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EVALUATION OF A COUNSELLING TRAINING PROGRAMME THAT TRAINS LAY COUNSELLORS FROM THE TOWNSHIPS

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ABSTRACT

In South Africa existing mental health services and resources are inadequate to meet the psychological needs of the population, particularly the Black population. This dissertation evaluates a particular lay counselling training programme which was devised as an appropriate response to the inadequacies in the delivery of mental health services. The theoretical basis informing the programme is seeing the individual as socially constructed. There is an attempt to share skills and democratise knowledge in order to help people gain control over their mental health.

The lay counselling training programme is analysed as a case study in which both the practical outcome and its theoretical bases are examined. The practical evaluation evaluates the trainee's counselling ability on the basis of his/her role play as a counsellor, before and after the training. Each trainee was also interviewed to determine her/his perception of her/his counselling ability, counselling experiences and of the training itself.

The repressive political climate adversely affected the smooth running of the training programme. Of the two groups used in this study, only part of one group returned to complete its training. *The small sample* size does not allow for generalisations. The trainees all felt that they needed further training, but all had counselled since their training. They had worked mostly with families of detainees in a supportive and educative role. The programme is felt to be theoretically sound, but needs further practical evaluation.

DECLARATION

I declare that this dissertation is my own, unaided work. It is being submitted in partial fulfilment for the degree of *Master of Arts in Clinical Psychology* in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination in any other University.

Julie Honor Green

10th day of March, 1989.

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INTRODUCTION

There is a crisis in mental health and mental health services in South Africa (Dawes, 1985; Moll, 1983; *Editorial, Psychology in Society*, 1983; Vogelman, 1986a). Firstly, existing mental health services and resources are inadequate to meet the needs of the population, particularly the Black population (Vogelman, 1986a). There is an extreme shortage of trained health workers particularly in the townships and in the rural areas (Buch, 1985; de Beer, 1986; Savage, 1979). This shortage also pertains to mental health workers (Freed, 1979; Vogelman, 1986a). Secondly, in South Africa people live under Apartheid and presently under a prolonged State of Emergency. This has a profound psychological impact on the individual (Dawes, 1985; Foster and Sandler, 1985; Vogelman, 1986a). Thirdly, prevalent Western psychological theories and practices have been questioned as to their appropriateness in South Africa (*Anonymous, 1986;* Dawes,1985; Lazarus, 1985; Moll, 1983; Perkel,1988; Vogelman, 1987)

Appropriate responses to the above need to be developed to alleviate the suffering of much of the population. Ultimately, however, it is only through

political and economic structural change that the mental health of the population and its mental health services can be adequately improved. This would be achieved by a more equitable distribution of *resources* concommitant with the dismantling of Aparthied. *Nonetheless,* people's present suffering needs to be dealt with - and this in a manner commensurate with particular theoretical and practical ideals in line with democratic principles.

This dissertation evaluates a counselling training programme for lay people, devised as an appropriate response to *the crisis in* the delivery of mental health services. The programme is presented as a case study in which both the practical outcome and its theoretical basis are examined.

This counselling training programme was chosen because it seemed to be different and more appropriate in content and ideology from more *traditional lay* counselling training programmes (Carkhuff, 1969). *Unlike* the traditional programmes, it firstly, attempts to locate mental health in a political and social context and tries to incorporate this in the actual training. Secondly, the counselling model has continually been adapted to fit the needs of the trainees in order to try to make it as relevant as

possible. Thirdly, it links in with the broad progressive movement (organisations committed to a *free, unitary,* non-racial and democratic South Africa), one of whose aims is adequate health and mental health care for all. The programme attempts to *start* realising this aim through sharing skills and democratising knowledge in order to assist people in becoming self sufficient and in gaining control over their own mental health. More specifically this is done by attempting to impart counselling skills to township residents so that they may *effectively deal* with the acute psychological distress and trauma of people in their communities. The trainers and trainees are accountable to organisations which *ensures a check* on the training and the dissemination of skills within their organisations. Fourthly, in contrast to more traditional counselling *training programmes,* the long term aim of the programme under evaluation, is the establishment of community based mental health care services where the *services are in* the interests of the community and where people have easy access to these services. This includes access to training and resources, and power *over* these resources. This dissertation evaluates whether the above has actually been achieved.

It is important to see the programme in context, in terms of its inception and functioning in the mid-1980's in South Africa. At the time extensive popular organisations emerged, including organisations working within the mental health field, (for example, the Organisation for Appropriate Social Services in South Africa [OASSSA] and Concerned Social Workers), which questioned the appropriateness of various psychological interventions. There was an increasing awareness of the maldistribution of resources, of the inadequacies of mental health services and a more general dissatisfaction with the existing political system.

Chapter 1 will look at some of the problems facing mental health workers in South Africa. This includes a discussion on the psychological sequelae of living under Apartheid with its racist laws and under the State of Emergency with its wide powers of detention and restrictions. The lack of resources both in terms of services and institutions and trained people will be considered. Chapter 2 looks critically at responses to the shortage of trained mental health workers, at attempts to develop more appropriate models of mental health care, and at the attempts that have been made to intervene in deprived communities in the most appropriate ways. Chapter 3 focuses on the

importance of theory in developing appropriate practice, and specifically the theory informing the counselling training programme under evaluation. How the theory is translated into practice in the training programme is discussed in Chapter 4 in terms of the development of the programme, its content and functioning. On a practical level, chapter 5 and 6 evaluate whether the trainees actually gained the counselling skills taught and practised. Consideration is given to whether and in what situations they have used the skills learned, and to the programme's effectiveness. The trainee's personal perceptions of her/his counselling ability and of the training are also examined. Chapter 7 is a discussion of the results of the practical evaluation study, looking at the effectiveness of the programme in terms of its theory and practice. Finally, chapter 8 concludes the dissertation and lessons learned for future progressive mental health programmes are discussed.

CHAPTER 1

PROBLEMS IN MENTAL HEALTH AND MENTAL HEALTH CARE IN SOUTH AFRICA

1.1. INTRODUCTION

In order to develop a clear understanding of the *counselling training programme* under evaluation in this dissertation in terms of its inception, role and development, it is necessary to briefly examine the relationship between socio-political conditions and mental health in South Africa and to review existing resources and facilities.

1.2. EFFECTS OF THE SOCIO-POLITICAL CONDITIONS IN SOUTH AFRICA ON MENTAL HEALTH

South Africa is a psychologically damaged society (*Cock, 1988, van der Spuy,* 1978). The material and social conditions under which the majority of the population live are not conducive to adequate health (Buch, 1987; de Beer, 1984;) and adequate mental

health (Dawes, 1985; Vogelman, 1986a). Apartheid and the present prolonged state of emergency affect people's mental health to a greater or lesser extent (Dawes, 1985; Turton, 1985; Vogelman, 1986a). For example, the Apartheid laws of statutory race classification, the Group Areas Act, the Homelands policy with its associated phenomena of mass removals and migrant labour has resulted in millions of people being relocated with often devastating psychological consequences (Dawes, 1985; Vogelman, 1986a). Research is starting to document the adverse effects of forced removals and relocations (Innes, quoted in Dawes, 1985; Western, 1981). Some of the effects documented include feelings of great sadness and distress resulting from the breaking up of friendships and family ties, and the people's perceived powerlessness and despair. Migrant labour, which is usually forced on people for economic reasons, results in disruptions in family life and inadequate and unsatisfactory living conditions causing much sadness, frustration and anger (APA Report, 1979). Each Apartheid law seems to have its consequent psychological effects.

Although Rutter and Madge (1976) investigated poverty and disadvantage in England, their findings are applicable in South Africa. According to them, a person's economic status and housing constitute two of

the most important aspects of an individual's material environment and that environment is the most crucial factor in terms of psychological well being. In South Africa there is poor and inadequate housing with the consequent problems of overcrowding and lack of privacy. It is estimated that four million South Africans are without jobs and this figure is likely to remain or increase since it was estimated in 1986 that in order to rid itself of unemployment, South Africa needs to create 2000 jobs a day between then and the end of the century (SASPU, 7 (2) 1986). The average monthly wage of Black workers is about R300. Together with the large numbers of unemployed, the majority of South Africans live in poverty (Vogelman, 1986). Poverty shows important associations with poor physical development and many other indices of disadvantage, for example, inadequate housing, low educational attainments, problems in parenting and crime (Rutter and Madge, 1976). As Rutter and Madge (1976) state:

> "Numerous surveys have indicated an *association between* low social status and mental disorder, a pooling of disorders in socially disadvantaged areas of cities ... and important links between mental disorder and family disruption and disorganization". (Rutter and Madge, 1976, p. 193).

Whites also seem to be affected by the societal structures (Cock, 1988). For example, the divorce rate and the incidence of coronary diseases are among the highest in the world; suicides are dramatically increasing as are family murders (Cock, 1988; Dommisse, 1987). *More generally, as many as* 25% of South Africans between the ages of 12 and 25 years are actively engaged in some form of drug abuse; the number of vehicle accidents is among the highest in the world and rape is estimated to be occurring at an average of one every two minutes (Cock, 1988; Dommisse, 1987). Clearly, all of these events have profound psychological sequelae.

A major aspect in maintaining the edifices of Apartheid is the prolonged State of Emergency with its associated laws of indefinite detention, solitary confinement, restrictions and bannings. Over 5800 people have been detained over the past year, of which 5000 are State of Emergency detentions (ESG, 1988; Human Rights Commission, 1988). In 1984, before the *present State of Emergencies*, a total of 800 people were detained, clearly showing the huge increase in the numbers of people detained. Presently, 1500 people have been in detention for longer than a year (ESG, 1988). Many thousands of people are in hiding who fear possible arrest and the conditions of

detention resulting in psychological distress and suffering (Manson, 1986). More specifically, in a study on the effects of detention, Foster and Sandler (1985) found ex-detainees to have social and interpersonal difficulties, sleeping difficulties and *concomitant tiredness*, symptoms of depression, anxiety-type problems like changes in eating habits, tobacco and alcohol consumption and psychosometic complaints.

Social and political conditions in South Africa affect people's mental health, as seen above. Considerable evidence attests to the *heightened psychological* vulnerability of people who are deprived, impoverished or oppressed (Rutter, 1975). In addition to the above, Brown and Harris (1978) have shown that women living in poor conditions with young children with few social supports are several times more likely than better off women to become depressed. Children growing up in impoverished inner city areas are more *likely* to be disturbed in various ways (Rutter, 1975). Other *demonstrable* links between social conditions and mental health have been reviewed by Rutter and Madge (1976). Clearly, there are direct adverse effects on mental health caused by social deprivation and overt oppression.

1.3. RESOURCES AND FACILITIES

The fact that people's mental health in South Africa is adversely affected by the social and political structures of the country is exacerbated by health and mental health care's delivery system that is characterised by racism, sexism and a fragmentation of services (Buch and de Beer, 1988; Dommisse, 1983). This has the consequent effects of inadequate, inefficient, unco-ordinated and discriminatory services (APA Report, 1979; de Beer, 1986; Vogelman, 1986a). Furthermore, there is an extreme shortage of professionals, for example, psychiatric nurses, psychologists and psychiatrists, - particularly among Black people (Dommisse, 1987; Gardner, 1979; Lambley and Cooper, 1975; SAIRR, 1988). Each racial group within South Africa has its own budget for Health and Welfare, and there are presently fourteen different departments of Health (including the so called 'independent' homelands). The racial differentiation in expenditure results in very different services and treatment, with Whites having the best services and facilities and Blacks the least. For example, the APA Report (1979, p.1506) says of mental institutions for Blacks that:

> "(they) can be viewed as only a subsystem of the larger South African Apartheid system,

reflecting in microcosm some of its pathogenic governmental and social structures and processes. A powerful contrived reality has been developed in South Africa that favours and protects whites while excluding, neglecting or oppressing blacks".

Presently, approximately 5,5% of the gross domestic product (excluding the 'independent' homelands) is spent on health care in South Africa (SAIRR, 1988). This low expenditure on health is consistent with the Government's commitment to a policy of privatization, with the belief that health care is a privilege and that individuals rather than institutions should be subsidised. For example, because of the overcrowding in state mental institutions, the government has, since 1964, contracted the services of a private profit making company to accomodate over 10,000 certified Black patients in custodial care (Jablensky, 1977). These institutions are racially segregated and are for chronic psychiatric patients transferred from state institutions. Each patient is subsidised from an annual subsidy from the health budget (Jablensky, 1977). The subsidies for White and Black patients per day are very different - in 1977 a White patient received nearly four times the subsidy that a Black

patient received (Jablensky 1977). While these figures have surely changed over the last decade the difference based on racial lines remains.(1)

The policy of privatisation has grave implications for the delivery of health and mental health care in that the wealthier groups are able to purchase health and mental health care while the poor majority in the country either goes without care or receives the care within a hospital, with its racially differentaited resources and facilities (de Beer, 1986; Lambley and Cooper, 1975). Health and mental health care becomes a commodity, that is, something to be purchased, and not a right (de Beer, 1986). Perhaps another implication is that poor and working class people will tend to seek psychological assistance for only severe emotional disturbance because of the expense of seeking such help. Problems in living or problems caused by stress, repression or other socio-political factors will perhaps not be considered serious enough to take to a professional or helper which may lead to a decrease in the quality of the person's life.

