinic context it is pertinent to discuss work done in other similar clinic settings. Oliver-Bellasis (1998) for example writes on the Young People's Consultation Service (YPCS) in the United Kingdom, which caters to adolescents and young adults. She describes the philosophy of the service as being about "ease of access, confidentiality, informality and for there to be someone there" (p. 1). For Oliver-Bellasis a service like the YPCS is important because it is often the closest their clients will get to formal treatment. Indeed she notes, "there are also young people who are extremely wary of formal agencies and to whom a service like the YPCS with its ease of access, confidentiality, informality and limited setting appeals" (p. 6). Indeed, according to Oliver-Bellasis there appears to be much evidence for the utility and need for such somewhat less formal mental health facilities, especially considering that presenting problems at the YPCS reportedly range from relationship problems to bereavement and often include issues as severe as child sexual abuse. Dartington (1995) also describes the need many young people especially have for less formal counselling or psychotherapeutic settings. Dartington further notes that despite interventions at the YPCS

often being very short-term, many of their clients actually prefer a time-limited and brief therapeutic contract.

Altman (1995) writes on his experience of working in an inner city mental health clinic in the United States. In so doing, he elucidates theoretical and philosophical questions that working in such socio-economically poor contexts brought up for him as a psychoanalytically trained clinician. Altman contends that while psychoanalysis is generally considered apolitical and perhaps even inappropriate in socio-economically poor contexts, "the viability of psychoanalysis will be best served by maximising the extent to which humanistic values inform our theory and practice and by expanding the domain in which psychoanalysts make their contribution" (p. xx). Altman argues for a re-reading of classical Freudian theory that acknowledges the social, political and economic context and notes several theorists including Fromm, Kernberg and Langer who have attempted to do this. Such a contextual view "calls our attention not only to the analytic dyad but also to the patient's and the analyst's relationships to the social context within which the analytic dyad functions" (1995, p. 79). For Altman our attention as clinicians also needs to be drawn to the pressing needs our brand of mental health work can effectively address in impoverished and socio-economically poor contexts. The present research into individual work at the CGC attempts then to provide a local example of a psychotherapy clinic within which the applicability and utility of individual work in the complex local context can be explored.

Teaching and Learning Psychotherapy

As well as being a fully functioning psychotherapy clinic, the UCT CGC is also first and foremost a training institution for psychology graduates entering the clinical psychology profession for the first time. As such, any thorough account of the work done at the CGC needs to acknowledge this pedagogical context and the potential influence such a context has on clinical interventions at the Clinic.

Postgraduate clinical psychology training at UCT is offered as a Masters degree, done in collaboration with internship sites over three to four years and comprising an initial year of coursework and some practical clinical work at the CGC, an internship year in psychiatric state settings as well as a requirement for a mini-dissertation. The first year of the Masters programme is not usually trainees' first-ever taste of mental health related work but it is

generally always their first real experience of and submersion in the clinical psychology field or paradigm. It follows then that this first year is also the time that trainees generally first become fully aware of the professional demands of the psychotherapeutic work. Factoring in this fact that trainees are largely inexperienced will be important in the present research's appraisal of the efficacy of the Clinic's work.

Kottler and S. Swartz (2004) write on the experiences of trainee therapists during this initial year of the clinical Masters programme and describe it as in many ways being 'a rite of passage' and much like an initiation into the profession. Kottler and S. Swartz acknowledge that as with most cultural initiations clinical psychology training "is widely known to be an arduous process" (p. 55). The change that trainees are expected to undergo is largely around navigating between one's personal identity and one's newfound professional identity. For Kottler and S. Swartz this change is a process that requires rigorous self-reflection and self-scrutiny while at the same time, perhaps almost paradoxically also requiring great personal strength and resolve. As already implied the authors draw on anthropological theory's concept of the initiation as embodying this training process. Kottler and S. Swartz argue that as in cultural initiations, individuals in the Masters course go through three distinct stages of change. The first involves initial separation from mainstream society and a detachment from themselves and their lives prior to their enrolment in the programme. Following this is the 'marginal phase' "which entails a symbolic death" and where the trainee "experiences an annihilation of his or her own sense of identity and all that he or she has come to know about himself or herself and the way he or she operates in the world" (p. 58). Finally, towards the end of their year at the CGC clinicians are generally re-entering society as professionals.

The tremendous pressure on trainees while at the CGC is important to acknowledge as it constitutes a continuous influence on trainees and on the work that they do. Kottler and S. Swartz describe trainees speaking of feeling as if they are "exploding" during the programme (p. 61). However, not all trainees find the course especially traumatic and all will experience it in their own idiosyncratic way. Indeed as Kottler and S. Swartz note, individual characteristics probably play a large role in how trainees respond to the demands of the course.

Trainees' cultural and race differences too can come to play a significant role in their experience of the course, with some previous CGC trainees complaining of a sense of cultural alienation in their training and subtle race-related condescension for example from clients (Kleintjes, 1991). Indeed the usually significant White, middle class constituent of the Masters class prior to the early 1990s especially would understandably have set up trainees who did not fit that profile to feel marginalized (1991). Added to this context is the fact that much of the literature dealt with in the course originates from Western "predominatly white, middle-class, heterosexual-as-norm discourses" (Kottler and Swartz, 2004, p. 61). Lee and Tracey (2008) argue that given the significance often ascribed to cultural factors in the clinical trainees' case formulations, which formed the basis of their study "psychotherapy training programs as a whole may wish to consider highlighting the pervasive importance of culture in their work" (p. 520). The complex socio-cultural context that surrounds the CGC then may be seen as especially necessitating such culturally sensitive approaches to the work done at the Clinic and as such, increasing the expertness required by the trainee.

Developing a new professional identity is immediately required by the nature of the work alone once trainees start seeing clients, which happens generally mid-way through their first year at the CGC. It could be argued then by implication that the professional service such trainees bring to sessions with clients may not always be as good as it would be from a more experienced and qualified psychologist. It is this specifically pedagogical context then that the present research has to acknowledge and explore as potentially impacting on the quality of the work done at the Clinic. It is important though to also note that all work done in the CGC training programme is closely supervised by experienced clinicians and as such is regularly vetted for its quality.

Sharpless and Barber (2008) who write on the subject of 'intervention competence' in clinical psychology training, argue intervention competence is an ethical issue and needs to be regularly assessed with a view to safe-guarding client's rights. While acknowledging professional competence is "a life-long endeavor" the authors also underline the importance of "establishing thresholds and benchmarks for competence" (p. 50). Sharpless and Barber argue trainees go through five roughly identifiable stages of professional development from novice to expert while gradually moving away from "a reliance on rules" towards a state of competence and nuanced appreciation of "context, appropriateness, values and

23

accountability" (p. 51). This characterization of clinical psychology training infers again that a process towards becoming competent takes place during clinical training and that trainees certainly do not embark on this process already competent. Indeed Lee and Tracey note in their study of 91 clinical trainees that "significant differences in expertness were found between each level of clinical training" (p. 518).

The Role of Case Formulation in Psychotherapeutic Intervention

The clinical case formulation is a document that offers a cohesive and thorough understanding or conceptualisation of a client's presenting problem and the basis for it in their psychic structure and interpersonal context. While definitions of exactly what such conceptualizations should include or stress or from which theoretical standpoints they should arise vary, there is generally consensus that the case formulation is integral to good clinical interventions (Falvey, 2001; McWilliams, 1999; Perry, Cooper & Michels, 1987; S. Swartz, 1999). It could be said then that ascertaining the extent to which case formulations are used to inform clinical interventions is of particular interest at the CGC where both case formulation and clinical intervention skills are only beginning to be developed by clinical psychology trainees. In their examination of 91 psychotherapy trainees' work abroad, Lee and Tracey conclude that there is a need "for more research exploring how case conceptualization skills may relate to actual client outcomes" (p. 521).

McWilliams (1999) argues that "there is an ongoing need for our training literature to explicate the bases on which most experienced therapists draw their treatment conclusions" (p. 10). For McWilliams this basis should first and foremost be to understand the individual as thoroughly as possible within the structure of the case formulation. Indeed, "it seems to me self-evident that unless one understands someone's unique, personal subjectivity, one cannot infer the best treatment approach for that individual" (p. 9). McWilliams elaborates that "by understanding the idiosyncratic way an individual organizes knowledge, emotion, sensation, and behavior, a therapist has more choice about how to influence him or her in all these areas and to contribute to the improvements in life for which he or she has sought professional help" (p. 11). It could be argued then that the informed choices case formulations can provide would be especially important to those largely inexperienced trainee therapists who have yet to establish their own repertoires of intervention strategies from which to draw. Backing up this view Messer, Tishby & Spillman (1992) found that there was a significantly positive

association between the extent to which therapists integrated their case formulations of clients into their clinical interventions and their clients' progress.

Yet as S. Swartz (1999) has argued, the psychodynamic case formulation specifically is often relegated to the status of a training exercise in psychiatric settings due to its association with long-term expensive interventions and as such faces the threat of being side-lined. While S. Swartz acknowledges that in private practice or in-patient psychotherapy settings psychodynamic case formulations are often seen as centrally important tools, she draws attention to the threat posed to psychodynamic thinking and intervention in state services especially where limited material resources are behind a move towards more short-term interventions and pharmacotherapy. For S. Swartz, psychodynamic thinking in the form of the psychodynamic case formulation remains "a fundamental part of our therapeutic culture" and that "routine psychodynamic formulations of all patients is helpful to their management, regardless of the form that the intervention takes" (p. 47). This is arguably so because good case formulations provide an accurate picture of clients' key internal psychic structures and can thus serve to both predict clients' behaviour and emotional reactions as well as to increase clinicians' insight into clients' own points of view. The present research sets out to examine the role and nature of case formulations in individual work at the CGC and in so doing offer some conclusions on their use and utility locally.