The American Psychiatric Association (APA) investigated private psychiatric facilities in South Africa in 1978. Within institutions for Black patients, they found an unduly high death rate and

evidence of needless deaths, substandard care, some abusive practices, grossly inadequate number and quality of professional staff, lack of accountability of professionals to their place of work and very inadequate resources and facilities. They found that the institutions were usually located far from people's homes which made it difficult for patients' relatives to visit and maintain contact with them. This contributed to the social isolation and chronicity of patients and made the task of rehabilitation difficult (APA Report, 1979). Within the institutions themselves, the black nursing staff earned much lower wages than their white counterparts which lowered their morale (APA Report, 1979). They recommended immediate changes and improvements and said that

> "the drastic discrepancies in the care and funds available to white and black patients be remedied as soon as possible. Apartheid cannot be a justification for inadequate, substandard medical care" (APA Report, 1979).

They concluded that Apartheid is a pervasive problem affecting the mental health and well-being of black and white South Africans alike.

Savage (1979) listed four key features that characterise medicine in South Africa and which hinder efforts to make it effective. These features also characterise psychology and mental health in South Africa. They are:

i) The bulk of medical resources are devoted to health services that are curative rather than preventive and are therefore disease and hospital oriented rather than health and community oriented. (Similarly, in psychology very little attention has been given to preventive mental health practices).

ii) South African medicine (and mental health services) are organised primarily to serve the needs of the White urban population despite the fact that the bulk of disease and suffering occurs in the Black population and in rural areas. There is thus a maldistribution of doctors (and of mental health workers) and resources.

iii) South African medicine has weakly developed ancillary services in many vital areas, for example, pharmacies, health visitors, health educators and institutions for the mentally ill and handicapped.

iv) The organization of South African medicine (and mental health services) is dominated and controlled by Whites and is deeply permeated by the structures of

Apartheid in terms of salaries, training, duplication of expensive facilities on an unequal basis (Savage, 1979, p.147-149).1.

Clearly, the facilities and resources for dealing with psychological distress are inadequate and insufficient for the majority of the population.

Notes

1. It is difficult to get current figures about expenditure and conditions in the mental health field as the Mental Health Amendment Act of 1976 virtually imposes a ban on information and free discussion of the prevailing conditions and policies in the mental health services (Dommisse, 1987).

CHAPTER 2

ATTEMPTS AT ALTERNATIVES

2.1. INTRODUCTION

It is evident from the previous chapter that there is a great need for psychological services in South Africa but the resources and facilities available for the majority of the population do not match that need. There has recently been a questioning by mental health workers about the appropriateness of psychological theories and practice in South Africa (Dawes, 1986; Moll,1983; Vogelman, 1986a). Most universities and mental health professionals use a Euro-American middle class orientation to training and practice, and psychology has been criticized for its inability to "contribute meaningfully to a South Africa increasingly in the throes of a deep structural crisis" (Editorial, Psychology in Society 1, 1983, p.1). The current political climate with its mass resistance to Apartheid structures, the challenge to professionals about the nature and relevance of their interventions as well as the academic and professional

isolation has forced many mental health workers to review their position and to question the appropriateness of their interventions.

The problems facing mental health workers may be viewed in different ways - obviously resulting in different practices. For example, if the gross inadequacies of services and the grave shortage of resources are given priority, then an option may be to train adequate numbers of mental health workers, and to use those workers as effectively as possible. In many community psychology and crisis intervention programmes lay counsellors have been trained and used (see 2.3). If cultural beliefs and practices are seen as the most important concern to mental health care, then adherents to this position will study and explore these and use them in therapeutic work, as discussed in 2.2. (Holdstock,1988). Furthermore, if the problem within psychology in South Africa is seen in terms of its bourgeois origins and its inappropriateness to all situations here, particularly in working class communities, then there will be an effort to work towards a more appropriate psychology for South Africa and to develop different and more suitable models for interventions and practice (Editorial, Psychology in Society, 1983; OASSSA Collective paper, 1987). There could also, of course, be some form of combination of

these - like a programme which is based on a suitable model of intervention which would train and use many more mental health workers (see chapter 4).

This chapter then, looks at some of the alternatives practiced which have tried to provide more adequate psychological services. These alternatives are critically examined to determine their appropriateness to present mental health needs in South Africa, and the lessons that can be learned from them. As background to the counselling training programme under evaluation appropriate theories and practices in community psychology are considered, which includes the use of non-professionals, crisis intervention theory and practice as well as primary mental health care. The chapter ends with the consideration of two examples of community mental health projects and lessons learned from them.

2.2.CROSS CULTURAL PSYCHOLOGY

Different concerns exist within the cross cultural approach to psychology and psychiatry (Cheetham and Griffiths, 1980; Holdstock, 1988; Swartz and Foster, 1984). These include those who argue that the

practice of traditional healers, diviners and herbalists are superstitious and unscientific but despite such 'backwardness', these traditions should be sympathetically understood and similarities identified with western psychotherapy, as well as those who stress the importance and greater appropriateness of African culture in treatment (Cheetham and Griffiths, 1980; Cheetham and Rzadkowoldki, 1980; Holdstock, 1981; Editorial, South African Medical Journal, 1979; Swartz and Foster, 1984).

Holdstock, (1981) as a representative of the latter position calls for greater awareness of the African context which includes the importance of African culture in the training of clinicians and in the practice of therapy. This position stresses the importance of traditional healers and diviners in dealing with the psychological distress of black people (Holdstock, 1981; Buhrman, 1979). There is also support for using psychological techniques in promoting intergroup relations. Holdstock's (1988) Africentric approach to psychology is within an individualistic humanistic paradigm and aims for the achievement of self actualization. Empowering the individual and experientially understanding black people's situations, culture and lives are important

goals. There is the belief (or hope) that this broader conception of the individual in her/his society may have universal application in mental health care.

The cross cultural position has two principal flaws (Dawes, 1985). Firstly, it reifies African culture and experience and thereby supports a different treatment approach which oversimplifies the varieties of black experience as well as cultural transitions (Dawes, 1985, p.57). Secondly, it ignores power in intergroup relations. As Dawes (1985) points out, the notion of cross cultural work obscures the power differential between the members of different 'cultures'. The 'empowerment' aimed for in cross cultural psychology is individual empowerment within a humanistic framework rather than seeing power in socio-political terms. There is an emphasis on culture as the central problem, a notion central to Apartheid ideology, rather than on domination and power relations. Perhaps the emphasis on culture and cultural practices contains within it the contradictory manner in which Apartheid has responded to African cultural practices in general (Nzimande, 1986). On the one hand in order to justify Apartheid it must demonstrate the 'stupidity, backwardness and primitiveness' of African culture and at the same time 'protect' that culture and give it some measure of

respectability and authenticity in order to use it as a tool of domination (Nzimande, 1988). The cross cultural position implicitly accepts the political status quo and the therapy addresses casualties rather than trying to prevent psychological distress.

Perhaps what is important in the cross cultural approach is the recognition of the richness and variety of people's culture and social history which must be respected and explored for a better understanding of the individual. Traditional healers, diviners and herbalists are important mental health workers in Black communities and cognisance needs to be taken of them and their practices studied. Furthermore, by acknowledging the use of traditional healers, diviners and herbalists in African communities, there is the acceptance of an implicit existence of a complex set of conceptions of mental health as well as ways and means of coping with madness or psychological stress (Nzimande, 1988). Nzimande (1988) calls this the 'hidden discourse and says:

> "failure to open a dialogue with these conceptions have not only deprived us of an understanding of the most popular conceptions of mental health, but have also abandoned this project to bourgeois scholarship and practice". (p.2).

Therefore, when interventions are made in African communities, it is not into an empty terrain but one filled with its own practices, conceptions of mental and ill health, which affects the way conflict and stress is experienced. Perhaps what needs to be explored is the place and significance of traditional methods in working with black people and their conceptions of mental health.

2.3. COMMUNITY PSYCHOLOGY

Community psychology is gaining popularity and attention in South Africa as evidenced in the increasing number of courses offered in community psychology at the universities as well as increasing numbers of projects embarked on in various townships (Vogelman, 1986b). In order to understand these initiatives it is necessary to look at the start of community psychology in the United States, its implications and effects and influence on community psychology in South Africa.

Community psychology arose in the 1960's in the United States because of an increasing awareness of the impact of social forces on the individual and the

inequality in the distribution of psychological services to members of the community (Lazarus,1986). There was a call to move the care and treatment of the mentally ill back into the community so as to avoid the disruption of an individual's life and the estrangement of that life that often comes with distant and prolonged hospitalization; to make the full range of help that the community had to offer readily available to the troubled person; to increase the possibility of early detection and fast help to a distressed person and to strengthen the resources of the community for the prevention of mental disorder (Brewster-Smith & Hobbs, 1969).

The Community Psychology Division (division 27) of the American Psychological Association defines this approach as one which seeks to broaden the perspective of applied psychology to include not only the individual, but also the relationship between the person and her/his environment and the ecological interaction between settings and systems (Lazarus, 1986). It is acknowledged that problems in living may be most effectively alleviated and prevented by changing the environment or system in which the individual exists (APA, Div 27 Statement of Aims). The community psychological approach is usually multidisciplinary including medical, psychological,

social and social service fields in its attempt to understand the social context in which the individual finds her/himself and to effectively and appropriately help her/him (Lazarus, 1986). The major values and aims of community psychology include empowerment and competence; prevention; an ecological viewpoint; sensitivity to minorities and under-represented groups; scientifically meaningful as well as socially useful research; cultural relativity and diversity; community and organizational development; and social advocacy (Lazarus, 1986).

There are different models within the community approach which form the basis for analysis and intervention (Lazarus, 1986; Vogelman, 1985b). Examples of these approaches include the person-centred approach which focuses on the development of strengths in the individual through interventions like stress management, development of self esteem etc; the environment or community-centred approach which emphasizes the reduction of environmental stressors, the improvement of socialization practices and social support structures (Lazarus, 1986).

Lazarus (1985) conducted a study in which she discussed the relevance of community psychology with a number of psychologists in South Africa. She found that despite the strong support for this approach there was no unity of aim or approach amongst psychologists which, she says,

> "reflects the way in which community psychology lends itself to differential interpretations" (Lazarus, 1986, p.4).

Seemingly, the orientation and values of the mental health worker will determine the type and relevance of the community work done (Vogelman, 1986b).

The American interest in community psychology and its official recognition by the American Psychological Association in 1967 did not occur in a political vacuum (Vogelman, 1986b). The sixties in America was characterized by challenges to the prevailing culture, by the militancy and strength of the civil rights movement and by racial tensions. An anti-poverty programme was introduced which was humanistically motivated but which also preserved the dominant social relations as well as undercut the increasing social and labour militancy (Vogelman, 1986b).

In most of the different models of community psychology, for example, the person-centred approach, the environment or community centred approach, there is no coherent political and economic analysis of American society nor any mention of psychology's historical role in preserving much of the class, race and sexual inequality within American society (Vogelman, 1986b). This criticism can also be applied to much of the community centred approach in South Africa. Further criticism of the community strategy in mental health care is that it is not necessarily a route to improved services, it oppresses women by entrusting much of the care of mentally ill patients to women in its attempt to decrease the numbers in mental institutions, and contributes to the ideological retreat from welfare (Santon et al, 1985).

Criticism levelled at the community psychology practised in South Africa includes community psychology's fundamentally humanistic ideology, its interactional approach to the relationship between the individual and society and to psychology and society (Dawes, 1985; Lazarus, 1986). Like the criticism levelled at cross cultural psychology, community psychology can also be criticized for perceiving communities as homogeneous with the consequence of ignoring power relations within communities and

ignoring different experiences. Perhaps because of the many different approaches and orientations within community psychology the most important way of evaluating it in South Africa is by looking at the ideology informing the particular practice, seeing whose interests are being served and whether it preserves the status-quo in the socio-political system in South Africa.

2.3.1. Non-professionals in Mental Health Care

Within many community psychology projects, lay counsellors have been used (Sobey, 1970; Turton, 1985). A specific way of responding to the shortage of professionals in the mental health field is to train lay counsellors or non-professionals. The training of lay counsellors and the use of non-professionals is not new. Non-professionals have been used in the mental health field for many years both in South Africa and elsewhere as lay counsellors, aides in community mental health centres, peer leaders etc. A non-professional is defined as:

> "A paid or unpaid person (without a formal training in any of the professional health

disciplines) who works directly with individuals or community groups in providing mental health services to the public" (Sobey, 1970, p.12).

Other reasons for using non professionals in the mental health field include responding to different conceptions of service, for example, bridging the gaps between professional and patient; changing the nature of the relationship; using the special attributes of the non-professional, like enthusiasm, commitment; being able to extend service programmes with the increased personnel; stimulating volunteer activity either for the purpose of increasing general citizen participation in community service programmes or improving community understanding of mental health programmes; providing informal, sustaining relationships to patients and clients (Brewster Smith and Hobbs, 1969; Carkhuff, 1969; Sobey, 1970). The above reasons were found to be the most common for using non-professionals in a study which surveyed 185 National Institute of Mental Health projects using over 10000 non-professionals in a wide range of settings throughout the United States (Sobey, 1970). Sobey (1970) found that non-professionals were considered capable of addressing the needs of understanding, warmth, friendship and concrete problem solving for the mentally ill and others in their community. She found that non-professional roles,

based on fulfilling the above needs benefit the mental health programmes surveyed by extending and enriching the service given to the mentally ill and to the total community as well as freeing the mental health professional to use her/his specific expertise. Guerney (1969) claims that in certain situations, for example, with naturally significant others, like parents, non-professionals therapeutic effectiveness goes beyond that which would be achieved by professionals. Gordon 1969) sees all these above factors as important particularly as he feels that working class people need more active involvement and participation. Non-professional counsellors would need to make contact with potential clients, to motivate them and to interpret the particular helping agency in the community as well as to actively follow up the client in their home, community and work. Increasingly, there have been attempts to keep patients out of hospitals because of the costs involved and more particularly because of the adverse effects on the individual. These include a lowering of self esteem, the stigma of being in a mental institution and the difficulties of reintegration into the family and community (Morrice, 1976). In arguing that effective treatment of the mentally disturbed should be treated in the individual's community, which would mean the marshalling of resources in a different

fashion from that traditionally practised, Morrice (1976) advocates fuller use of non-professionals. However, it has been found that the burden of caring for mentally ill patients in the community has largely fallen to women, which has meant greater oppression for women and keeping women in their homes attending to distressed people without any reimbursement (Banton et al, 1985).

Concern has been expressed about the use of non-professionals and specifically lay counsellors because they may lower professional standards (Carkhuff, 1969). There is also the concern that their much shorter training does not equip them to counsel adequately. In programmes using lay counsellors there is usually an emphasis on supervision and support to counteract the above (Carkhuff, 1969; Gordon, 1969).

It has been found that frequently people giving help are benefitting from their role as helper and this is particularly so in self-help therapies, for example, Alcoholics Anonymous (Riessman, 1969). Riessman (1969) found that with indigenous non-professionals, in the course of their work their own problems diminished greatly. Some of the reasons postulated for this

include an upward social spiral, and that being in a helping role can be rehabilitative by improving self esteem by being perceived as a helper of others.

In conclusion, non-professionals have been used in a wide variety of situations and have been found to be useful often specifically because of their non-professional status, despite some drawbacks. Non-professionals have also been used extensively in crisis intervention. There does seem to be extensive scope for their use in mental health services in South Africa, particularly as there is such a shortage of trained people in the field. An example of their use will be given later (see 2.3.4.2.).

2.3.2. Crisis intervention and Crisis Theory

The use of non-professionals is common in crisis intervention and in crisis situations (Morrice, 1976; Sobey,1970). The non-professionals are able to deal quickly with some cases of emotional distress or emergency and to refer to appropriate agencies or professionals when deemed necessary if given adequate training, guidance, support and supervision (Morrice, 1976).

Crisis theory underlies much of the practice of crisis intervention. This theory has evolved largely through the work of Erich Lindeman, Gerald Caplan, their students, colleagues and followers and has its roots in the clinical experience of these practising professionals (Ewing, 1978). In Lindeman's 1964 study on grief reactions, he noted that normal grief reactions were generally acute, had an identifiable onset, passed through predictable and identifiable stages and endured for a relatively brief period of time (Ewing, 1978). He noted that serious psychopathology may arise as a sequel to these normal transitory difficulties and that the psychopathological sequelae could be minimised by appropriate and timely interventions directed towards helping the individual deal with her/his stressful situation.

Caplan (1964) has provided the essential theoretical base upon which most current crisis intervention practice rests. His theory is grounded in the concept of emotional homeostasis. A crisis is regarded as an individual's perception of a threatening situation to which s/he perceives her/himself as being unable to cope with her/his existing problem solving mechanisms. Caplan (1964) identifies many accidental and developmental precipitators of crisis for an

individual. In terms of his theory the essential factor for determining the occurrence of crisis is an imbalance between the perceived difficulty and the significance of the threatening situation and the resources available for coping with the situation (Ewing, 1978). Caplan (1964) identifies four stages in a typical course of crisis from being able to mobilise resources to deal with the crisis to ever increasing internal tension, until major personality disorganization occurs. In summary, Caplan regards a crisis as an individual's emotional reaction to a perceived stressful situation, as a struggle for adaption and adjustment to temporarily insoluble problems and the person being in an internal state of imbalance. A consequence of being in crisis is the potential for psychological growth and development with adequate resolution to the crisis or the danger of increased vulnerability to psychopathology. He further states that during a crisis an individual experiences an increased desire to be helped by others and is more open and amenable to outside intervention; hence the importance of crisis intervention. In most cases a crisis is resolved within four to six weeks of its onset with either positive or negative consequences depending on the individual or the assistance received.

An important feature of crisis theory in relation to practice includes the timing of the intervention. It has been found that an intervention is more likely to be successful if it occurs during the acute phase of the crisis rather than when the crisis is passed (Horrice, 1976). Furthermore the helper should try to assist the client and her/his family frequently, but over a short period of time, by providing psychological help and support.

Two assumptions underlie Caplan's crisis theory. Firstly, the individual wishes to maintain balance in her/his life, that is, homeostasis and therefore a crisis is a situation perceived as being severely disruptive to this motive. Secondly, with the increase in arousal there is a corresponding increase of anxiety and tension within the individual (Murgatroyd and Wolf, 1982). Caplan's theory of crisis intervention underlies most crisis intervention programmes. Over the years his theory has been broadened to include the family and the larger social sphere of the individual but its basic tenets have not been adequately challenged.

Caplan's and other theories in this field are conceptualised within a positivist paradigm. Positivism assumes that observations can be made

objectively, that measures can be defined operationally and applied in a precise, replicable fashion and that theories can be constructed on the same causal, deterministic basis as in the natural sciences (Ingleby, 1980). Furthermore, explanations within the theories are assumed to be causal. There is a belief that scientific theory reports neutrally or objectively on the world and this leads directly to the atomistic method (Moll, 1985).

The relevance and applicability of a positivist approach to different psychological theories and practice is debatable. However, it is not the intention of this dissertation to go into an exhaustive critique of positivism, but rather to highlight its shortcomings in terms of crisis theory and its applications in practice. Perhaps the most fundamental criticism is its unidimensional and fixed concept of homeostasis with the implication of the immutability of people and its simplicity in its conception of environmental stresses (Quicke, 1982). In contrast, a Marxist perspective would see the world as a constantly changing totality of relations and would be able to appropriately explain the concentration of many determinants which make up the extremely complex whole of human society (Moll, 1985; Quicke, 1982).

Crisis theory, as postulated by Caplan (1964), emphasizes the environment in causing psychological stress which may lead to a crisis where the individual's existing coping mechanisms are no longer adequate. There is a causal notion of the environment which does not take into account the complexities of the construction of the individual within ideological relations.

The ideology informing crisis theory is individualistic and in the interests of the ruling class in the sense that it upholds the existing status quo by not recognising and challenging the contradictions within society and its effect on the individual. Also underlying crisis theory and practice is the notion of the breakdown model, where individuals can no longer cope with their existing coping mechanism and go into a crisis and can breakdown. The breakdown model assumes that once the breakdown is remedied everything can return to some notional condition of smooth functioning. Underpinning this notion is the conformist idea that the natural state of society is to run smoothly, that breakdowns are individual affairs to be treated while leaving the social fabric untouched (Banton et al, 1985). Mental illness may also be viewed in this light. Furthermore, illness or psychological distress

is located within the individual and somebody else's expertise is required to help them. This discourages people from using their own practical and emotional resources to deal with distress or effect changes in their environment (Hayes, 1983). Thus political issues become reduced to individual private matters that must be dealt with by an expert (*Banton et al*, 1985). There is a denial of the *relevance of gender, race, class and politics to people's lives.* There is a focus on *individuality and a weakening* of the power of *individuals to control* and define their experiences (*Banton et al*, 1985).

While the bulk of the theory is felt to be too simplistic and deterministic, there are useful concepts that need to be retained, like the importance of early detection and treatment of psychological distress, the openness to therapy when in a vulnerable situation and the need for frequent counselling contacts but for only a brief period of time.

2.4. PRIMARY MENTAL HEALTH CARE

Another alternative response to the inadequate and maldistribution of resources and facilities in the health field in South Africa is to focus on primary health care (Buch and de Beer, 1988). This focus can also include primary mental health care. In the United States the impetus for primary mental health care arose partly from the humanistic intention of mental health services being accessible to all, of there being a continuity of care and the possibility of care for all people, and partly from the pragmatic reality of the very high costs involved in hospital services (Miller, 1983).

In working towards primary mental health care, there is an implicit political strategy involved. The declaration of Alma Ata (1978) which defined primary health care and launched the worldwide commitment to it as a means of attaining the goal of health for all by the year 2000 is essentially a political statement which requires political steps to attain (Buch, 1987). The three central elements of the definition of primary health care, which can also include primary mental health care, are firstly, an attack on the socio-economic causes at the root of poverty; secondly, a redistribution of health resources to

ensure equity, universal access and the provision of essential health care to all and to make community health care the main focus of the health service; and thirdly, that care is practised in a supportive and progressive fashion (Buch, 1987).

More specifically, primary mental health care essentially involves an emphasis on community involvement, a more equitable distribution of resources, a stress on prevention and health promotion, a multi- disciplinary approach and accessibility of community services (Vogelman and Green, 1987). Of particular importance in preventing mental illness is mental health education (Meforah, 1987). Furthermore, Banton and his associates (1985) propose that primary mental health care services need to be provided at all places in the community where the need arises, like at home, school, workplace, union, and attempt to develop indigenous service for all subgroups, especially women and minority national and class groups; they need to be responsive to the need of the community and be managed by community members who would actively campaign on behalf of the community. To quote Banton et al (1985):

> 'Thus a community mental health strategy cannot concern itself simply with providing more accessible treatment services to people already

categorised as 'mentally ill'. It must also take up the struggles that influence the quality of mental health: struggles around work, housing, child care and health care, battles against sexism and racism ... These struggles represent opposition to those elements of oppression which link community deprivation and psychological distress" (p.188).

David Werner (1980) suggested, in reviewing a number of programmes in Central America all of which were concerned with primary health care, that these programmes can be seen to fall along a continuum between the two diametrically opposed poles of being community supportive or community oppressive.

"Community supportive programmes are those which favourably influence the long range welfare of the community, that help it stand on its own feet, that genuinely encourage responsibility, initiative, decision making and self reliance at the community level, and that build on human dignity."

In contrast, he refers to

"Community oppressive programmes which, while invariably paying lip service to the other aspects of community input are fundamentally

authoritarian, paternalistic, or are carried out in such a way that they actually encourage greater dependency, servility and unquestioning acceptance of outside regulations and decisions; and those which, in the long run, are crippling to the dynamics of the community".

The difference between these two approaches highlights whose interests are being served, the community's in the former and the ruling class in the latter.

A UNICEF/WHO joint committee on health policy (1981) pointed out that in politically unfavourable situations of repression and economic and social control, the state will tend to run a community oppressive health service, with very good care for the wealthy and second-class care for the poor.