At the same time, however, a critical approach to case formulation focuses on how the various psychotherapeutic approaches, theories and ideologies that are taken on by clinicians in South Africa can be said to also construct and shape the therapeutic encounter in specific and different ways (Ivey, 1992; S. Swartz, 1999). According to Parker (1997) the client is always heard in a particular way, in a way that is in accordance with the clinician's theoretical stance. Similarly S. Swartz, (1996, 2005a) writes on the power that the clinician wields over the client when they write case notes and formulations. For her, "patients are narrated into spaces which psychiatric knowledge has the power to explain" (1996, p. 153). S. Swartz (2005b; 2006) draws attention to the often marginal degree to which clients' own ways of knowing are given representation in clinical writing.

Spivak (1992) argues that the voices of women and subaltern subjects generally are to a large extent actually suppressed in academic and professional discourse by implicit but hegemonic

ideologies incorporating patriarchal, classist and ethnocentric bias. Spivak goes as far as to question the possibility even that subalterns and those tasked with writing about them, separated as they are by often-significant cultural, political and socio-economic difference can participate in academic dialogue as equals. Spivak's view arguably has repercussions for the clinical psychologist and highlights the difficulties entailed in writing about psychotherapy clients, who as S. Swartz has explained assume a subaltern status when entering the consulting room. S. Swartz (1999) contends that the challenge then to trainee therapists is in part "not only to master psychodynamic theory sufficiently to be able to do a competent formulation, but also to modify the theory to take account of non-Western values" (p. 46).

Hay (1990) writes that as psychotherapy began to be offered at the CGC from 1957 onwards theoretical viewpoints were often in flux, with "the Clinic constantly revising and improving on diagnostic techniques in the light of new theories and knowledge" (p. 40). She notes that it was in the later half of the 1960s that viewpoints at the Clinic began to shift towards a psychodynamic and ego psychology framework. Hay also notes that "theoretical positions, however, always shift – often as new people join the Clinic/Department, or as new insights are gathered" (p. 40). For Hay this is evidence of how contextual factors like the theoretical stances of influential UCT Psychology Department members for example have often impacted on the type of work done at the CGC. As such, the calls for and the move towards a more culturally inclusive theoretical approach to psychodynamic thinking and case conceptualization could be characterized similarly as to some extent the product of contextual forces; in this case political and social changes occurring in the 1980s and 1990s in South Africa.

Evaluating Psychotherapy

As the present research does in part provide data on clinical outcomes and prognoses it is important to present an account of the literature surrounding psychotherapeutic evaluation. Research into the efficacy of psychotherapeutic interventions can be said to have begun in the 1960s and gained ground in the 1970s as medical insurance was extended to psychotherapy practice (Carruthers, 2007). Smith and Glass (1977) for example conducted a meta-analysis of 375 studies focusing on psychotherapeutic efficacy and found that the condition of patients in ongoing psychotherapy were generally better than 75% to 77 % of controls receiving no

psychotherapy. Similarly, Smith, Glass and Miller (1980) concluded from their meta-analysis of 475 randomised controlled efficacy studies that psychotherapy was more effective than no psychotherapy. While such findings are widely queried in the literature, other researchers including Wampold (2001), Elliot (1998) and Andrews and Harvey (1981) have gone on to confirm Smith and Glass's original and seminal work. A number of other studies have looked at psychothearapy's efficacy as compared to pharmacotherapy. Erbaugh's (1995) meta-analysis of studies concerning treatment of depression for example found psychotherapy to be approximately as effective as pharmacotherapy.

Carruthers (2007) concludes from her extensive analysis of efficacy studies that the efficacy of psychotherapy has in fact already been established. Carruthers explains academic interest has since shifted to ascertaining which therapeutic modalities best fit which clinical presentations, how therapist-client relationship dynamics impact efficacy as well as how broadly contextual factors affect client outcomes. The present research then, while perhaps not needing to prove psychotherapy can be effective, sets out to investigate how or if clients' social, political and economic contexts together with therapists' theoretical and pedagogical contexts interact to affect clinical outcomes.

Given criticisms of the "non-falsifiable theoretical tenets" of clinical psychotherapy's evidence base like those made by Kagee (2006, p. 233) it is arguably important for the present research to consider both which theoretical and methodological orientations are generally salient at the Clinic and whether there is evidence for their use. Despite its history of being predominantly psychodynamic in orientation (Melvill, 2000; Smit, 1997) the CGC today trains clinicians in a broad range of theoretical approaches. As such, trainees' individual work is likely to comprise an eclectic range of theoretical and therapeutic modalities including for example cognitive behavioural therapy (CBT), person-centred counselling and narrative therapy, as well as psychodynamic work. While the evidence base for CBT and behaviour therapy is arguably stronger than most other modalities, the efficacy of dynamic and analytic therapies specifically is generally also widely accepted (Carruthers, 2007).

In a review of studies investigating the evidence base of psychodynamic psychotherapy specifically Connolly Gibbons, Crits-Christoph and Hearon (2008) write that "over the past

decade, multiple studies have been published supporting the efficacy of dynamic psychotherapy for the treatment of specific mental disorders" (p. 93). Keeping in line with Chambless and Hollon's (1998) strict criteria for therapeutic efficacy Connolly Gibbons et al. conclude from their assessment of the literature that dynamic psychotherapy should be considered "efficacious" in the treatment of major depressive disorder and "possibly efficacious" in the treatment of panic disorder, borderline personality disorder and opiate dependence specifically (p. 93). They go on to suggest that although "there are still a number of mental health disorders of high public health significance for which there is not a single well-done randomized controlled trial of dynamic psychotherapy" (p. 103) there are also many well-done non-randomized controlled studies that do show evidence of dynamic therapy's efficacy. Thus while psychodynamic psychotherapy at the CGC may not have as substantial an evidence base as the cognitive and behavioural modalities also present at the Clinic have, there is at least some acknowledgement in the literature of its efficacy.

Chapter Summary

In the preceding literature review it has been argued that individual psychotherapy in South Africa operates within a complex socio-economic, historical, political and cultural context. This specifically South African context is not only complicated but also arguably especially salient both to local individuals' personal development as well as by extension to local individual psychotherapy. As a result, any research on the CGC would arguably benefit from considering the potential influence of such intersecting class, sex and racially related demographic contexts on the work done at the Clinic. Such a view is in line with a range of perspectives in the local literature that argue for a specifically local therapeutic and theoretical orientation that explicitly includes and makes adaptations for the needs of South African clientele. An ecodevelopmental theoretical orientation is thought to offer one such socially contextual perspective that adequately addresses the nuances of this complex context, at least for the purposes of the present research. A history of the CGC has been presented in the literature review that positions the Clinic within its relevant socio-political and historical context in an attempt to highlight the shifting but continuous influence of the Clinic's context on its work. Giving consideration to the challenges of training to be a psychologist that arise while trainees are at the CGC as well as those that arise in relation to learning to write about clients in our local context the potential impact of the Clinic's pedagogical context on work done at the CGC was highlighted. The review concluded with an examination of the evidence

base for the different psychotherapeutic modalities present at the CGC. Taken together, these discussions aim to provide the background that is relevant to the present research's examination of the practice, utility and applicability of individual work both at the CGC and in the local context.

CHAPTER TWO

METHOD

The CGC Case File Sample

The present research follows on from three previous archival studies examining CGC case files (Hay, 1990; Melvill, 2000; Smit, 1997). As such, it may be said that the Clinic case files have been of interest to researchers for some time. Unlike previous studies, however, the present research specifically examines individual psychotherapeutic cases.

The present exploration and examination of the case files from the year 2000 up until and including 1999 included clients' key demographic information, the diagnoses accorded to them, the type of case formulations written for them, the nature of the interventions embarked upon as well as client's apparent outcomes on termination. More in depth discussion of each of these areas of interest will follow in the proceeding sections. Only those cases in which planned interventions of individual psychotherapy had been embarked upon and in which the intervention had been conducted for at least two sessions were included in the sample.

The Research Design

Archival Methods

Elder, Pavalko and Clipp (1993) write that although archival data has been the subject of academic study "for many decades by historians and social scientists . . . these investigators did not develop their procedures in written form as a logic of enquiry or methodology" (p. 5). Since approximately the 1960s though, archival research methodology has become more systematic and an emphasis on longitudinal and life-course research specifically has emerged (1993). The authors elaborate that, "one of the clearest examples of interlocking developments involves the relation between data and the research question" (p. 6). For archival researchers today then the crucial task is to ensure an adequate and proper fit between their data and research question. As the present research is broadly exploratory and descriptive in nature, this fit between the data and the research question has come to emerge almost organically as the research has progressed.

Mahrer and Boulet (1999) make a case for the utility and importance of doing 'discovery-oriented' research. Their approach involves whole teams of researchers exploring and judging

clinical subject matter with a view to discovering surprising and unforeseen facts and insights. The authors note that "it is common to think of most traditional research perhaps as starting with a phase that frequently is looked down upon as exploratory, pilot, observational, soft, naturalistic or preliminary" (p. 1487). They contend, however, that discovery-oriented research, which embraces such research orientations, can in fact be "elegant" and provide an important contribution (p. 1487). The present research then follows a similar line to discovery-oriented research in that any number of relationships within the data are explored as potentially holding significance. Indeed, instead of following the typical methodology of setting out to disprove a null-hypothesis as Popper (1980) recommended for the sake of conceptual power, discovery-oriented methodology "invites researchers to look for better and better ways of achieving some goal, aim or use rather than doing research to show that some particular way works" (1999, p. 1488).

Data Collection

Data was gathered directly from the case files, which were accessed at the CGC and from the UCT Archives. Relevant data from each file was gathered and entered into a Microsoft Excel spreadsheet. This data comprised 18 different variables of interest per case. In total 156 case files were identified as being appropriate for the sample.

Each individual client seen at the CGC is allocated a case file, which includes clients' demographic information, a detailed client history, an etiological and/or theoretical formulation, an intervention plan, process notes as well as a termination summary report. Files also include any other relevant documents and include a roster of attended and missed sessions. On the front cover a summary of key information is presented, partially in code form. Information includes the source of the clients' referral, the type of intervention embarked upon, the client's social class, the degree of improvement or deterioration seen on discharge as well as the total number of sessions the client was seen for. Clients' social classes are categorized according to the main breadwinner's income and position of employment. Social class categorizations are as follows: 'Class I' which includes professionals, large business owners or executives; 'Class 2' which includes smaller business people, semi-professionals and white-collar workers; 'Class 3' which includes clerical workers, machinists, apprentices or students; 'Class 4' which includes semi-skilled workers; 'Class 5' which includes unskilled workers, and 'Class 6' which includes breadwinners that

are unemployed. Although reportedly present in earlier decades, clients' racial categorization is now omitted in the files (Melvill, 2000). In addition to demographic information, space is made for a multi-axial DSM diagnosis. A key to the codes for this summary cover page is made available to all trainees and Clinic staff [See appendix A].