To have community supportive health and mental health services requires a political commitment of adequate health and mental health for all, including the socio-political factors which will make that possible. This is clearly not the case in South Africa. Attempts to start progressive primary health care services, independent of the State, have begun, for example, the progressive primary health care network (PPHC). However, there are financial and political difficulties in implementing adequate

primary health care services. There are differences between programmes involved with primary mental health care in terms of whose interests are served, community participation and effectiveness, and hence should be individually evaluated in terms of the above.

2.5. EXAMPLES OF COMMUNITY MENTAL HEALTH PROJECTS

2.5.1. Battersea Project

A community project in Battersea, England will be considered as an example of community mental health care as lessons learned from that project are pertinent to interventions in South Africa. The project began with the realisation that a service which effectively tackled psychological or interpresonal relationship difficulties while at the same time helping the individual to affect her/his social or environmental problems would contribute more to the well being of a neighbourhood than a service which tackled only one side of these interacting forces (Holland, 1979).

The Battersea area is a poor working class area and there was much unemployment, poor housing and poverty. A neighbourhood mental health centre was set up which established a counselling service in the context of a network of neighbourhood action groups both within and without the centre. These groups were actively involved in trying to improve the conditions of local working people, both socially and psychologically which in turn, influenced the centre's reputation. The basic assumption of the project was that the root cause of mental problems was to be found in the interaction between interpersonal relations and the social context in which they occurred. Their approach to counselling incorporated both the short term aim of alleviating immediate individual suffering and the longer term aim of utilizing and developing neighbourhood structures which could have a preventive influence.

The programme lasted for eight years and was forced to close due to a change in government and the cutting off of funds. It was restarted the following year in a different area but with certain changes learned from past errors. The following lessons were learned: Firstly, that skilled counselling is useful in a neighbourhood setting where it can be accepted in short 'doses' over a long period of time and in the

context of everyday life with its material struggles. There seemed to be a stigma attached to seeking psychological help. Having a multi-purpose centre seemed to alleviate this problem. Secondly, because multi-faceted problems were so frequent, an *essential* skill demanded of counsellors was to be able to make an initial judgement on which requests required practical advice and an introduction to the activist groups and which required additional counselling. This meant that an individual did not automatically receive psychotherapy for a particular problem but only if it was deemed necessary. They found that only when people saw that the counsellors tried to tackle their material problems with them would they trust them with their interpersonal difficulties. Thirdly, they were relatively unsuccessful in attracting volunteers to work in the centre. "Giving rather than selling one's labour is seen as a luxury for only the privileged or the eccentric" (Holland, 1979, p.102). Earning money empowers people in domestic struggles. The lesson learned was to obtain funds for paying local people who wanted to be involved in the centre. This economic basis would ensure that the project developed towards a real incorporation of local working class people in addition to the trained professionals serving them. A final lesson was seeing the importance of using familiar language, for

example, not using "mental health" but rather material health and ways had to be found to more adequately talk about mental health (Holland, 1979).

2.5.2. Soweto Counselling Programme

The idea of training counsellors from the townships where both the counsellor and client would come from the same community, speak the same language and probably have similar values, was put practice during the mid-1970's (Turton, 1986). This programme was founded by an organisation which traditionally provides short-term counselling to mainly middle-class White clients. A counselling centre was established in Soweto, a Black, largely working class urban area. This centre was established in response to a request from a group living in the township. It was staffed by lay counsellors drawn from that community. The service was under-utilised and closed after six years. Turton's (1986) evaluation of the project will be discussed in some detail as it is very pertinent to the programme under evaluation in this dissertation. He argues that the theory and practice of counselling was so shaped by bourgeois ideology and that the Black counsellors were so encapsulated in this ideology that

the working-class Black clients were unlikely to find the service useful or rewarding. The counselling practice employed by the service was essentially Rogers' *non-directive* method, supplemented at the level of theory by Maslow's hierarchical system of needs. Its primary emphasis was on helping clients to gain insight into *their feelings* rather than on helping clients to deal with their material problems with which most clients presented. Turton (1986) says:

> "In its adoption of individualism, humanist psychology reveals its neglect of social relations; it neglects the social construction of *individuals and the* role which this plays in the reproduction of social relations. By locating the solution to an individual's problems inside the individual *him/herself, this psychology* avoids the challenge of changing 'pathogenic' social relations ... It has, despite its frequent invocation of 'holism', an atomistic *world-view as* it reduces social problems and social relations to personal relationships" (p.88).

Furthermore, he argues that the effort to locate *essentially* bourgeoise counselling in Black working-class communities is a politically problematic undertaking. Turton suggests that progressive or alternative services *should open their* theoretical

preserves to members of working class communities and to allow these communities to contribute to and shape theory as well as practice.

The most important lesson to be learned from this programme seems to be that despite having counsellors from the same area, speaking the same language, and knowing the conditions of the particular area, the programme failed and that other, perhaps more important factors contributed to that failure. These factors centre around the theoretical orientation of the programme and its translation into practice.

Chapter 3

THEORISING AN APPROPRIATE ALTERNATIVE

3.1. INTRODUCTION

Theorizing a *community* intervention programme contains two main thrusts. Firstly, a theory of the indivual within social relations is necessary. Secondly, principles of service provision is required. This chapter discusses these two aspects which form the background to the lay counselling programme discussed in chapter 4.

3.2. THEORY OF THE INDIVIDUAL WITHIN SOCIAL RELATIONS

3.2.1. CONTEXTUALISATION OF MENTAL HEALTH CARE

The previous chapter established that the theory and ideology informing a particular intervention or programme is important in terms of how it determines

the aims, *functioning* and outcome of the particular *intervention or programme*. From this it is c ear that the *theory must* be made evident and examined. In order to understand the development of an individual, individual suffering and distress and her/his relating in the world necessitates a contextualization of mental health and mental health care. It is argued here, following Dawes (1985) and Vogelman (1986a), that mental health must be located within a political, social and economic context as these conditions directly affect an individual's mental and physical health, life chances, life experiences, access to facilities and consciousness. Not only is it important to site the individual in society, but also to recognise that the way one assists another in distress will be informed by one's conception of the individual and the way that her/his distress came about.

Clearly the social, political and economic conditions in a society affects the development, personality and functioning of the individual, for example through the provision (or not) of food, shelter, work, health care, rule of law, government, education etc. The devastating effects of some of the Apartheid legislation have been detailed above and numerous studies have shown the effects of disadvantage on

individual development and personality (Foster and Sandler, 1985; Rutter and Madge, 1976). However, there are also more subtle effects that the political, social and economic milieu have on the individual.

In most theories that inform counselling practice cognisance is given to the environment affecting the individual but no adequate detailing of how it does so (Ford and Urban, 1963; Tyler, 1969). The individual is the focus of attention rather than the individual within ideological and social relations. In community psychology, for example, there is an acknowledgment of the effects of the environment on the individual but the interactional understanding of it seems to ignore larger social forces. There needs to be more focus on social relations which are more directly implicated in mental health practice.

Economic and political practice are essential in specifying the context of mental health practices and also in affecting people's mental health. Within this broad context ideological practice is particularly important. It explains how the contradictions within society are experienced by individuals and informs an understanding of the construction of individual consciousness (Banton et al, 1985). Ideology is important in the development of relationships and in

influencing people's needs, desires, hopes and fears and therefore should be considered in dealing with individuals in distress. Furthermore, ideological relations are material and "can be construed as codifications of power relations" (Banton et al, 1965, p.7). An implication of this is that an individual is not thought of as a passive recipient of ideological imprinting.

Noting that the world in which people live is dynamic, full of contradictions, has classes etc and that each person has her/his own unique experience in terms of upbringing and parenting but common in terms of class and society, there is a need for a theory that can accommodate these experiences. A theory of the construction of the individual within ideological relations seems appropriate to these demands and needs to be examined. It is also important to understand how power relations are bound up with ideology, and its effect on the individual within a counselling setting.

Althusser's (1973) theory of ideology will be discussed as it is useful in helping to understand the nature of ideology and how the individual is constructed in society. While recognising that there are many diverse theories of ideology, and that there

have been many criticisms of Althusser's ideas, there are still many useful concepts in his theory that help explain the social construction of the individual within society.

3.2.2. ALTHUSSER'S THEORY OF IDEOLOGY

Althusser's (1973) account of ideological practice differentiates it from economic and political practice in a way which makes it autonomous yet also partially determined by them. Althusser (1973) distinguishes between the repressive State Apparatus and the Ideological State Apparatuses (ISA), the former being always repressive and including the police, courts, prisons, army, the administration and government. He says:

> "The State Apparatus, which defines the State as a force of repressive execution and intervention in the interests of the ruling classes in the class struggle conducted by the bourgeoisie and its allies against the proletariat, is quite certainly the State, and quite certainly defines its basic function" (1973, p.132).

The ideological State *apparatuses* include the *religious* ISA, the educational ISA, the *family ISA*, the legal ISA, the *political* ISA, the trade union ISA, the communications ISA and the cultural *ISA* - clearly a *plurality of* ideological State apparatuses. Mental health can be considered *an ISA* (Freeman, 1988). Thus, *ideology* is material in the sense of being *embodied in* social *institutions* (marriage, police) and is expressed in objective social *forms* (*language*) (Benton *et al*, 1985). While the repressive State Apparatus belongs entirely to *the* public domain, most of the ideological State apparatuses are part *of the* private domain. *The* important distinction between the repressive State *apparatus and* the ideological State apparatuses is that the former functions *predominantly* by violence *while* the latter functions predominantly by ideology. The ISA's perpetuate the ideology of the *ruling* class by reproducing the capitalist *relations* of production. As *Althusser* says:

> "To my knowledge, no *class can* hold state *power* over a long period without at the same time exercising *its hegemony* over and in the State Ideological Apparatuses" (Althusser, *1973*, p.139).

In explaining the structure and functioning *of* ideology, Althusser (1973) proposes two theses,

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> "To my knowledge, no class can hold state power over a long period without at the same time exercising its hegemony over and in the *State Ideological Apparatuses*" (Althusser, 1973, p.139).

In explaining the structure and functioning of ideology, Althusser (1973) proposes two theses,

firstly, that ideology represents the imaginary relationship of individuals to their real conditions of existence. The individual subject's link with social structures is through an "imaginary" relationship, that is, the subject lives its relation to its conditions of existence as if it were a subject. The "as if" relationship is the reality of the subject, the way in which he/she experiences the world (Banton et al, 1985). This means that there is no way that the individual can step outside the system that constructs her/him. Struggles for change in the economic and *political realm, particularly socialist* struggles, are concerned with changing the content of the "as if" relationships, so that the relationships engendered by it are more equal, less divisive and oppressive. As Banton and his colleagues (1985) say:

> "For both therapeutic and political practice, the ultimate yardstick will be the quality of human relations that a particular therapy or political system produces...Socialism is an attractive *political goal because* it holds out the promise of more equal, open and fulfilled human relations." (p.38)

Secondly, Althusser says that ideology is "eternal, exactly like the unconscious" (Althusser, 1973, p.152). Ideology is used to refer to the lived

relation between the individual and the world. It is

> "profoundly unconscious ... Ideology is indeed a system of representations ... but it is above all as 'structures' that they impose on the vast majority of men, not via their 'consciousness'. They are perceived - accepted - suffered cultural objects and they act functionally on men via a process that escapes them" (Althusser,1965,p.233).

In concluding this brief resume of his theory of ideology and leading on to a discussion of the social construction of the individual, it is important to look at the subject and how s/he is constituted.

3.2.3. SOCIAL CONSTRUCTION OF THE INDIVIDUAL

According to Althusser (1973), there is no ideology except by the subject and for subjects. With the rise of bourgeois ideology the category of the subject is the constitutive category of all ideology but only insofar as all ideology has the function of constituting concrete individuals as subjects.

> "In the interaction of this double constitution exists the functioning of all

ideology, ideology being nothing but its functioning in the material forms of existence of that functioning" (Althusser, 1973, p.160).

There is no way in which an individual subject can experience the 'truth' of her/his world in an unmediated fashion, because the conditions of existence never exist in a form available to perception. Instead they exist as principles in which the individual subject her/himself is constituted (Banton *et al*, 1985). *The subject is not some* essential, irreducible entity but is constituted as a subject by the social world.

In order to understand the development and functioning of the individual, there is a need for a theoretical framework that encompasses the contradictions as well as the oppressions of the social world and the lived experience of the individual. Perhaps the basic organizing principles that characterise our society are class, patriarchy and racism, which are articulated in ideology and provide the *basis for the* ideological construction of the individual. However, they are rarely experienced in a pure form - rather there are multitudinous ways of perceiving and articulating relationships that compete for dominance with the underlying class and gender structures

determining which of them are most likely to predominate" (Banton et al, 1985, p.16). Thus a variety of discourses may coexist in contradiction to one another, some of them being submerged but still supplying a tension which ensures that ideological practice is never experienced as homogeneous and unproblematic. The discourses that dominate, within as well as between people are likely to be those that can be enforced by the power relations that characterise the social world (Banton et al, 1985).