Information pertaining to any reported childhood sexual abuse history, ongoing domestic violence or any other type of severe trauma history was also collected from client history documents for the purposes of the present research. Any information indicating ongoing substance abuse was also included for each case.

Apart from demographic and diagnostic data, which was collected in part using the case file cover coding system, there was a need for some of the other less obviously distinct data variables to be coded into mutually exclusive categories. This was the case for the type of case formulation used, the nature of the intervention decided upon as well as the prognosis of the client on termination. In terms of the case formulations, they were divided up into being 'generically psychodynamic', 'theoretically specific', 'mixed theoretically', 'aetiological', 'lay' or 'missing'. Categorization choices were validated on a sample by an experienced clinician. Theoretically specific formulations made reference to one key theory or theorist and stuck to this theoretical framework throughout. In contrast, theoretically mixed formulations made reference to multiple theorists or theories that are not necessarily theoretically linked. Generically psychodynamic formulations omitted any specific reference to a theory or theoretician while still clearly following broadly psychodynamically orientated perspectives on the case. Aetiological formulations were very simple to identify as they were often labeled as such and followed a linear and chronological account of the precedents and other causal factors behind the presenting problem. Finally, lay formulations made no reference to any psychological theories or language, omitted an aetiological account of the case and presented a basic and often very brief and limited understanding of the problem. It is important at this stage to stress that CGC trainees are generally expected to write a theoretically specific or at least broadly psychological formulation for all their cases. Indeed, in most years trainees are expected to write both a theoretical and aetiological formulation. When both types of formulation were present, the theoretical formulation was assessed to the exclusion of the aetiological formulation. This is because theoretical formulations specifically are widely considered to be integral elements of good psychotherapeutic case management

(Falvey, 2001; McWilliams, 1999; S. Swartz, 1999) and as such an examination of this type of formulation at the CGC was especially relevant to the present research.

In terms of the nature of the intervention embarked upon, it is important to stress that only individual psychotherapeutic interventions were included in the sample. The majority of interventions at the CGC historically has generally related to scholastic problems (Melvill, 2000) and may thus involve psychometric testing and referrals to specialized remedial services. The remaining presenting problems are generally emotional in nature and relate to either interpersonal or behavioural problems. These broadly psychological cases are then either managed with family therapy involving at least two family members or otherwise are managed individually. The present research focuses exclusively upon these entirely individual cases. Cases were selected as individual in nature on the basis of the presenting problem being broadly psychological and the client being seen alone. Clients' ages were not considered as an exclusionary criterion. Indeed cases with clients as young as 4 were included as long as they fitted the criteria above. In such cases and in those with clients aged up until the age of 12 approximately play therapy was generally the prescribed intervention. Individual play therapy was included in the sample due to it being psychotherapeutic in scope.

Data on clinical outcomes was gathered both from the case file cover summary page [see Appendix A] and from trainees' termination summary reports where specific mention of prognosis was made. These reports on clients' prognoses were categorized into one of seven groups, being; 'very good', 'good', good but needs to continue', 'fair', 'fair but needs to continue', 'poor' and 'poor and needs to continue'.

Due to this outcomes information generally relying on the subjective judgment of the trainee its clinical veracity has to be acknowledged as being questionable to some extent. Trainees may for example, wish to give positive prognoses and outcomes measures for their clients as a way of bolstering their own and others' perceptions of their therapeutic competence. Trainees may also think clients have good prognoses simply out of a wish for their clients to be well, however unfounded these prognoses may be. Furthermore, trainees are largely inexperienced and so the prognoses they make may not be as accurate as those made by more experienced clinicians. Nevertheless, it must also be noted that all trainee's casework

including their prognosis and outcome decisions is monitored and ratified by experienced supervisory clinicians. Such outcomes information is thus arguably for the most part a reasonably dependable indicator of clients' actual outcomes.

Data Analysis

Once the data had been collated into a single dataset, it was analyzed in terms of descriptive statistics. Descriptive statistical analyses were used as they offer a simple and clear account of the CGC data, which for the most part is categorical in nature. This statistical modality is also in line with the partly descriptive nature of the research design. Multiple Microsoft Excel pivot tables were initially created for all the data collected in order to ascertain the relationships between clients' demographic information, their presenting problems, the Clinic's case management and clients' clinical outcomes. This initial stage of the analysis provided a detailed and broad picture of the distribution of the data between the 18 variables. In so doing it also highlighted which relationships between the variables appeared to be the most substantial in terms of the data's distribution. Chi-squared analyses were then undertaken with these identified key variables in order to better elucidate the strength of the apparent associations between them. As the research is also exploratory in nature, the potential significance of relationships between variables was generally unclear to begin with and was thus investigated as part of an ongoing process.

Reflexivity

The present research has involved both objective and subjective analysis of clinical information. As such, some self-reflective discussion and examination of the research as a whole is warranted. Much research into psychotherapy client profiles and clinical outcomes focuses on issues of statistical power and design and less on the actual clinical context of the work being done (Beutler et al., 1995; Goldfried & Wolfe, 1998). Goldfried and Wolfe write that, "despite the advances in psychotherapy outcome research, findings are limited because they do not fully generalize to the way therapy is conducted in the real world" (p. 143). For them "it is all too easy to get caught up in a research paradigm and lose sight of its ecological shortcomings" (p. 143). The issue the authors raise then is the importance of clinical research having adequate external validity if it is to be useful in the real world. One way to ensure such external validity may arguably be "to forge a liaison between clinician and researcher in the design and implementation of outcome research" (1998, p. 147).

The present research could be said then to be going some way towards forging this liaison as it has been designed and carried out by a clinician in training and who furthermore has experience working as a trainee at the CGC. This first-hand experience has undoubtedly influenced my choice of subject matter for my dissertation as well as my research question. It is perhaps pertinent at this stage to acknowledge too that as an ex-trainee of the Clinic myself my view of it is likely to be biased to some extent. Nonetheless, every effort has been made to exhibit adequate objectivity and a self-reflexive attitude to the data and the research question throughout. This has been done both through a conscious effort to appraise my conclusions and arguments for bias but also through having made use of objective statistical analyses. Indeed a self-reflexive stance has been argued for in the literature with many writers recognising the ever-present potential for objectivity by the investigator to be limited while at the same time advocating the continued incorporation of subjective analysis into research (Giddens, 1976; Parker, 1992).

Ethical Considerations

As this research is based on archival data, there was no direct contact with clients or other research subjects during the data gathering process. However, since the research focuses on human subjects and on their often most private information, diligence and scrupulous care had to be maintained throughout to ensure their records and information remained confidential. Anonymity was ensured by assigning a number to each case instead of using clients' names. Furthermore all CGC clients sign a consent form giving access to their clinical information for research purposes. Ethical clearance and permission to examine the files was granted in 2008 by the then Director of the CGC, Dr Shabalala.

CHAPTER THREE

ANALYSIS

This section begins by outlining the key descriptive statistics for each of the main demographic, diagnostic and clinical variables under review for the period 2000 until and including 2009. In addition to clients' demographics, these main sections include a focus on clients' diagnoses and presenting problems, on the CGC's case management as well as on the course of treatment. Each of these broader sections is broken down into subsections of more specific variables and all are discussed in greater detail below. Following this broad sweep of the data further investigations into potential interactions of interest between and within these variable groupings are presented. In-depth discussion of the results follows in the next chapter. Calculation figures are reported with two decimal points.

Client Demographics

Sex

Data from the 2000 to 2009 CGC files indicates female clients were far more frequently seen at the Clinic than male clients were. In total 103 (66.03%) individual female clients were seen compared to 53 (33.97%) male clients, out of the total number of 156 individual psychotherapy cases in the sample. Female clients were also consistently in the majority throughout the ten years under review (see Table 1).

TABLE 1

Year	Female	Male	Total
2000	9	4	13
2001	6	5	11
2002	12	9	21
2003	9	4	13
2004	9	8	17
2005	15	6	21
2006	10	4	14
2007	8	3	11
2008	11	6	17
2009	14	4	18
Grand Total	103	53	156

Age

The most common age of clients seen for individual psychotherapy was eight years of age (7.69%), followed by 33 (5.76%), 23 (5.13%) and 20 (4.49%) years of age. A cumulative percentage of 34.62% of clients were below or at the age of 13 while 58.97% of clients seen were at or over the age of 18. Thus the majority of individual psychotherapy cases were conducted with adults, although a fairly large proportion of individual work was with minors. The youngest client seen was four years of age and the oldest was 54 years of age.

Class

By far the the most common social class category seen was 'Class 3', as labeled by the case file summary key and into which 51.28% of clients fell. Clients categorised as 'Class 3' came from households where the main breadwinner was a skilled worker such as a machinist, a clerical worker, an apprentice or a student. The percentage of clients coming from the generally higher earning 'Class 1' and 'Class 2' categories was 8.33% and 23.72% respectively. A proportion of 11.54% of clients fell into the socio-economically poorer 'Class 4' category, 1.93% fell into the 'Class 5' category and 3.21% fell into the so-called lowest 'Class 6' category. In order to better understand this seemingly quite broad range of socio-economic classes it is useful to note that a cumulative percentage of 32.05% of clients hailed from either of the so-called higher 'Class 1' and 'Class 2' categories while 67.96% of clients were from households from 'Class 3' and lower socio-economic categories.