Power is generated in the structures within which relationships take place and every aspect of the structure can be seen to possess positive and negative functions (Banton et al, 1985). For example, in the doctor- patient relationship, the doctor is perceived as the expert which discourages people from using their own resources to deal with their problems or bring about changes in their environment. Furthermore, the problem is seen as originating in an individual. There is a weakening of the power of the individual to control and define her/his experience.

Banton and his associates (1985) introduce the concept of the ideological unconscious to explain how the social relations and social structures affect an individual and more specifically her/his mental

health. The ideological unconscious provides the structure in which conscious experience takes place and recognises that *a person's experience* is continually being influenced by relations beyond the conscious access of the individual. Every relationship takes place in a context, including therapeutic relationships, which affects and influences that relationship. The distinction between the psychoanalytic unconscious and the ideological unconscious is crucial in avoiding the *reduction of* the political to the personal or the personal to the *political in any simple way.* Furthermore, the concept of the ideological unconscious accounts for how society enters the formation of the individual including one's social role and individual differences. In sum, the unconscious is more than an effect of ideology and ideology is more than a manifestation of human psychology. The two realms are interrelated but not equivalent. *This view suggests* that political activity can legitimately be directed towards internal as well as external power structures (Banton et al, 1985).

Some of the theories that inform counselling practice, for example, Rogers, Sullivan and Dollard (Ford and Urban, 1963) are humanistic, interactional or behaviourist in orientation. In all these, but

particularly in the humanistic theories, for example, *the person centred* theory of Rogers (1951), there is an essentialist notion of the individual, where people have independent 'original' selves that are not constructed by the social system in which they emerge and that individual existence predates social experience (Banton et al, 1985). The essence of an individual is assumed to be preexistent and pre-social and there is the notion of the unity of the self. Society is perceived *as external and certainly* affecting the individual but not forming her/him, that is, the individual is constructed outside it (Banton et al, 1985). Politics and power remain external to the individual and social forces simply modify the way *in which one's essential* characteristics are expressed (Banton et al, 1985, p.46). Rogers (1951) view of the individual epitomises this position where society allows a person to 'actualise' and to become who s/he 'really is'. Alternatively, society may limit the 'potential' of the individual to be what s/he 'really is'. A person's experience can be explained totally in relation to her/himself and humanistic therapy reflects this, as the aim of *therapy is always a* change in the individual and not, for example, in political and economic relations (Freeman, 1987). The theories also tend to be microsocial, that is, concentrating on the immediate experience of the child

or adult with no consideration of ideology. Banton (1985) argues that all theories of the individual which do not explicitly deal with the social construction of individuality are essentialist, no matter what weight they place on the socialization process. The implication of these essentialist theories is that they cannot explain the complexity of subjective experience, nor understand personal distress or social injustice.

Perhaps it is important here to replace the notion of the unity of the self with Freud's conception of a person as fragmented, self-contradictory and alienated from his own experience (Hoggett & Lousada, 1985; Ingleby, 1981). Furthermore, fragmentation of ev life is seen when relationships become . and destroyed by factors such as social and geographic mobility, relocations and displacements (Hoggett and Lousada, 1985). Much fragmentation also affects the non-physical environment, for example, the impact of deskilled work, education and mass culture upon the human capacity to imagine, play and create (Hoggett and Lousada, 1985). From birth, a baby enters a social and ideological world with her/his own drives and needs and her/his caretakers are themselves ideological beings with their own conscious and

unconscious needs. As Freeman (1987) says : "Ideology is the psyche and it reflects itself in relation to the lived-in world and in relation to the Ideological State Apparatuses" (p. 6).

If one's conception of the individual is one of being socially constructed and as a fragmented and dynamic being with a conscious and an unconscious motivating her/his actions then this conception must be perceived in the therapeutic situation for both therapist and *client. Furthermore, because* of the complexity of the links between social structures, ideological practice and unconscious feelings, the links between politics and therapy are multipally determined (Banton et al, 1985).

The notion of the unconscious, and particularly the ideological unconscious, goes a long way in explaining how social conditions affect the individual and the part they play in constructing her/him. How one conceives of the individual will also determine one's *view of mental health and mental illness. If one sees* her/him as being constructed in society, then psychological disorder must be seen in the light of a process of social induction undergone during development and reinforced in ideological practice and that individual suffering may represent universal

experiences of power and oppression (Banton et al, 1985). The implication of this position is that political and therapeutic practice are linked and that both the past and present reality need to be worked through in order to *bring about personal and political* change. Furthermore, political activity must be directed towards both internal and external power structures (Hogget & Lousada, 1985).

3.3. PROGRESSIVE PRINCIPLES OF SERVICE PROVISION

In moving from the conceptualisation of the individual to the broader community in which he/she lives, it is necessary to outline progressive principles of intervention and of service provision by mental health workers. This is done within the paradigm of the social construction of the individual and within the parameters of the broad progressive movement (organisations committed to a *free*, unitary, democratic and non-racial South Africa).

Perhaps the first principle of intervention and of service provision by mental health workers is to empower the individual and the community in which he/she lives. Empowerment implies an ability to act on

one's own environment in order to change one's situation (OASSSA Collective, 1987). It also implies a sharing of skills and a democratising of knowledge. Both of these aspects of empowerment will be considered below. For empowerment to be gained from a particular community project, there would have to be certain preconditions. Firstly, a 'community' would have to be identified by a group of people and their common interests and needs discussed. Secondly, if this community felt that they needed assistance or outside intervention, it is important for them to request that help. The process leading up to this would have entailed extensive discussion of what the problems were, how they came about and what they must do to alleviate them. Through this process, the community members would become increasingly aware and conscious of their problems, their causes and possible solutions obviating outside 'experts' deciding what a particular community's problems are and coming in in a paternalistic way. This means that mental health workers should not impose their values, views and perceptions of problems and solutions on to a community (Berger and Lazarus, 1987). From the perspective of the mental health worker or expert who has been asked to intervene, it is important for her/him to be sure of who the people are who are approaching her/him and which interests they represent

in the community. If satisfied that these people are truly representative of their community then they could move on to a definition of their respective roles in the ensuing project (OASSSA Collective, 1987). However, a situation may arise where an outside expert does perceive a problem and may feel that an intervention is necessary. It is always important to respect the views, feelings and values of a particular community. Before embarking on any project it is essential to discuss one's view of the problems with the community or appropriate leaders of that community and for the community to decide whether to accept the expert's analysis or not and, finally, to develop a course of action together. Thus, the expert or mental health worker's role may be seen as developing and facilitating deeper levels of understanding of the nature and causes of problems faced by the community (OASSSA Collective, 1987). This role tends to avoid paternalism and the risk of depriving a community of its powers and decision making. It is important for the mental health worker to see a particular problem in its larger context, noting the link between politics and mental health - and of course to see the individuals involved within the ideas of social construction.

Looking specifically at a particular project in terms of empowering people through community work, the project itself would have to be conducted in a democratic way where the people involved are free and able to contribute meaningfully to the planning, working and evaluation of the project. This presupposes a level of organisation within that community. Furthermore, to be empowered through community work means that what the people receive from the process of the particular project is the ability to act on their own environment in order to change their situation. Adequate structures of accountability need to be set up within the community to ensure the continual democratic functioning of the project and to prevent the project itself becoming divisive within the community. A second aspect of empowerment includes the sharing of skills and the democratising of knowledge. However, giving skills is not necessarily empowering (OASSSA Collective, 1987). Therefore, to ensure that the passing on of skills does empower those people, it is important to consider the ways and reasons for doing it. Firstly, it is important for both the skilled and unskilled person to understand why the one is skilled and the other not in terms of the particular history of each individual and the socio-political context in which they live. Secondly it is important to recognise that all people

have knowledge and skills and that imparting a specific skill must not negate resources or existing skills within the community. Thirdly, it is important to have a mandate from, and an accountability to, those that will be serviced so as not to create hierachies and elitism within the community, empowering some at the expense of others (OASSSA Collective, 1987). Finally, it is important not to create dependence on the skilled person. The *imparting of skills is an attempt to empower people.* It can also be seen within the context of working towards a democratic country.

The above hypothetical situation is clearly an ideal one. There is a presupposition of organised communities, with democratically elected representatives and with structures of accountability. It also presupposes a high level of active participation by a person in his/her immediate environment and community. Another presupposition is the existence of adequate financial and human resources. While the ideal clearly does not exist in South Africa it is important to have guidelines of appropriate community interventions which will be refined by work and experience.

In conclusion, the basic tenets of the theory informing the counselling training programme have been discussed, as well as progressive principles of community interventions. The next chapter deals with the practical application of the theoretical ideas outlined above.

CHAPTER 4

TRANSLATING THEORY INTO PRACTICE: THE LAY COUNSELLING TRAINING PROGRAMME

4.1. INTRODUCTION

It is evident from the previous chapters that there is a great need for more appropriate psychological services in South Africa. Given that part of the problem is the extreme shortage of trained mental health workers, particularly in the Black communities, a particular response to this need has been to train lay counsellors from specified communities to provide counselling services in those communities. Once implemented, this would alleviate the great shortage of counsellors, and skill community members in the townships to be of assistance in their own communities, in accordance with the 'progressive' principles outlined above (3.3.).

Broad theoretical tenets informing this training programme are seeing the individual as:

a) constructed in society within ideological relations,

b) fragmented and dynamically motivated, and

c) living within repressive and exploitative social and economic structures.

The aims and objectives of the training programme have been conceived within the framework of progressive primary mental health care. Lessons learned from other relevant programmes have influenced the programme.

4.2. RATIONALE FOR THE COUNSELLING TRAINING PROGRAMME

The training of lay counsellors was seen as an appropriate response to the extreme shortage of mental health workers in South Africa. Once trained, the counsellors would be able to respond to some of the distress and problems of people in their communities. They would also have gained skills which will be of benefit to themselves and to their larger community.

Progressive psychologists could contribute to the democratic struggle by sharing the skills and knowledge they have because of their privileged backgrounds, education and training. This contribution could be achieved through a counselling training programme where not only counselling is taught, but where discussions about mental health and

its roots in the economic, political and social structures are held. Furthermore, because of the Apartheid structures of our society, there is little inter-cultural knowledge or sharing of different realities and experiences. This counselling programme brings largely white professionals and black activists together to share ideas and learn from one another.

The training programme may be conceived as an initial step towards primary mental health care in that there is a start to providing services where few existed before, where community aspects of the service are stressed, where help is given in a supportive and progressive fashion and where prevention is entailed in the educative aspects of the training. Furthermore, the counselling service may be available at places in the community where the need arises, such as at home, school or within a union.

4.3. BACKGROUND TO THE COUNSELLING TRAINING PROGRAMME

In 1984 there was extensive popular opposition to State repression and the oppression of Apartheid. There was a rapid growth of popular organisations to spearhead this resistance. However, there was also

much State resistance to this opposition to its power. In the townships surrounding Vereeniging in late 1984, there was a very strong police and army presence and many instances of brutality and violence. There were many casualties, both physical and psychological. It was very difficult, if not impossible, for doctors and psychologists to enter the townships and render assistance. There were also very few resources within the township to deal with the distress and trauma. In order to help alleviate the suffering and provide assistance, a request was made by political organisations in the townships to progressive health organisations to provide training in first aid and counselling skills to community members. This included a mental health component.

The requests were carefully considered and it seemed possible to implement a programme that considered an individual in her/his socio-political environment, which took into account the shortcomings of other programmes, for example, the counselling training programme in Soweto (see 2.3.4.2.), and which could be the start of a community based mental health service. The people requesting training knew the problems in their area, would speak the same language and would have a similar class background to the people they helped. There was the recognition of the inadequacy

of mental health services in the township, of the shortage of trained people to deliver the required services and the possibility then of training community residents as lay counsellors. The training programme also seemed to provide the opportunity of sharing skills and democratising knowledge which would give community residents more control over their own mental health and so help to empower them. There was also an urgency for trained people to help deal with psychological trauma in the townships. The townships in the Vereeniging area were not unique and it was recognised that skilled people were needed in all townships, particularly in the political climate of the mid-1980's. Furthermore, requests for training came from organisations from all over the country.

A counselling training programme was developed and started in mid-1985. It provided counselling training to a number of organisations from townships mainly from the Transvaal. It is still operating, although with many changes from when it first started.