Client Presenting Problems

Diagnosis

CGC clients' Axis I diagnoses were attributed by trainees under clinical supervision using the standard DSM-IV/DSM-IV TR criteria. In total 32 different diagnoses were made for the 156 cases of the sample (see Chart 1). Parent-Child Relational Problems emerged as by far the most frequently made diagnosis, with 19.23% of the sample falling into this category. Following this, Major Depressive Disorder (MDD) and Dysthymic Disorder were the second most frequently made diagnoses, both accounting for 12.18% of the sample's distribution each. No diagnosis on Axis I was made for 9.62% of the sample while Major Depressive Episode (MDE) and Adjustment Disorder diagnoses made up 5.77% of the total sample each. PTSD accounted for 3.85% of diagnoses made.

CHART 1

Distribution of Axis I Diagnoses
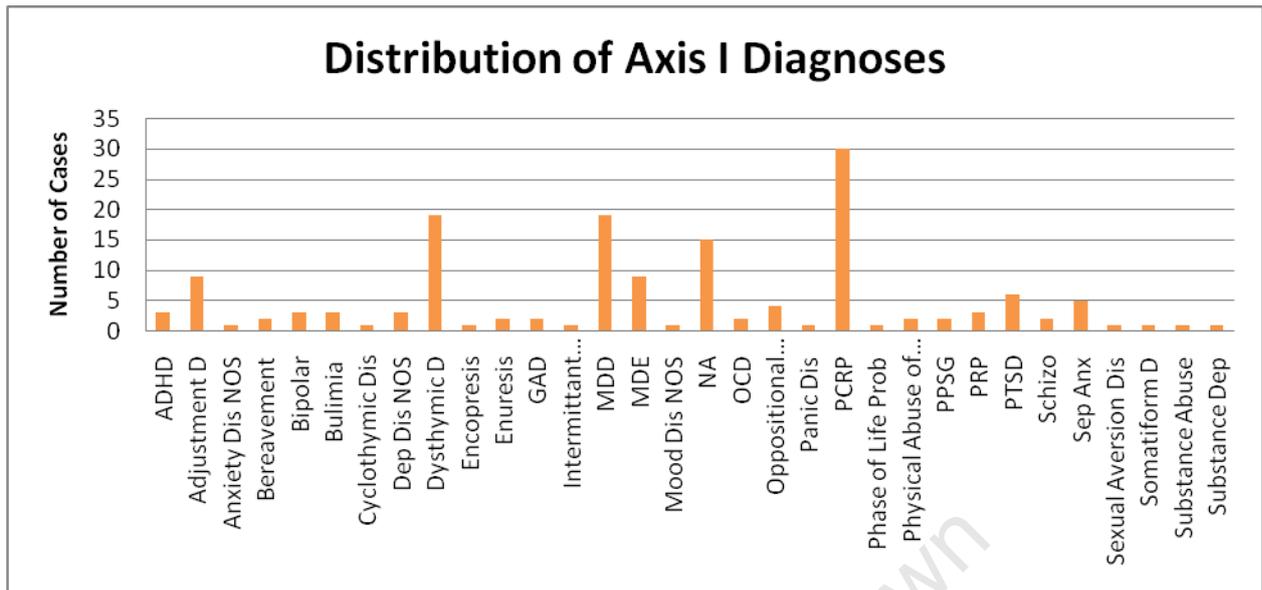
No diagnosis was made on Axis II for 67.31% of the sample. Added to this 8.33% of the sample's Axis II diagnosis was specifically noted as being Deferred. Thus 75.64% of the sample received no discernable Axis II diagnosis or otherwise did not qualify for one (See Table 2). Borderline Personality Disorder (BPD) accounted for the largest diagnosed Axis II disorder category, accounting for 7.69% of the total sample. Borderline traits were the second largest grouping at 7.49% of the sample.

In terms of Axis IV General Assessment of Functioning (GAF) scores the majority of cases fell into the 61-70 category (43.59%). A quarter of the cases (25%) fell into the 51-60 GAF score category and a full 8.33% of cases obtained a GAF score of below 50. No GAF scores in the sample were higher than 90 or lower than 31 (See Table 3).

Other Clinically Relevant Data

Out of the total 156 cases files reviewed 27 (17.31%) reported the client having a history of childhood sexual abuse. A total of 41 (26.28%) reported evidence of ongoing domestic violence and in 17 cases (10.9%) clients reported a history of other severe trauma. In a proportion of 10.9% of cases ongoing or recent substance abuse was reported.

TABLE 2

Axis II Diagnosis	Total Number
Avoidant	2
BPD	12
BPD traits	7
Deferred	13
Dependent	1
Dependent traits	2
Histrionic	1
MMR	2
Na	105
Narcissistic traits	5
Narcissistic	3
OCD traits	1
Personality Disorder NOS	2
Grand Total	156

TABLE 3

Axis V GAF Score	Total
31-40	3
41-50	10
51-60	39
61-70	68
71-80	34
81-90	2
Grand Total	156

Case Management at the CGC

Year by Year

In the ten year period between the year 2000 and 2009 the highest number of individual

psychotherapy cases were seen in 2002 and 2005 (21) while the least number

(11) were seen in 2001 and 2007. The most common number of clients seen during this ten-

year period was 13.

Referral Route

The most common route of referral for clients was from other health professionals (47.44%) followed by the category 'other' (14.12%), relatives and friends (13.46%) and parents (12.82%). Perhaps surprisingly for a Child Guidance Clinic schools and welfare organizations accounted for the smallest number of referrals, just 8.33% and 3.85% respectively.

Case Formulation

A total of 57 cases (36.54%) were formulated using a 'generically psychodynamic' perspective with this kind of case formulation being the most common type of case formulation seen (see Chart 2). Closely following this category, however, were 'theoretically specific' formulations, which accounted for 32.05% of the formulations in the sample. Half this percentage (16.03%) were formulated using a 'theoretically mixed' perspective. Finally 8.33% of case formulations were limited to being simply aetiological, 5.13% were considered lay perspectives and in 1.92% of the sample there was no formulation present in the file.

CHART 2
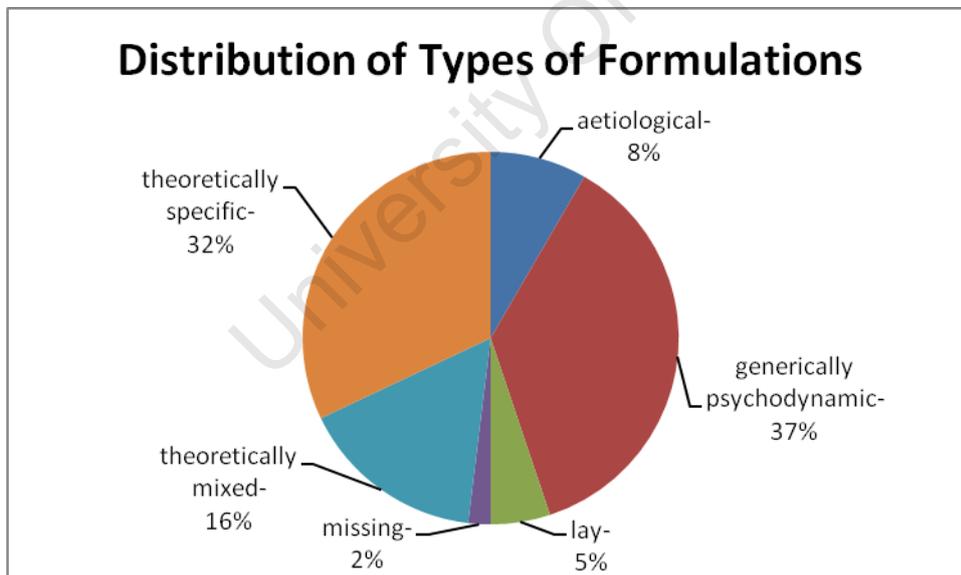
Interventions

The majority (59.62%) of individual psychotherapeutic interventions embarked upon were clearly connected to corresponding case formulations with trainees plainly stating their plan of action in their intervention notes while making reference to their formulations. The

remaining 40.38% of intervention strategies examined were unconnected to corresponding case formulations and bore no evidence of these formulations having been drawn upon.

The Course of Treatment

Sessions

The most frequent number of sessions clients were seen for was 10 sessions, with the maximum number going up to 59 sessions and least being 2 (see Chart 3). The majority of clients were seen for approximately 18 sessions or less and only a minority saw trainees for any length of time over this.

CHART 3
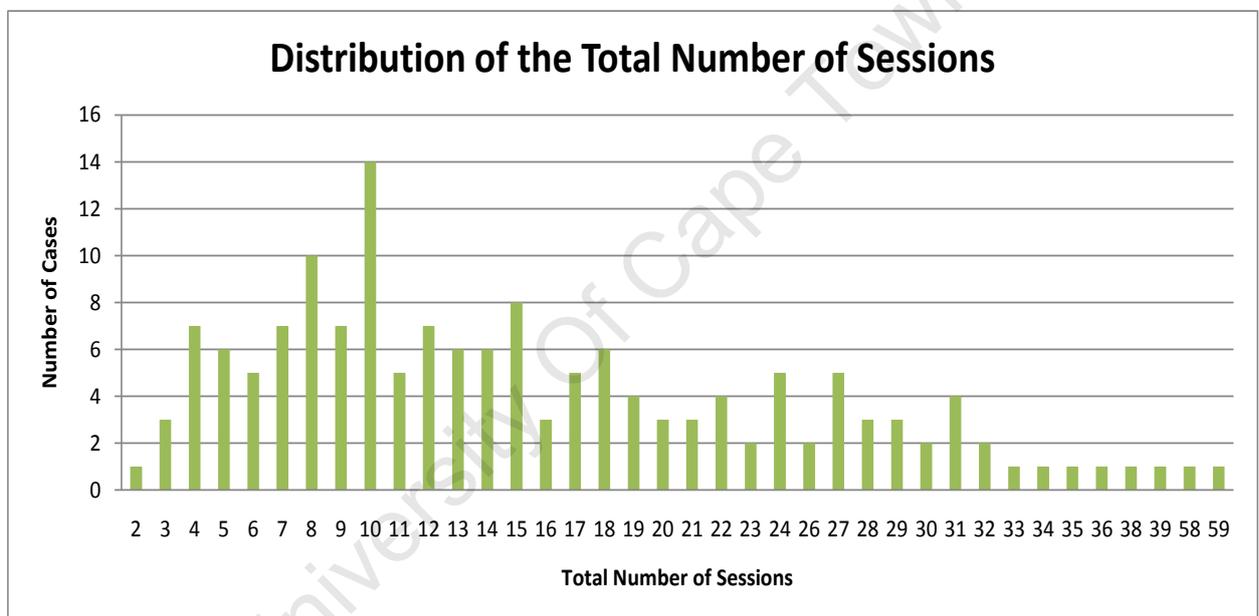
In terms of sessions missed the majority of clients (30.13%) did not miss any sessions at all. A proportion of 39.10% of clients missed between one and three sessions. The number of clients who missed sessions declined inversely proportionately to an increased number of missed sessions (see Chart 4).

Prognosis

The majority of prognoses given on termination were broadly categorized by trainees as 'good' (41.02%) while 23.08% were considered 'fair' and 7.05% considered 'very good'. Thus in total 71.15% clients received a generally positive prognosis upon termination. In

contrast 28.85% of clients' prognoses were considered by trainees to be 'poor' on termination. A proportion of 17.31% of trainees stipulated further on their various prognoses that clients would need to continue psychotherapy.

CHART 4
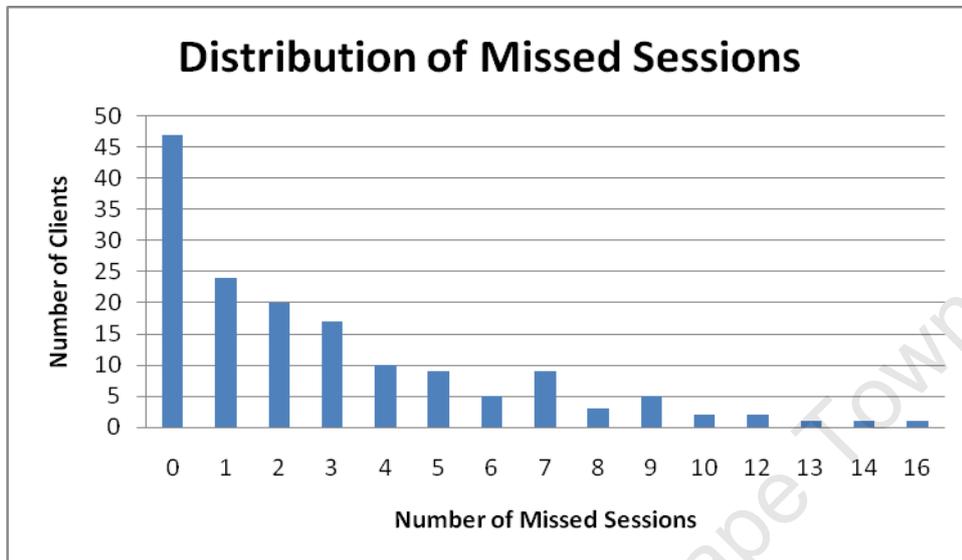
Apparent Outcome

This separate measurement was also given by trainees and can be said to offer further clarity on clients' outcomes upon termination as well as perhaps strengthening the validity of such outcome data. Indeed analysis into the possible interaction between these two outcome measures revealed good consistency in the cross-distribution of their results with by far the large majority of cases falling to related outcome and prognosis categories.

Trainees classified a majority of 91 clients (58.33%) as having shown 'improvement' upon discharge while 5.77% were classified as 'apparently recovered'. A total of 42 clients (26.92%) were judged to have remained 'unchanged' and 5 clients (3.2%) were seen to have 'deteriorated' during treatment.

Multi-variable Relationships

Considering that the focus of the present research is on individual psychotherapy in the local context specifically it is pertinent to investigate possible relationships between variables that are perhaps especially relevant locally. This section sets out to investigate the data of the

sample for any such relationships in an open-ended but generally linear fashion. As such, variables will be dealt with as far as possible in the same order as they have been presented so far. These investigations also specifically focus on those associations revealed in the pivot table analysis to be especially substantial in terms of the distribution of the data.

Sex, Class and Diagnosis

In terms of clients' demographic variables, their socio-economic class is arguably the most key to consider in the South African context. Factoring in class when examining clients' sex for example revealed that while females were by far the majority of clients overall, there was a higher proportion of female clients in the so-called higher socio-economic classes than in the so-called lower classes. Indeed 78% of clients that were categorized as either from 'Class 1' or '2' were female while of those categorized as falling into 'Class 3' or below only 60.38% were female.

In a cross-examination of class and diagnoses on Axis I the most common relationship seen overall was between 'Class 3' categorization and diagnoses of either Parent Child Relational Problem (14 clients), MDD (11 clients) and Dysthymic Disorder (11 clients). The second most frequent relationship was between diagnoses of either Dysthymic Disorder and No Diagnosis and a 'Class 2' categorization, which occurred for seven clients respectively. Given the present research's focus on class and mental health as well as the apparent patterns in the data's distribution along class lines the relationship between class and Axis I diagnoses was further investigated statistically. A Chi-squared test, χ^2 (31, N=156) = 33.10, p= 0.3649 was insignificant but the effect size given as Cramer's V was still substantial at 0.46. Thus although not possible to conclude the relationship is statistically significant it appears as much as almost half the variance between the variables is explained by there being a relationship between class and Axis I diagnosis.

Indeed of the six PTSD diagnoses made overall all were with clients categorized as either from 'Class 3' (5 clients) or 'Class 4' (1 client) categories. Of the clients diagnosed with a mood disorder, including MDD, MDE, Dysthymic Disorder , Depressive Disorder Not Otherwise Specified and Bipolar Disorder a clear majority of 37 were from 'Class 3' or below while 17 were from 'Class 2' or above. Diagnosis of a mental disorder was held back

entirely for nine clients who fell into either 'Class 2' or 'Class 1' categories and for six clients who fell into either 'Class 3' or so-called lower socio-economic categories.

Mood disorders were diagnosed in 37.86% of female clients and in 30.19% of male clients respectively. Diagnoses related to aggressive or violent behavior such as Intermittent Explosive Disorder and Oppositional Defiant Disorder were found to be largely limited to male clients (4 clients) as opposed to female clients (1 client). A Chi-squared test, χ^2 (31, N=156) = 38.82, p= 0.1578 was insignificant although the effect size given as Cramer's V was substantial at 0.49. This suggests a large proportion of the variance between the sex and Axis I diagnoses data is explainable in terms of there being a relationship between the two variables.

Considering Axis II diagnoses and sex together, it was found that Borderline Personality Disorder (BPD) was far more prevalent with female clients. 10.68% of all female clients were diagnosed with BPD compared to just 1.89% of the male clients. Furthermore if those clients diagnosed with Borderline traits are included in the comparison 17.48% of female clients were diagnosed with some form of borderline personality pathology compared again to just 1.89% of male clients. Interestingly female clients were more likely to be given an Axis II diagnosis than male clients were, with 86.79% of male clients either not receiving an Axis II diagnosis or receiving deferred Axis II diagnoses compared to 69.9% of female clients. However, a Chi-squared test, χ^2 (12, N=156) = 17.64, p= 0.1272 was insignificant and the effect size given as Cramer's V was 0.33. Thus there is some evidence for a relationship between Axis II diagnoses and clients' sex and this warrants further exploration.

The proportions of clients reporting ongoing substance abuse was very similar between those clients categorized as either 'class 1' or '2' (10%) and those categorized as from so-called lower classes (11.32%). A very similar picture was found between the sexes with 11.32% of male clients reporting ongoing substance abuse compared to 10.68% of female clients.

Sex, Class and Trauma
Female clients were also found to have higher rates of reported childhood sexual abuse with 23.3% of all female clients seen reporting childhood sexual abuse compared to 5.66% of all male clients. A Chi-squared test, χ^2 (1, N=156) = 7.60, p= 0.0058 was significant, indicating

clients' sex and rates of reported childhood sexual abuse are contingent on one another. The effect size of 0.47, calculated as a tetrachoric correlation is substantial and provides further evidence that female clients' had a significantly higher preponderance of childhood sexual abuse histories. Similarly, more women (28.16% of the whole female sample) reported ongoing domestic violence in their homes than male clients did (22.64% of the whole male sample). In terms of other severe trauma again more women reported such experiences (12.62% of the whole female sample) compared to male clients (7.55% of the whole male sample).

Factoring in socio-economic class it was found that 14% of clients categorized as from 'Class 1' or '2' had a history of childhood sexual abuse compared to 18.86% of clients from 'Class 3' or so-called lower socio-economic categorizations. A Chi-squared test investigating the potential relationship between childhood sexual abuse and socio-economic class, χ^2 (1, N=156) = 0.56, p= 0.4532 was, however, insignificant. The effect size, calculated as a tetrachoric correlation was insubstantial at 0.12. Domestic violence was, however, also found to be more commonly reported in so-called lower socio-economic class categorizations with 30.19% of clients from 'Class 3' or lower class groupings reporting ongoing domestic violence as compared to 18% of clients from 'Class 1' or '2' groupings.

Client Variables, CGC Input and the Course of Treatment

In an examination of the possible influence of class on outcomes, it was found that 62.26% of clients categorized as in 'Class 3' or below achieved positive outcome measures reflecting either 'improvement' or 'apparent recovery'. Of those clients categorised as 'Class 1' or '2', 68% achieved the same positive outcomes. Given the present research's focus on socio-economic context it was important to further investigate the potential relationship between socio-economic class and clinical outcomes. A Chi-squared test, χ^2 (4, N=156) = 2.86, p= 0.5818 was insignificant. This together with the minimal effect size of 0.14 given as Cramer's V suggests clients' socio-economic class had very little or more likely no relation to their clinical outcomes.

Further examination of the potential impact of socio-economic class differences on the course of treatment revealed that of those clients missing just three or fewer sessions 67.59% were categorized as from between 'Class 3' and 'Class 6' while 32.41% were categorized as from

'Class 1' or '2'. A Chi-squared test, χ^2 (14, N=156) = 14.46, p= 0.4155 was insignificant and Cramers' V was calculated at 0.30. This indicates some relationship between clients' socio-economic class and the number of sessions they missed. Of those remaining in therapy for ten or more sessions the majority of clients (67.27%) were from households categorized as 'Class 3' or below with the remaining 32.73% hailing from higher socio-economic class categories. A Chi-squared test, χ^2 (37, N=156) = 23.09, p= 0.9640 was, however, insignificant and the calculated Cramer's V effect size was 0.38. This is indicative of a relationship between the number of sessions clients stay in therapy for and their socio-economic class, and further research into this relationship is warranted.