4.4.THE COUNSELLING TRAINING PROGRAMME

4.4.1. Groups Trained

Initially, it was envisaged that people from organisations within the townships would be trained as trainers, that is, as people who would learn counselling skills sufficient to enable them to train others in their community. However, it soon became apparent that this was not possible and the goal was reduced to training counsellors themselves.

The programme developed within the larger structures of the progressive movement, that is, organisations and groupings committed to a non-racial, democratic and unitary South Africa. Therefore groups trained came from within those structures and included members from youth, civic and women's organisations. The skills taught could be used in those organisations and as a service which that organisation could provide to the larger community. Furthermore, the trainers and trainees would be accountable to their organisations. As members of political organisations, and part of the broader progressive movement, there was a commitment to sharing skills and knowledge, and a commitment to an appropriate mental health care service.

Initially the groups trained came from a very wide area of the country and from urban and rural areas. Because of the short training period (two days) many groups could be trained during a year. Since mid 1985 to July 1988 forty-two groups were trained in the Transvaal.(1)

While no formal evaluation took place, it became clear to the trainers that some groups were trained more successfully than others. Important factors were identified which seemed to contribute to the success or failure of the programme. Firstly, the level of organisation seemed to be a crucial factor. It seemed that groups who were well organised were more successfully trained than groups from less organised or poorly organised communities. Secondly, urban organisations tended to be stronger and more cohesive than rural organisations and hence were more successfully trained. Both of these factors posed a dilemma for the trainers as often the poorly organised communities were those most in need of counselling resources. The reason for their lack of organisation was often due to severe repression. However, it was decided to train people from well organised urban communities as it was felt that the skills would be more easily learned and used in those communities. To identify those organised communities a large

progressive body was consulted who demarcated four large areas around Johannesburg. Members from organisations in those areas were trained from the start of 1988.

4.4.2. Selection Procedures

The trainees are selected by their particular organisation, but are also partly volunteers. The rationale for this is that organisational members are best able to decide who among them will benefit from the training and who the most appropriate people will be in terms of time, commitment and energy. As active committed members they would use their skills in the organisations to assist that organisation and in the larger community as a service offered by that organisation.

However, the trainers give guidelines to the organisations to assist them in their selection. The organisations are encouraged to send people who tend to help others with their problems, who deal with people and perhaps their problems in their work or organisations, who are conversant in English, who are not front line activists and who are not too young.

The reasons for these guidelines are that it is hoped that the people who come for training have some experience in listening to and helping other people and the training would build on those skills. Secondly, the training is largely conducted in English. There are many discussions about the training and about mental health in general. Thirdly, the training is designed to provide skills to people who would be able to offer a counselling service to their organisation and to their larger community. Front line activists often go into hiding or can be detained and so would not be available to do the counselling (see 4.5.1.1). Furthermore, because the training programme arose as a result of a crisis situation, it was envisaged that the skills learned would be used in crisis situations. These skills would perhaps need to be used on front line activists. Finally, an age requirement was included as it was assumed that older people have more knowledge and experience than young people, and again the counselling would build on that knowledge and experience.

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1967). It seems that there are conflicting viewpoints about the importance of trainee personality variables on effectiveness as a counsellor. These views range from favouring no selection to careful selection based on specified personality variables (Loesch et al, 1978; Tinsley and Tinsley, 1977; McLennan, 1985; Viney, 1983).

The programme under evaluation is different from most counselling training programmes in that the selection of trainees is done collectively within the organisation and not by the trainers. There is also a voluntary element in the selection in that people interested in mental health or counselling will put themselves forward for selection. The responsibility for selection is solely that of the different organisations. The rationale for the lack of selection on the part of the trainers is that because the organisations select trainees from among their members, they control who is trained. Therefore, accountability structures are clearer and more defined. It is also assumed that with the guidelines from the trainers as well as the knowledge of individual members, the organisations are in a good position to select appropriate trainees.

4.4.3. Duration of Training

Initially the training took place over two days spaced six weeks apart. From feedback received from the trainees, and from the perception of the trainers, it became clear that the two days of training was not sufficient. The advantage of this short training was that more groups could be trained with more people becoming skilled. However, it was felt that for the skills to be imparted adequately a longer training would be necessary and that the goal of training as many people as possible would have to be subsumed to give priority to a better training. From the beginning of 1988, the training programme has been extended to four weekends (eight days), spaced approximately a month to six weeks apart. The time spaces between each training period is designed to encourage the trainee to use her/his skills during that time, and so to come with problems and difficulties at the next training weekend.

Because of the extended programme, only four groups were planned to be trained during 1988. The implication is that fewer groups are trained, but in more depth and hopefully, they are better trained.

This counselling training programme is relatively short. However, many researchers have found that the training of lay counsellors is effective in short periods of time, ranging from as little as fifteen hours to eight days (Borck et al, 1982; Carkhuff, 1969; Carkhuff and Truax, 1965; Martin & Shepel, 1984).

4.4.4. Content of the Training Programme

The counselling training programme is informed by the following theoretical tenets. Firstly, to understand the development of an individual, her/his suffering and distress and her/his relating in the world necessitates a contextualization of mental health and mental health care. This is done by locating the problems the trainees face in their communities and discussing them in terms of how they affect the trainees, how they came about, their effect on the community and their consequences. Thus mental health is placed within a political, social and economic context and the link made between this context and an individual's mental health, life chances, life experience, access to facilities and consciousness. Many of the problems discussed lead on to the

psychological sequelae and a clearer understanding of why people suffer and have problems and how they manifest themselves *emerges*.

Secondly, the social construction of the individual is recognised, that is, that an individual is constructed within ideological relations. The *importance* of the *organizing principles* of class, patriarchy and racism that characterise our society are recognised. This recognition is by the trainers and is not overtly discussed within the training programme. However, it does *inform the way in* which the course is conducted. There is also the recognition that the discourses that dominate, within as well as between people, are likely to be those that can be enforced by the power relations that *characterise* the social world (Banton et al, 1985). The trainers try to render the trainee's life activity more conscious. This implies an acceptance of the unconscious and the ideological unconscious, that is, that an *activity* is influenced *by forces* beyond the person's recognition. By becoming more aware of these influences the person is able to reach a better understanding of her/himself in her/his world and to better act upon *his/her* world. The *activity of rendering* the trainee's life more conscious is the result of a co-operative endeavour between trainers and trainees. This is also

translated into the counselling by the trainee's awareness of the social, political and economic effects in influencing her/his client's mental health.

If one conceives the individual as being constructed in society, then psychological disorders must be seen in the light of a process of social induction undergone during development and reinforced in ideological practice and that individual suffering may represent universal experiences of power and oppression (Banton et al, 1985). This implies that political and therapeutic practice are linked and that both the past and present reality need to be worked through in order to bring about personal and political change. This informs the discussion on why one counsels and the importance of the talking cure. In the training programme the link between political and therapeutic practice is implicit in that only members of political organisations are trained with the assumption that the skills learned and the discussions held will inform their political practice and that their political practice will inform their counselling. For example, if poor housing and overcrowding are recognised as causing psychological problems then the organisation can mobilise people to work for better housing and better living conditions.

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Also, listening skills can be used effectively in both counselling and within the organisations themselves.

Listening is a very important part of the programme. As Hogget and Lousada (1985, p.138) so succinctly say:

> "Where no real dialogue exists *within the alliance* constituted by the patient and therapist, or the party and the class, each is left talking to itself - each becomes witness to the other's *soliloquy*".

Listening skills are taught and practised by discussion and role plays. In the development of the programme, it became *apparent* that listening skills were difficult to learn. Also, the trainees seemed frustrated by only listening and would try to be more active and try to solve their *client's problems*. It was decided to include a problem solving model into the programme, particularly as it was anticipated that the lay counsellors would often have to deal with *people coming* to them with material problems. It seemed that the way to solve the problem of the difficulty with listening was by introducing a more concrete *practical problem solving model*.

Because of the repressive situation in which we live, a great deal of time is spent on the *ways people deal* with their world and the different stress responses to

it. Some of the questions addressed include how they cope with their poor material environment, what effects it has on them, how their relationships are affected, and if they can no longer cope on their own what they do and where they seek help.

One of the aims of the programme is to be democratic in the style of teaching and to learn from one another. The methods of teaching are always participatory, often experiential and much use is made of open discussion. A wide range of topics are discussed, from the immediate material environment of the trainee, to repression, stress, detention and its effects, etc. Role plays are used to practice skills learned where the group and the trainers comment on the role plays and offer constructive criticisms and assistance. Occasionally didactic input is given, for example, on uncommon stress responses, like psychosis, epilepsy and severe depression, and the need to refer such people to professionals.

Language is an issue that has continually been discussed. Firstly, the training is conducted in English, which is not the first language of any of the trainees but is the first language of the trainers. While most of the trainees speak English, and can translate for those who do not understand, there is

always the *difficulty of* learning in a second or third *language*. Secondly, there is a lack of appropriate words with which to talk about distress (Hogget and Lousada, 1985). This is perhaps even more difficult to do in a second or third langu ge. Thirdly, it is recognised that the trainers' language will influence the trainees, in terms of how they *perceive the world*, and in terms of the *trainers' class background*, the venue *of the training*, *etc.*

The spacing of the weekends enables the trainees to counsel while the training is in progress. The latter weekends are used for supervision and revising skills learned and attempts are made to deal with problems trainees have encountered .

The *counselling training* programme evolved slowly, *accommodating* to problems experienced in the workshops and from feedback from trainees. The greatest change to the programme was changing from a two day to an eight day programme and enlarging and expanding on the programme.

4.5. RATIONALE FOR THE PRESENT EVALUATION STUDY

4.5.1. Recommendations from Previous Evaluation Studies

There have been two previous evaluation studies on the programme under evaluation, both of which will be considered briefly for their findings and recommendations.

The first study evaluated the larger programme of which the counselling training forms a part (Metrikin, Weiner & Zwi, 1987). It was conducted before the programme was extended and its recommendations were taken into consideration in deciding to extend the programme. It focused on the development of organisation that took place in communities as a result of some of their members attending the initial workshop. It was conducted in order to ascertain whether the objective of training people so that they can use their skills for the benefit of the entire community was realised or not. The sample included members from eight groups on the final day of training in the period from March 1986 to January 1987.

Using group interviews they found that the workshop was successful in catalysing the development of organisation in the following ways. Firstly, in terms of administration, community meetings were set up, as well as meetings between people who attended the workshops. Secondly, there was wide use of the skills learned. However, the organisations were unable to deal with the problems of finding suitable venues. Counselling skills were not disseminated and there was poor contact with related professional people in the townships, like social workers.

Metrikin et al (1987) recommended more discussion on how best to disseminate information to communities, the process of transferring skills, and the importance of venues for different purposes, for example, for meetings, practising or teaching. They recommended that lower profile activists should be trained at workshops so as to prevent the "disappearances" of skilled people during police crackdowns. They recommended that the training should attempt to resolve the problem of community members not trusting the competence of the trainees. However, they felt that this might reflect a lack of competence, or a lack of confidence, or both, on the part of the trainees and needs to be addressed. They recommended that counselling skills be taught to older more

experienced members of the group to maximize community trust in trainees. Finally they recommended research in the following areas:

- the competence of trainees in counselling skills;
- the effectiveness of the teaching methods employed in the workshop;
- the time allocation at the workshop, that is, whether only a day for counselling was justified since counselling is difficult to grasp. This recommendation was put into practice at the start of 1988. The former two areas are included in this study.

The second evaluation study was conducted in Durban on a counselling training programme which is similar in content and method to the earlier two day programme in the Transvaal, run by the same organisation that runs the programme discussed here (OASSSA Durban Collective paper, 1988). The sample included representatives from seven groups who were trained and came to two evaluation workshops where all were interviewed.

This study found that all trainees felt that they had benefitted from the training, largely in terms of improving their own interpersonal skills and management of their skills in general. They found that in township based groups, organisational weakness, lack of trust, police surveillance and

divisions in the township prevented effective organisation and the skills learned were not transferred. Most of the groups had not called an organisational meeting nor had made any communication with their community.

They felt that the implications for training were that more energy needed to be directed to the selection and recruitment process and that there must be more input on how to organise around the implementation of the skills within the training model. They felt that more time needs to be spent on contextualisation and problem management. Furthermore, more time needs to be provided within the programme to look at issues like how to communicate with their organisations.

They recommended that further research be conducted to determine the effectiveness of the training and whether the skills taught are transferred. Also, they stressed the need to evaluate current helping strategies used by the trainers. The present research study attempts to address these questions.