Turning to an examination of the impact of the CGC trainees' interventions on treatment it appears that the degree to which trainees' case formulations informed and were connected to their interventions had an influence on clients' progress and clinical outcomes. Indeed a proportion of 78.65% of clients who received interventions clearly connected to their case formulations were judged by trainees to have positive outcomes while 21.35% were judged to have either 'deteriorated' or remained 'unchanged'. In contrast, of those receiving interventions unconnected to their case formulations a proportion of 51.72% were judged to have had positive outcomes.

It was also noted that there were some differences in the distribution of the types of formulations made over the years, with for example there being a preponderance of 'theoretically specific' formulations (15 or 30% of all theoretically specific formulations in the sample) being made in 2005.

CHAPTER FOUR
DISCUSSION OF PRINCIPLE FINDINGS

Focus in this section is initially given to the demographic representativeness of the CGC sample, to the types of presenting problems clients typically came with as well as to their course of treatment at the CGC. In so doing, the discussion also deals with significant relationships of interest between the key variable groupings in the sample. An attempt is also made throughout the discussion to unpack the influence of the social context in work at the CGC. The discussion closes with a consideration of the utility and applicability of individual psychotherapy in the local context.

Demographic Representation

The degree to which clients from a broad range of demographic categories are represented in the sample is a key aspect of the present research's focus. This question of demographic representativeness relates not only to a number of issues pertaining to the specific socio-historical context of the Clinic and its clinical practice but also to individual psychotherapy in the local context more broadly. Despite there being some consensus in the literature that long-standing political, societal and economic factors are likely to influence the mental health of Western Cape communities (Evans & L. Swartz, 2000; Long, 2002; L. Swartz, 1998) the degree to which such influence is actually recognisable in clinical presentations at the CGC over the past decade especially has until now remained unclear.

Socio-economic Class

Considering Smit (1997) and Melvill's (2000) findings that there has been a general shift at the CGC towards treating socio-economically poorer classes since the 1980s and into 1990s the present research's finding that just over two thirds of the sample come from lower-middle class and working class households substantiates this notion of a shift in the CGC client profile. In fact, it seems what was once a shift in direction, instigated by complex political changes in the 1980s, has now become the status quo at the Clinic, where socio-economically poorer classes are routinely accepted and inducted into individual psychotherapy. This has to be appreciated as being a major change both from the earlier and long-standing segregationist policies of the Clinic prior to the 1980s but also from the more recent demographic picture in

the 1980s and 1990s where the majority of the Clinic population had reportedly remained middle class (Melvill 2000; Smit, 1997).

Furthermore such a finding goes some way towards challenging the extent to which individual psychotherapy remains entirely "a middle-class, often white, luxury commodity" at least at the CGC (Swartz, 2007, p. 180). This shift towards working with so-called lower socio-economic classes implies that a more socially inclusive selection process is at play at the Clinic, one that is perhaps a continuation of the more socially-conscious ideologies that surfaced at the Clinic in the 1980s. Despite such encouraging signs, however, Melvill's assertion still arguably holds true that "beyond the immediate horizons of the CGC" there remains "the considerable challenge of providing culturally relevant psychological services to an historically disadvantaged clientele" (p. 140). However, it must also be said that clinical psychology community service requirements have meant that many CGC graduates regularly now spend a year or more in often remote and rural locations and that this is likely to be doing much to increase psychotherapy's representation nationally.

It is important to note that while information on the racial categorization of the CGC clients is no longer stipulated in case files, socio-economic categorization can be considered as being to some extent as significant today as race was during Apartheid (Seekings & Nattrass, 2005, Smit, 1997) and as such is perhaps often as dependable a variable as race is for denoting previous and ongoing political and economic disadvantage. Indeed the very fact that race is now omitted from case files when it used to be included is significant in its own right and suggests a reluctance on the part of the CGC administration to continue overt racial profiling. This in turn may perhaps in part be out of a sensitivity to vocal calls for the establishment of a non-racial society made since the end of Apartheid. If this is the case it would be evidence again of the influence of changing socio-political contexts on work done at the Clinic.

Sex

Out of the 156 individual cases worked with over the past decade, 103 were with female clients, a majority that is almost double the number of male clients. This is clearly in contrast to Melvill's (2000) findings that the majority of Clinic clients in the 1990s were male. Indeed female clients were in the majority every year of the past decade. While the reasons for this apparent turnaround in sex representation at the Clinic are difficult to guess at, the present

demographic picture does support the commonly held view that males are less likely to seek or engage in psychotherapeutic work.

While many more female clients than male clients were seen overall, the fact that fewer female clients from socio-economically poorer classes were seen than from middle-class households is noteworthy. The reasons for this pattern are not clear but it could be postulated that perhaps middle-class women are more likely to be in a position to be able to seek out and engage in psychotherapy than socio-economically poorer women are. The fact though that poorer women still made up the majority of treated cases in the sample to some degree confirms local research by Spangenberg and Pieterse (1995) which identified low socio-economic class as a significant cause of mental distress for women specifically.

Age

Both Smit and Melvill describe a discernable shift in the Clinic population away from educational work with school-age children in the decades preceding the 1980s to work encompassing more psychotherapeutic interventions with young and older adults in the 1980s and 1990s. The presence of the continuing trajectory of such a shift today is confirmed by the present findings, which show the majority of individual clients over the past ten years have been above the age of 18. Indeed, considering the majority of cases seen during the 1980s and 1990s were school-age clients it can be said the latest data heralds a significant shift in the Clinic's demographic profile towards work with adults predominately. The still-significant proportion of young clients seen over the past decade though is also important to acknowledge as it provides an example of how psychotherapy is still routinely conducted with children as young as four at the CGC.

Presenting Problems in Context

Axis I Diagnosis

Despite this shift in the age profile of clients over the past decade, Parent-Child Relational Problems were found to be the single largest diagnostic grouping in the sample. While a considerable number of adults received this diagnosis in respect of their presenting problems being familial in nature, the frequency of this diagnosis may also be explained by the significant proportion of Clinic work still being with children and adolescents (31.03%).

Apart from Parent-Child Relational Problems the second most frequently made diagnosis was of a mood disorder of some type, an arguably fairly common presenting problem in individual psychotherapy and one for which there is much evidence of psychotherapy's efficacy (Connolly Gibbons et al., 2008). What is perhaps especially significant to note, however, is that the vast majority (68.52%) of clients diagnosed with mood disorders were from socio-economically poorer classes. Such a finding is difficult to interpret with confidence as many variables are likely to be at play but it does at least suggest low socio-economic class plays a substantial role in the genesis and subsequent presentation of depressive symptomotology in the CGC sample. By extension then, affluence could be characterised as a potential mitigating factor for developing mood disorders. This would certainly be in line with critical and ecological perspectives on clinical psychology such as those of Peterson (1998) and Dawes and Donald (2000) that highlight the pervasive impact of socio-economic position on mental well-being generally. Further exploration of this relationship would be useful.

Another potential influence of class may, however, be a reluctance on the part of trainees to diagnose and thus pathologise clients from higher socio-economic classes, contrasted with less trepidation in diagnosing those from poorer classes. There is, for example, evidence of trainees often opting not to diagnosis clients from higher socio-economic classes with a mental disorder. This is in contrast to clients from lower socio-economic classes. Such a dynamic could then also be said to potentially explain the significantly higher rates of mood disorder diagnoses seen in poorer classes in the sample. Conversely, it may also be that trainees are less willing to diagnose poorer clients with stigmatizing disorders such as BPD and Anti-social Personality Disorder, instead preferring to diagnosis them with mood disorders. This needs to be explored in further research.

Apart from socio-economic class, sex and gender difference was also identified as having some influence on diagnosis rates. While the difference is not especially substantial, 7% more female clients were found to be diagnosed with mood disorders than male clients were. This difference is in line with Melvill's findings from the 1990s that more female clients were diagnosed with mood disorders than male clients were and implies this pattern has continued throughout the past decade (2000). This together with the substantial effect size seen between clients' sex and Axis I diagnoses in the present research strongly suggests there is an

underlying relationship between these variables. Similarly, diagnoses pertaining to aggressive or violent behaviour patterns were found to be largely limited to male clients in the present research, as had been the case in Melvill's sample. Ascertaining the reasons for such apparently long-standing patterns in diagnosis rates in the CGC client population with any certainty is difficult but from a post-structuralist perspective they could arguably be due to clients and clinicians' immersion in a patriarchal society that in many ways demands men be strong and aggressive and women to be emotional and weak (Butler, 1997). Clinicians and clients alike then would be understood to unconsciously reproduce behaviour and diagnoses respectively that reinforce ways of being that are expected by their society.

Substance Abuse

Although generally not formally diagnosed with substance abuse problems, a relatively high proportion of the sample (10.9%) reported ongoing substance abuse. This is thought likely to be due to trainees not considering clients' substance abuse as the primary presenting problem in these cases. This absence of clear substance abuse diagnoses is problematic considering the specialised case management skills required for this type of presenting problem. The fact that such a significant proportion of the sample abused substances underlines both the severity of presenting problems seen in the Clinic sample as well as the clinical demands the CGC puts on trainees. Such a finding may also be likely to reflect the high rates of substance abuse in South Africa more generally.

The fact that only minimal differences were found with regard to potential socio-economic class or sex differences in substance abuse rates suggests this social ill is similarly prevalent across class boundaries and within both sexes. This casts some doubt on the assertion made by Bray, Adams and Mc Queen (2003) that males are at greater risk for substance abuse, at least in so far as the Clinic sample is concerned. The present findings are also to some extent in contrast with research by Kaplow, Curran and Dodge (2002) and Dishion et al. (1999) that found evidence of low socio-economic class predicting later substance abuse.

Axis II Diagnosis

Axis II diagnoses appeared generally not to be favoured by trainees. Over three quarters of the sample received either a deferred diagnosis or more commonly no Axis II diagnosis at all. While this does perhaps indicate an absence of personality pathology in the sample it may

also suggest trainees are neglecting to consider the personality disorder traits clients may have. This may be due to trainees feeling uncomfortable making such Axis II diagnoses, given the generally poor prognosis for such personality pathology and because of their lack of experience in learning to diagnose objectively and accurately.

The fact that the largest Axis II diagnostic category by far (15.18% of the sample) was Borderline Personality Disorder is noteworthy and again highlights the severity of the presenting problems trainees face at the Clinic. This is arguably so because BPD is widely seen by clinicians as a notoriously difficult disorder to work with psychotherapeutically. The fact that more than a quarter of the sample was given Axis IV GAF scores of 51-60 or even lower again supports this notion that presenting problems at the CGC are often very severe in nature.

Substantial sex differences were found in Axis II diagnosis rates with approximately ten times more female clients being diagnosed with BPD or Borderline traits than male clients. Furthermore, female clients were found to be more likely to be given an Axis II diagnosis than male clients were. These clear sex differences in Axis II diagnosis rates suggest either female clients presented with more personality pathology, which is possible, or alternatively that trainees are unwittingly continuing a local but also widespread pattern of conceptualising women "as more emotional than men", a pattern Shelmerdine identified in local diagnosis rates from the 1930s (2001, p. 11). The latter reading would suggest implicit bias at the CGC towards pathologising women's behaviour and emotions while overlooking men's. Nonetheless it is quite possible that female clients did in fact present with more personality pathology than male clients did and if so this pattern might be best explained by Wesely's argument that women's unequal social position and associated difficulties "set them up for social, emotional, and behavioural deficits" (p. 325). This area needs further research, best done perhaps by way of a set of case studies.

Trauma
Of the six clients diagnosed with PTSD all were from poor socio-economic classes, a finding that does potentially suggest the adverse and indirect influence of low socio-economic status on psychosocial well-being. Added to this is the fact that both childhood sexual abuse and domestic violence were both more common in poorer socio-economic groupings. This

finding supports Engeland, Jacobvitz and Sroufe's (1988) conclusion that the likelihood of an individual being sexually or physically abused is in part related to their socio-economic status. It is important to stress, however, that the nature and reasons for this relationship are unclear and cannot be considered evidence of an innate failing in poorer communities. Indeed, according to an eco-developmental perspective such results should rather be understood as a psychopathological product of social and economic marginalisation.

That female clients reported far higher rates of childhood sexual abuse, ongoing domestic violence and other trauma is also a significant finding of the present research and implies sex and gender difference plays a central role in accounting for who was victimised in the sample. Childhood sexual abuse rates were significantly different between the sexes and this could be said to indicate that girls are at much higher risk of being sexually abused in the local context than boys are. This would lend support to Wesely's view that women are very much more likely to be the object of "sexual, emotional and physical violence" (p. 324).

It may also be that male clients were less willing to disclose past or present sexual abuse than women were. This could in part be due to the influence of patriarchal ideologies that post-structuralist theorists such as Butler (1997) and Fuss (1989) argue permeate society and that disallow men from discussing their difficult emotions and their victimisations for fear of being branded less masculine. Nonetheless, it cannot be said with any certainty that male clients' rates of abuse were in fact any higher than they were reported to be or that there was a reluctance on their part to disclose sexual victimisation. Interestingly though, rates between the sexes for domestic violence and other severe traumas were not as far apart as might be expected. It is thus important to acknowledge that a substantial number of male clients at the CGC reported being the subject of ongoing domestic violence and reported a history of severe trauma. The fact remains, however, that women were still significantly more likely to be victimised overall.

Moreover, the reality that as much as 17.31% of the total sample reported a history of childhood sexual abuse, that 26.28% reported ongoing domestic violence and that 10.9% reported a history of other severe trauma is crucial to properly appreciate as a whole. These proportions of the sample having experienced trauma are arguably very high in any social context, but especially so for a community clinic traditionally specialising in learner

assistance and in child and adolescent psychotherapy. Given that such a large proportion of the sample reported a history of significant trauma, the extent to which this reflects a similarly widespread problem in the greater Western Cape population has to be considered. As van den Berg asserts (2000) child sexual abuse and violent crime are common social ills in this province. The relationship seen then between socio-economic class and reported abuse in the CGC sample further highlights the dire consequences of poverty for individuals and their communities in the Western Cape and underlines the desperate need for local socio-economic and personal development.

Treatment in Context

Psychotherapeutic interventions operate in spaces where a multitude of clinically relevant variables all come to play a part at once. Clients' individual differences, their demographic positions and their presenting problems as well as clinician's competence and their case formulations arguably together all influence and determine clinical outcomes. This section attempts to articulate significant aspects of this complex process in the CGC sample.

CGC Case Formulations

Psychotherapeutic treatment should ideally always begin with a good case formulation. This view is espoused by Falvey (2001), McWilliams (1999), S. Swartz (1999) and Messer, Tishby and Spillman (1992) among others. Lee and Tracey argue though that there remains a need "for more research exploring how conceptualization skills may relate to actual client outcomes" (p. 521). In a similar vein McWilliams writes that "there is an ongoing need for the training literature to explicate the bases on which most experienced therapists draw their treatment conclusions" (p. 10). Such observations bring into relief the importance of examining the position of the case formulation in the local and pedagogical CGC context specifically.

Case formulations appear to generally be embraced by trainees at the Clinic as important elements of their clinical casework. This is seen in the fact that the vast majority of clients receive a theoretically-orientated psychotherapeutic case formulation. Interestingly a large proportion of formulations in the sample were found to be 'generically psychodynamic', a finding that confirms the Clinic's reputed predilection for psychodynamic theory. This would also suggest that the shift towards psychodynamic theory that Hay (1990) identified as arising

in the 1960s at the CGC has continued well into the twenty first century. However, the substantial proportion of case formulations in the sample that were considered to encompass a broad mixture of psychotherapeutic theory including non-psychodynamic theory also points towards the use at the Clinic of a range of other psychotherapeutic perspectives as well.

Worrying though was that 15% of case formulations had no discernable link to psychotherapeutic theory at all and provided little in the way of a deeper psychological understanding of the reasons for clients' presentations. The fact that as much as 40.38% of case formulations examined in the sample were not clearly drawn upon in corresponding clinical interventions is also cause for concern. This is clearly problematic considering the importance generally attributed to theoretical case formulations in good case management and suggests a considerable proportion of trainees are not recognising the need to link formulations with case work.

It must be noted too though that in some cases intervention strategies change as the case unfolds. A parent for example might be inducted into individual psychotherapy after a full case formulation and management plan has already been made for the initial primary client, the child. In these cases another case formulation may not be written for the parent even though a new case file has been opened up for them. While still somewhat problematic, such exceptions may account for a proportion of the formulations that were judged to be either unconnected to interventions or lacking in theoretical depth.

The fact that 'theoretically specific' formulations were by far more prevalent in 2005 specifically may be said to support Hay's (1990) assertion that different supervisor's theoretical viewpoints and shifting pedagogical paradigms at the Clinic have an influence on the style of case management and the type of theoretical formulations made in certain years.

CGC Case Interventions

The majority of individual psychotherapeutic interventions examined at the Clinic were, however, connected to and enriched by corresponding and theoretically-based case formulations. Moreover, this majority of interventions that made explicit reference to clients' case formulations were found to have higher rates of positive clinical outcomes upon termination than those interventions that did not. Such a finding provides evidence of the

importance of applying and connecting theoretical case formulations to clinical intervention strategies. It also serves to support findings by Messer, Tishby and Spillman (1992) in particular that clinical interventions are more effective when they make use of and integrate the psychological insights case formulations ideally provide.

Given the positive clinical outcomes seen in the sample it may be said that the general quality of clinical interventions at the CGC is effective, despite the difficulties that the complex local socio-cultural and political context of the Clinic could raise in working with clients (Ivey, 1992; S. Swartz, 1999). While socially embedded interpersonal dynamics and challenges arguably continue to be omnipresent in local therapeutic encounters, clinicians at the CGC generally appear to manage well in negotiating relevant cultural and social power dynamics, at least in as far as they are able to be of some assistance to clients.

Most interventions in the sample were found to be short-term with the most frequent number of sessions being ten. Bearing in mind that a majority of clients were considered to have benefitted from their treatment this relatively low number of sessions is noteworthy and suggests perhaps that short-term treatments are sometimes the most appropriate therapeutic modality for clients at the Clinic. Such a conclusion would be in line with Dartington's (1995) assertion that many clients in community clinics prefer shorter-term interventions. This more time-limited framework may even serve as a draw card to some clients, as Oliver-Bellasis (1998) argues as it suggests a less formal therapeutic atmosphere than traditional and standard long-term individual psychotherapy.

Client Compliance at the CGC

Another measure of the degree to which trainees successfully managed the complex socio-cultural dynamics at play in consultation rooms at the Clinic is arguably the length of time clients were prepared to continue psychotherapy for. For the most part, it seems trainees sustained contact and encouraged motivation to continue therapy, with a majority of clients not missing any sessions at all in their allocated treatment contracts. Such a finding is important to appreciate as it suggests a certain willingness, commitment and positive attitude towards psychotherapy on the part of CGC clients despite the difficulties such work can and does bring up.

Furthermore, taking into account both that clients from so-called lower socio-economic classes actually missed substantially fewer sessions than middle-class clients did and generally stayed in therapy the longest it could be said that commitment to psychotherapy is paradoxically, strongest in those who can least afford it. This pattern may, however, also be due to middle-class clients being more easily able to switch to more experienced private therapists.

Clinical Outcomes at the CGC

The simple fact that as much as 64.1% of the whole sample were considered to have improved or even recovered by the termination of treatment at the Clinic is significant and arguably reflects the power of individual psychotherapy to initiate positive psychological change. Supporting this finding was the second clinical outcome measure, which indicated an even higher percentage of 71.15% of clients having generally good prognoses upon termination.