4.5.2. Further Reasons for Evaluation

It is important to evaluate this counselling training programme for the following reasons:

- This programme seems different from other counselling training programmes in a number of ways. Firstly, the theory which informs the programme is different from most lay counselling programmes which are informed predominantly by humanistic theories. Furthermore, it locates mental health in a political and social context and tries to incorporate this in the actual training. Secondly, the programme links in with the broad progressive movement, one of whose aims is adequate health care, and in this context, mental health care for all.

- The training programme has been operating in the Transvaal for the past three years and a number of groups have been trained in that time. Most of those groups no longer function as counselling groups and the skills imparted seem not to be used. It is important to know why those groups are not operating, whether it is for reasons beyond the control of the trainers, like state repression, or whether it reflects on the training programme and whether the skills taught are useful or not.

- Many new methods and ideas are continually incorporated into the training programme, often on the basis of evaluations given by trainees during the workshops and it is important to know whether these methods are effective and useful or not.

- Much time and energy is spent in planning, organising and running the programme and an evaluation of the programme can determine whether that energy is well spent or whether it needs to be redirected.

4.6. AIMS

In this dissertation, the evaluation includes a consideration of whether the trainees actually gain the counselling skills that are discussed, taught and practised. Other broader issues, like the motivation for doing the counselling course and whether and how the counselling skills were used, and any problems arising from this are examined. Personal issues in terms of whether the counselling was useful for the individual trainee and more general issues on the value of counselling and the usefulness of the

training programme are also evaluated. A further area of evaluation will be looking at the effectiveness of how the theory is translated into practice.

This evaluation study is felt to be relevant because it attempts to evaluate important aspects of a service programme which it is believed can be of benefit to various urban communities and progressive organisations. It could also be of value to the organisation running the training as the information from this study could help them assess the efficacy of the training programme.

Notes

(1). Once the appropriate organisations had started working together in running the training weekends, their branches in other areas around South Africa took the initiative and started similar training all over the country. Presently six regions are conducting training for members of progressive organisations, and 94 groups have been trained in total between mid-1985 to mid-1988. The groups range from five to over twenty people.

CHAPTER 5

RESEARCH DESIGN

5.1. INTRODUCTION

This dissertation is designed as a case study of the lay counselling training programme discussed in the previous chapter. Three specific aspects are examined. The first area of evaluation is to determine whether the trainees actually gain counselling skills. This is done by rating the counselling ability of trainees in role plays before and after the training. The second area of evaluation looks more broadly at the trainees themselves to determine their perception of their counselling ability and of the training, how they have used their skills and in what situations, and what problems and difficulties they might have encountered. This information is obtained from an interview. Results of the above can be found in chapter 6. The third area of evaluation is a theoretical evaluation of the programme and will be discussed in chapter 7.

5.2. SUBJECTS

Four groups were planned to be trained during 1988, coming from five different areas. The first group was a double group with two areas being represented. The commencement of the training for each group was staggered over the year, but all should have completed their eight days of training by the end of the year. The first two groups should have completed their training by October 1988.

All trainees in the first two groups were used in the study and twenty five subjects were anticipated. This number would satisfy the requirements for the use of the Wilcoxon- Matched Pairs Signed-Ranks Test to statistically evaluate the ratings. It was also felt that the findings from the first two groups would be generally applicable to the other two. All trainees who did not attend the full training programme, that is, the first three weekends, were not included in the evaluation study.

Because of numerous problems in the townships and within the various organisations (to be discussed in chapter 7) only four people returned for the third weekend, and hence the sample size is four.

5.2.1. Profile of the Groups Used in the Research Study

Group 1 consisted of thirteen trainees, five from one township and eight from another. Of the five people from the first, one dropped out and the remaining four formed themselves into an active counselling group and returned for subsequent training and were used in the sample. The eight from the other township have not and will not return for the final weekends of training and so could not be used in the sample as final measures could not be taken from them.

Group two came from three different townships and from different organisations within those townships. These areas experienced a great deal of repression with many detentions, disappearances and people being forced to go into hiding. Because of the repression, many organisational structures were weakened and could not operate freely. This, of course, affected the smooth running of the training programme as people could not be appropriately and adequately selected. People thus arrived for the training who were not delegated from their organisations. These reasons partly account for why group two did not return for further training. Clearly follow up measures could again not be taken.

5.3.METHOD

(i) Transfer of Skills

Before the start of the programme, each trainee was asked to role play a counsellor and another a client coming with a problem of her/his choice. The role plays were recorded. At the start of the third weekend a second role play was recorded with each trainee role playing a counsellor. (All the training has been completed by the start of the third weekend, and the remainder of the programme is spent on supervision, revision and educational discussions). Once all the recordings were taken, each counsellor was rated by three independent clinical psychologists on nine five point scales measuring counselling abilities (see Appendix A for rating scales). Each trainee is used as her/his own control. For this reason a control group was not used as it was felt that the trainees could not gain counselling skills with the passage of time or through random day to day experiences.

(ii) Interviews

After the final role plays were recorded, an interview was conducted with each trainee to gain information about the trainees, and their perceptions about their own counselling ability, the training and their experiences. (see Appendix B for interview schedule and Appendix C for the summaries of the interviews).

(iii) Theoretical Evaluation

A theoretical evaluation of the programme is done by discussing the appropriateness of the theory informing he counselling training, the functioning of the programme in the various communities, the actual running of the training and the context within which the training occurred.

5.3.1. Rationale for this Methodology

(i) Transfer of Skills

The best way of rating counselling skills would be to have tape recordings of actual counselling sessions

between the counsellor and her/his client, one before the training programme began and then again after the training was completed. The tape recorder may influence what is said, however. In this programme, it was not possible for the trainees to use a tape recorder because very few, if any, had one. Also, security and confidentiality in the township are perhaps even more important between counsellors and their clients than elsewhere and a tape recorder may have has implications of risk and breaking of trust. Many of the counselling sessions also seemed to happen on an ad hoc basis rather than in one particular setting.

The next best alternative was to measure counselling skills during the training, that is, before the training actually started and then again after the counselling skills had been taught and practised. Role plays were used for this purpose with each trainee's performance as a counsellor being rated. This alternative immediately restricted this part of the study by excluding the clients coming for help as a source of evaluation. Only attributes of the counsellor could now be measured. Furthermore, there could be no evaluation of the outcome of the

counselling and whether it was effective or not. (This could perhaps be part of a larger future evaluation study.)

Role plays were used as the vehicle for measuring the counsellor's skills as it is felt that role plays simulate a real counselling situation and that the measures obtained from them are an accurate reflection of the trainee's counselling skills. Role plays are an integral part of the training programme. One of the best ways to learn how to do something is through guided practice. They also provide a lively, realistic way of practising skills that involve working and communicating with people (Werner and Bower, 1982; Carkhuff, 1969). In role plays, both the counsellor and client have to think things through, use observation, analysis, imagination and feeling to communicate with each other. (1)

One might argue that this evaluation study could have been more controlled by having more standardized role plays by having the same client come with the same problems to each counsellor. While it might have controlled for some variables, it was felt that a counsellor's skills should be evident in any problems that s/he has to deal with and that the variety of problems encountered is more in line with what the

counselling and whether it was effective or not. (This could perhaps be part of a larger future evaluation study.)

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counsellor *will have to deal* with in her/his *community*. Furthermore, 'made up' or 'role- problems' are usually unsatisfactory as the client in these situations cannot easily portray real feelings and the counsellor may become frustrated by trying to understand a problem *which* the client is not actually *experiencing* (D'Agueli et al, 1980).

The final recording was taken at the start of the third weekend. By this time all the training *is* complete and the trainee *will have* had time to use *her/his skills*. It was not done at the end of the weekend as the weekend's training would have biased the recordings. Further measures were not taken as no group had completed its training by the end of 1988.

(ii) Interviews

Information about the trainees' counselling experience and their perceptions about their *own abilities* and about the *training programme* are best gathered by an interview asking these specific questions.

There are limitations to using an interview. Firstly, in the face-to-face situation, the trainee *may answer* questions *positively in order* to please the

interviewer. To guard against this, the interviewer was a neutral person unrelated to the training. Secondly, the interviews were conducted in English which is not the first language of the trainees. Sometimes the language did appear to be a problem and on occasion questions had to be repeated or explained. The information gained from the interviews would, in all probability, have been greater had they been conducted in the first language of the trainees. Thirdly, it was recognised that the answers to the questions were the trainee's own perceptions of particular experiences, for example, the number of times they counselled. However, the researcher wanted to tap the trainee's perceptions of their abilities and experiences. Despite the limitation, the interview was felt to be useful and appropriate for the information wanted.

(iii) Theoretical Evaluation

Political, personal and other value considerations are usually not included in a counselling research study because of their difficulty in being quantified. They are nonetheless, basic to any total evaluation of a counselling programme (Burck, Cottingham and Reardon, 1973). Positivist research is one important facet of

the broader process of evaluation but is not sufficient. Therefore, as part of the present evaluative study, discursive consideration is given to broader aspects of the training programme like the context in which it operated, its appropriateness and reasons discussed for possible difficulties experienced.

5.4. RESEARCH INSTRUMENTS

5.4.1. Rating Scales

Nine rating scales were used to measure counselling abilities. (see Appendix A for the rating scales).

In the training programme under evaluation, the following qualities and attributes were deemed to be important in counselling, taught in the training programme and hence measured:

the counsellor's facilitative ability to allow the client to tell her/his story and to uncover her/his main concern (scales 1 and 2). It is important for the counsellor to understand why the

client is seeking help and so identify the problems that need to be dealt with (Tyler, 1969).

Often a painful problem is difficult to speak about and the counsellor needs to be sensitive and perceptive in picking up cues to uncover the major concern of the client (Ernst and Goodison, 1981; Tyler, 1969). It also requires the counsellor to be accepting of the client and willing to understand what is troubling her/him and to understand the client's feelings (scales 3 and 4). Part of understanding another person's feelings is to reflect what those feelings are and scale 4 measures the accuracy of detecting and reflecting the client's feelings (Carkhuff, 1967; Rogers, 1951). Scale 4 is of Carkhuff's (1967) scales and has been used repe[illegible] in studies on effectiveness in counselling and has proved to be a reliable and accurate measure.

The counsellor's problem solving facilitation is also measured (scale 5). During the training programme, a seven step problem solving model is taught and practised and this scale measures the counsellor's ability to guide the client through these stages and come to some form of action to deal with it.

Another aspect taught and measured is the counsellor's ability to allow the client to make her/his own decisions which links in with her/his

respect for her/his client and belief that with adequate understanding and facilitation, the client is able to make her/his own decisions (*scales 6 and 7*). The extent to which the counsellor allows the client to make her/his own decisions is measured as it is felt that the more responsibility and autonomy that is given to the client, the more s/he is empowered. The counsellor's level of respect enables the client to explore her/his feelings and difficulties (another of Carkhuff's scales).

Scale 8 measures the counsellor's ability to help the client speak about her/his difficulties in a concrete and focused way and is one of Carkhuff's (1967) scales.

The final scale (scale 9) measures the overall impression of the counsellor's ability and effectively summerises all the qualities that the above scales measure.

5.4.1.1. Rating Counsellor Variables

One of the greatest problem in counselling research is the great number and complexity of variables in the therapeutic situation. This has led some researchers to focus exclusively on client-therapist interaction

variables (Burck et al, 1973). The basis for such process research has been to find out what and in what ways variables make a difference in counselling. The present study is limited to measuring only counsellor variables which were taught in the counselling programme and which were considered to be important in counselling.

It seems that no matter what the orientation of the counsellor, certain variable are universal in counselling (Carkhuff, 1969). Before a client can be helped it is important to know what her/his problems are as fully as possible. Whether the counsellor then uses behaviour modification to change the behaviour, or interpretation to uncover the motivation behind the problem or whatever other procedure, the preliminary step of uncovering the main concern, allowing the client to speak about her/his problems and life situation as fully as possible seems common to all approaches. The length and depth at which this is spoken about and facilitated differs in each approach. Hence, the first four scales seem to measure universal counselling requirements but are focused here quite specifically in terms of problems.