In line with the present research's consideration of the potential influence of socio-economic context on psychotherapeutic work, it is noteworthy that socio-economic class was found to have an insignificant relationship with clinical outcomes in the sample. That more affluent clients did have slightly better clinical outcome rates is perhaps suggestive of both their readiness to embrace the psychotherapeutic modality and their familiarity with it. That a proportion of only 5.74% fewer poorer clients achieved similarly positive outcomes, however, underlines that clients' socio-economic class has little or no influence on the efficacy of psychotherapy. By extension then, it is arguable that psychotherapy is as appropriate an intervention for socio-economically poorer individuals as it is for its more traditionally affluent client base.

Applicability and Utility of Individual Psychotherapy in the Local Context

Given the apparently positive outcomes and prognoses given for the majority of individual psychotherapy clients at the CGC over the past decade a case has to be made for the utility and appropriateness of individual psychotherapeutic work being done in the local context more broadly. Furthermore, the fact that clients from so-called lower socio-economic contexts missed far fewer sessions and stayed in therapy for substantially longer than richer clients underlines the appropriateness of individual work for socio-economically poorer

clients. Added to this is the fact that socio-economic class appeared to have an insignificant effect on clinical outcomes, with clients generally showing positive outcomes regardless of their socio-economic class. Far from having limited value in the post-Apartheid South African context then, as has previously been suggested by Kagee and Price (1994), mainstream individual psychotherapeutic practice appears to show great potential, at the CGC at least in providing assistance to individuals from socio-economically and historically disadvantaged contexts.

Considering the higher rates of child sexual abuse and domestic violence seen in clients from poorer socio-economic classes in the sample and the terrible damage such abusive experiences typically inflict on individuals, the need for psychotherapeutic interventions with individuals from such communities is clearly urgent. Accessible and well-resourced individual psychotherapeutic services together with broader social developmental strategies would likely go some way towards averting and lessening the potential psychopathological effects of abuse and trauma. That trainees at the CGC appear to manage well, despite both client presenting problems often being severe and the CGC generally being trainees' first real taste of psychotherapeutic work bears testament to the power of psychotherapy, even in less than ideal conditions.

Psychotherapeutic work at the CGC has arguably always been influenced by changing social and political contexts. Research by Hay (1990) and Smit (1997) in particular provides a historical account of the Clinic's ethically questionable past practices but also of its struggles to reform itself. The increasing numbers of clients from socio-economically poorer household seen at the Clinic in recent decades bears testament to a transformative agenda at the Clinic that again mirrors structural changes and ideologies at work in the larger South African political and social context.

The drive towards making psychotherapy relevant and useful in the South African context, which originated in the 1980s appears to have continued and grown in momentum in recent decades, at least in so far as the CGC is concerned. The fact that the majority of individual work at the Clinic now encompasses work with socio-economically poor individuals can be taken on its own as evidence of the CGC having risen to the challenge of making itself both useful and relevant in its local context. The CGC stands as an example of the potential of

individual work to move beyond its elitist associations to become a more powerful instigator of both personal and social change in this country.

CHAPTER FIVE

CONCLUSION

Concluding Summary

The viability of psychoanalysis will be best served by maximizing the extent to which humanistic values inform our theory and make their contribution. Both these goals are served by exposing, grappling with, and countering the elitism of psychoanalysis wherever it appears.. . . . The elitism that does exist is addressable by bringing racial, cultural, and class differences within the psychoanalytic domain and by being active in the public sector, as therapists and consultants, so as to bring the psychoanalytic vision to bear on work with people from a wider variety of cultural and socioeconomic backgrounds.

(Altman, 1995, p. xx).

It has until now remained unclear as to whether the complex and specific socio-economic, historical, political and pedagogical context of the CGC has influenced individual psychotherapeutic presentations, interventions or outcomes in significant or discernable ways over the past decade. Generally speaking it appears they have. Both client demographic variables such as their socio-economic class and sex as well as contextual forces relevant to the Clinic appear to exert considerable influence on the work that is done there. For example, the subtle yet pervasive influence of patriarchy is arguably seen in the considerable sex differences in clients' reported trauma rates and their diagnosis patterns. Similarly, the higher preponderance of trauma in poorer socio-economic classes highlights the potentially destructive impact such adverse socio-economic contexts can have on individuals. The fact that the Clinic has over the past ten years shifted to working predominantly with clients from poorer socio-economic classes also points to the potential contextual influence of a growing social developmental ideology present at the Clinic. These broad and disparate contextual influences are all present at the Clinic and play their part in the work that is done there.

Although case files are not always in line with stipulated requirements, the fact that the majority of individual psychotherapy clients were apparently assisted by their contact with trainees provides evidence of the generally high quality of the work being done at the CGC.

Furthermore that the majority of cases at the CGC today are conducted with clients from poor socio-economic classes highlights both the utility and applicability of individual psychotherapy in work with under-privileged individuals generally. At the same time, such findings pertaining to the increasingly socially inclusive nature of individual practice at the CGC are also evidence of a state of affairs that is worlds apart from the Clinic's past segregationist stance to client selection.

That community clinics such as the CGC can shift to work with under-privileged individuals and that such work appears to often be successful, despite the preponderance of severe trauma and personality pathology seen in the present sample stands as an important testament to both the applicability and utility of individual psychotherapy in our local context. Given the psychodynamic leanings of the CGC the present research's findings could also be said to constitute the beginning of a robust answer to criticisms levelled against psychodynamic therapy and it's appropriateness to the South African context.

Practical Recommendations Based on the Findings

Perhaps by far the most important practical recommendation arising out of the present research is that theoretical case formulations ought to play a more significant role in psychotherapeutic interventions at the CGC. The findings that the extent to which case formulations were connected to clinical interventions was likely to have a bearing on the quality of such interventions underlines how important it is that trainees come to see their case formulations as integral aspects of their case management. Furthermore, theoretical case formulations ought always to be written for all clients. Despite this already being an expectation for trainees at the Clinic, a substantial number of clients appear not to receive theoretical case formulations.

Trainees might also benefit from some form of additional awareness raising training concerning feminist theory and its potential implications for diagnosis and treatment, considering the significant sex differences in childhood sexual abuse rates and substantial sex differences in diagnostic rates that appeared in the sample. Although the present research found no specific evidence of trainees struggling with socio-economic differences between themselves and clients, increasing training and reading around the influence of socio-economic and cultural difference on psychotherapeutic work may also be useful to trainees,

especially given the increasing proportion of poorer economic classes at the Clinic. Considering the minimal number of referrals from welfare organisations, the Clinic could also further widen its client base by increasing welfare organisations' awareness of its services, if this is feasible in terms of its operating capacity.

Finally, the positive outcomes typically seen in the now predominantly socio-economically poorer CGC client population can be taken as evidence that a similarly positive impact may quite possibly be achieved on a larger scale in public health clinics. For this to be achieved such clinics would both need to better resourced and given the capacity to make more clinical psychology posts available.

Limitations of the Current Study

Even though a sample was checked by an experienced clinician the subjective nature of the categorization choices that were made for variable groups relating to types of formulations, interventions and prognoses leaves these data-gathering procedures open to the threat of bias on the part of researcher. However, in addition to my own rigorous self scrutiny, objectivity was also maintained by pairing and complementing the subjective aspects of the research methodology with more objective procedures and measures wherever possible, as was seen with regards to outcomes data for example.

The descriptive statistics that were used for part of the analysis do not provide unequivocal measures of statistical power. Such results thus have to be interpreted with caution as they are only descriptive in nature and as such only pertain to the present 2000 to 2009 CGC sample. Although arguments have been given for the representativeness of the sample to the local South African context the actual extent of this representativeness has not been ascertained unequivocally.

Useful Areas for Further Research

Qualitative analysis of client case files would be useful in offering insights into the ways cultural and socio-economic difference potentially influence case management, case conceptualisation and clinical interventions at the CGC.

Further research into individual psychotherapy done in similarly socio-economically diverse

local South African contexts would also be useful for potentially strengthening the case for increasing professional psychotherapeutic resources in the state sector. In addition, more research into the influence of socio-economic context on mental health in South Africa specifically would be useful.

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70

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APPENDICES

Appendix A

<u>KEY TO SYMBOLS USED ON CLINIC INFORMATION SHEET</u>

<u>CLINICIAN IN CHARGE</u>:

<u>SOURCE OF REFERRAL</u>:

    A. - Parents

    B. - Relatives, Friends

    C. - Schools

    D. - Doctors, Hospitals, Clinics & other prof. practitioners.

    E. - Welfare & other Organisations (including Legal).

    F. - Other

<u>NATURE OF PROBLEM</u>:

DSMIIIR AXES   I...

                  II..

                  III...

                  IV..

                  V...

<u>OR</u>   <u>Other</u>.......................................

<u>INTERVENTION</u>: Viz. After assessment procedures carried out.

    A.- Assessment only with brief feedback to parents and school.

    B. - Advisory or counselling interviews with parents.

    C. - Advisory report(s) to referring agents and/or to other professionals (incl GP and school).

    D. - Family Therapy.

    E.   Psychotherapeutic intervention with child (individual or group)

    F. - The major factor was a medical problem or special disability; once this was established the child was referred to outside specialist or consultant.

G.- Remedial teaching recommended.

H. Case incomplete: still undergoing assessment
    when Clinic closed, or case closed due to
    inadequate cooperation.

DEGREE OF IMPROVEMENT IF HANDLED BY CLINIC:

A. DETERIORATED

B. UNCHANGED

C. IMPROVEMENT (ON DISCHARGE)

D. IMPROVEMENT MAINTAINED (FOLLOW UP AT 12 MONTHS)

E. APPARENTLY RECOVERED

F. REFERRED

G. NOT APPLICABLE (PSYCHOMETRIC ASSESSMENTS ETC).

SOCIAL CLASS

Rate according to main breadwinner's income. If retired,
widowed or divorced, rate according to what employment used
to be.

Class 1:   Professionals, salaried business executives,
           owners or operators of large firm or business.

Class II: Small businessmen, small farmers, white collar
           workers, semi-professionals, qualified tradesmen.

Class III: Skilled workers (e.g.machinists) clerical workers,
           apprentices, students.

Class IV: Semi-skilled workers

Class V: Unskilled workers

Class VI: Unemployed.