In his extensive work on counsellor variable, Carkhuff (1969) found the following to be effective in the

helping process: self understanding, empathy, respect, warmth, genuineness, a balance of being actively assertive and passively responsive and discriminating. Three of Carkhuff's (1967) rating scales were used as they have good reliability and validity and have been used successfully in other studies (D'Augelli, Danish, Hauer and Conter, 1980; D'Augelli and Vellance, 1982). However, they are used cautiously in this study as Carkhuff's counselling training is within a humanistic paradigm and Rogerian mode whereas the counselling taught in the present study has a dynamic conception of the individual. The scales of Carkhuff's used measure certain general counselling skills, regardless of orientation such as, ability to listen carefully and accurately, respecting the client and keeping the client focussed. Other scales were devised specifically for this study which limits their reliability and validity but no appropriate scales were to be found. These scales were devised specifically to measure skills and attributes taught in the training. Rating scales have frequently been used in testing the effectiveness of counselling (Carkhuff, 1967; Borck et al, 1982).

5.4.2. Interviews

Because the training programme is more than just teaching counselling skills, an interview was used to gain wider information on the trainee and the training. The questions included biographical information such as, age and educational level, interest in mental health, reasons for coming on the training programme, knowledge of counselling, perception of counselling skills gained, use of these skills and with whom, difficulties experienced, personal gains and a perspective of the training (see Appendix A for interview schedule, and Appendix B for a full summary of the interviews).

5.5. CONCLUSION

It was anticipated that there would be a larger sample, and that trainees from three townships would have been studied. However, due to many problems, trainees from only one township returned to complete their training. The information obtained from them is to be found in the next chapter.

Notes

1. *In a private* communication with the researcher, one *of the trainees* told her that he was able to come for *therapy as* he realised that many of his problems could *be helped* by somebody who had skills and that he had *learned* to talk about his problems in the role plays. *He thus* felt able to talk about his problems to a *therapist*.

CHAPTER 6

RESULTS

This chapter looks at the results of the ratings of the trainees' counselling ability and the information gained from the interviews.

6.1. RATINGS

Each subject's counselling role plays (before and after the training was complete) were rated by three independent raters (three clinical psychologists) on nine five point scales (see *Appendix* A). Each value on the scale was described. A rating of 1 indicates no ability on the attribute being measured. A rating of 3 is regarded as the minimal level at which the particular attribute measured *is facilitative* (minimal *facilitative* level), while a rating of 5 indicates a very good ability. Below is a summary of the measures for each trainee on the nine scales.

	Before Training								After Training							
	Rater 1				Rater 2				Rater 3				Rater 1			
SS	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
1	1	3	2	1	1	2	3	1	1	1	3	1	4	3	3	4
2	1	2	2	1	2	1	2	1	1	2	2	1	1	3	3	3
3	1	1	2	1	1	1	1	1	1	1	2	1	1	3	3	2
4	1	1	1	1	1	1	1	1	1	1	1	1	2	3	2	1
5	1	2	2	1	2	1	3	1	1	1	2	1	1	2	2	1
6	1	1	1	1	1	2	2	1	1	1	2	1	1	3	3	1
7	1	3	3	2	1	3	3	2	1	2	3	2	2	4	4	3
8	1	1	2	1	1	2	2	1	1	1	2	1	1	3	3	2
9	1	3	2	1	1	2	2	1	1	?	2	1	2	4	4	2

	After Training			
	Rater 2			
SS	1	2	3	4
1	3	4	4	3
2	3	3	3	2
3	2	3	3	2
4	1	3	5	3
5	1	3	4	2
6	2	3	4	1
7	3	4	4	2
8	2	3	3	2
9	2	3	3	1

	After Training			
	Rater 3			
SS	1	2	3	4
1	3	3	3	2
2	2	3	3	3
3	2	3	3	2
4			3	3
5	1	3	3	2
6	2	3	3	2
7	2	3	4	2
8	1	3	3	2
9	2	3	3	2

Table 1. Ratings for each Subject on the Nine Scales by the three Independent Raters.

Because of the small sample size, statistical tests could not be used to compute inter-rater reliability. Therefore, complete (100%) inter-rater reliability was used, that is, all three raters agreeing on the measure for a particular trainee.

Rating Scales	Before					After				
SS	1	2	3	4	Total	1	2	3	4	Total
1	1			1	2					0
2			1	1	2		1	1		2
3	1	1		1	3			1	1	2
4	1	1	1	1	4		1			1
5				1	1	1				1
6	1			1	2		1			1
7	1		1	1	3			1		1
8	1		1	1	3		1	1	1	3
9	1		1	1	3	1				1
Total	7	2	5	9		2	4	4	2	

Table 2 Scales with Complete Rater Agreement

inter-rater reliability for before training ratings: 63,8%

inter-rater reliability for after training ratings: 33,3%

overall inter-rater reliability: 48,6%

There was a 77,7% inter-rater reliability level for subject 1 on his before training measures, all of which are rated 1 or 2, which indicates general agreement about his overall poor counselling ability. The inter-rater reliability dropp· to 22,2% for his after training measures indicating very little agreement on his ability. There was a 100% inter-rater reliability for subject 4 on his before training measures indicating complete agreement on his poor ability and again a drop to 22,2% inter- rater reliability to his after training measures. The inter-rater agreement for subjects 2 and 4 ranged from 22,2% to 55,5% for both before and after training measures.

What is perhaps more important though, than looking at complete inter-rater agreement is to look at the direction of the ratings. The ratings are generally in the same direction. Below is a table where the general improvement is recorded.

Rating Subjects	1	2	3	4	Total
1	1+	1		1	3
2		1	1	1	3
3	1**	1	1	1*	4
4		1	1		2
5		1+			1
6	1+*	1	1		
7	1 *	1	1		3
8		1	1	1*	3
9	1 *	1	1		3
Total	5	9	7	4	25

1 = improved on that scale

\+ = two raters rated as improved and the third rated stayed the same

* = improved, but still below a facilitative level

Table 2 Scales on which Subjects Improved

Subject 1 improved on *five out of the nine* scales but *despite* the improvement he was still rated as functioning below the minimally facilitative level.

Subject 2 improved on all nine scales. She received one rating of 2, and all the rest were 3 and above which indicates that her level of counselling is adequate and at least minimally facilitative.

Subject 3 improved on seven of the nine scales. He received two ratings of 2 and all the rest 3 and above which indicates that his counselling ability is adequate and at least minimally facilitative. He did not improve on scale 1 and 5.

Subject 4 improved on only four of the nine scales and of those two were below the minimal facilitative level. His counselling ability while slightly better after the training was still not adequate. His improvement was on scales 1 and 2, which meant that he was slightly better at allowing the client to tell her/his story and uncovering the main concern.

From the above it seems that subjects 2 and 3 gained sufficient counselling skills to be minimally facilitative counsellors whereas subjects 1 and 4 did not.

In the role plays each trainee, role playing a counsellor, dealt with two different problems (one before and one after training) brought by the trainee role playing the client. Below is a summary of the subject of the problems that the trainees confronted.

Problem	Number of Times
Detention	2
Political (fleeing the country)	1
Community/ : ocio-political	2
Relationship	3

Table 4 Problems that each Trainee Counsellor Confronted

Each trainee also role played a client coming with a particular problem. Below is a summary of the type of problem each trainee brought to the role plays before and after the training.

Subject	Before Training	After Training
1	relationship	relationship
2	detention	detention
3	relationship	relationship
4	detention	political

Table 5 Problems each Trainee brought to the Role Plays

6.2. INTERVIEWS - AN OVERVIEW

(see Appendix C for the interviews for each trainee).

The interviews were conducted with four trainees who came from the same township and who meet regularly and function as a counselling group. All have worked with the parents and families of detainees or political activists. In fact, all felt competent to deal with problems related to detention but not much out of that field.

The form of help included not only counselling but also much support work and actual physical assistance. For example, a person was shot dead in

the township and all four trainees went to the deceased's family to support them in their grief. They spent the day with the family, gardening, and helping to fill the gap of their lost son. When there are detentions in the township, one of the trainees is usually informed. They would then often approach the parents and families of the detainee and offer what assistance they could. This assistance included listening to their feelings about the detention, which often included anger and sadness. They would also inquire what the family or parent needed and would assist them in finding a lawyer, in organising study material for the detainee and generally assisting the family in adequately coping with the detention of their child. Often they would go with the family member to the recommended place, for example, to the lawyer. They would also refer the parents to appropriate resources like the Dependents Conference.

One of the trainees expressed the original aim of the programme when he said that during a crisis psychologists could not enter the townships and so his reason for coming on the training was to learn counselling skills so as to be of assistance in his community, especially in a crisis. All trainees expressed an awareness of the problems and suffering in their communities, the lack of resources to help

people and their wish, as political activists to be of assistance to their community. All thought that counselling was important as counsellors can help people with their problems, help them with their feelings and give information and education on problems in the community, like alcohol and drug abuse, and detentions.

Since their initial training in February the trainees estimated that they counselled from four to fifteen people each. The counselling sessions were conducted in the client's home or in the counsellor's home. Two of the trainees spoke of the difficulty of setting up a place where they could counsel people. There is a security risk in having a permanent place to see people, particularly as they are dealing with parents and family members of detainees. There is also a perso[illegible] to themselves and at least one of the trainees is in hiding. Finally, the financial problem of setting up a counselling venue is a very real one.

In terms of competency as a counsellor, all said that they felt competent to counsel but all felt that they needed more skills and that counselling was a process which took a lot of time to learn. One of the trainees said that he felt competent to counsel parents and families of detainees only and not with

people with problems like having being raped, or family problems. While *all did* not *verbalise* the above, it is clear from the work that they engage in that all feel competent to work with the problems related to detention only. All felt that they needed more training and practice, and one (trainee 4) admitted late in the interview that he was not convinced that he could do counselling on his own, that he still struggles. He said his problems were that sometimes he felt he had done nothing for the client, *and that he found difficulty in finding out* what the client wanted. Another spoke of the difficulty of putting theory into practice and that he felt that they need much more practice in their counselling skills.

Each gained from the training programme in a different way. One spoke about how it had made *him more aware* about life, about problems in his community and that *there were* people like counsellors who could render assistance. The second spoke of how it had empowered him to help others in terms of dealing with problems that people experience on an intellectual and practical level. He felt he had gained skills and knowledge, particularly about detention and how to deal with it and what resources were available. The *third spoke of how she had become more aware of*

problems in her community and from where they came. The fourth felt more confident to approach people and more confident in himself in counselling people. All felt that the training and their counselling fitted into the broader political struggle because they were dealing with the effects of repression by dealing specifically with the problems related to detention, that they had skills to offer to their comrades and community to support and help them in their difficulties.

In terms of the actual training programme all found it very useful and worthwhile. There was general praise for the trainers that they were tolerant and patient and made the trainees feel free to ask any questions, made them think about things they might not have thought about before and explained the concepts carefully. However, all said that they wanted more contact between training sessions as the gaps were too long. One trainee suggested meeting once a month and felt that they needed more support between the training. There was some ambivalence about the training methods and style, all recognising that they were free to speak and ask questions, but one feeling insecure about a particular method until he understood the purpose of it, others saying that because of their poor education it took time to get used to the

different methods and that some may have felt shy to speak for fear of looking stupid. While none of the trainees interviewed felt that language was a problem, they did think it might have been a problem for other trainees, which would have made them even more reluctant to speak out and participate fully. The issue of language was discussed in one of their counselling group meetings and they decided that the ones more fluent in English would translate for those who did not understand well. One of the trainees had attended a training weekend a year or so before when the training took place over one weekend and he said that he wa a bit confused initially because of the changed emphasis. It seems that he was trained before the problem solving model was introduced. He also mentioned having to get used to different trainers.

The trainees said that the most useful aspects of the counselling training programme included gaining more knowledge and skills, particularly through the role plays. Role plays were seen as a very useful and practical means of practising skills which could then be used in the community and in learning about specific problems. The other most useful features of the training programme included discussing, understanding and recognising feelings in counselling, brainstorming, and having contact with people from

other regions and organisations. A counselling manual which was produced by the trainers was found to be very useful in terms of learning about possible problems and finding a solution for them, and helping to put into practice what they had learned.

CHAPTER 7

DISCUSSION

7.1. INTRODUCTION

This chapter considers the implications of the results of this study and the problems encountered in the research and in the training programme itself. It is important to look at why so few people returned for training and what the implications are for the training programme. The chapter ends with a discussion on the conceptualisation of the training, and of the major problems which were not foreseen and which future progressive mental health care projects would need to consider.

7.2. RATINGS AND INTERVIEWS

One cannot make generalisations about the results because of the very small sample size. On an individual level, however, out of the four people trained, only two improved to a minimally facilitative

level. The other two, although slightly improved, were still not adequate counsellors. However, while all trainees felt that they needed more training, all had had contact with families of detainees, and felt that they had done counselling. Two of the trainees can be considered to be minimally facilitative counsellors who could counsel but the other two could not. The two that improved to a facilitative level were generally rated at a higher level before they started the training than the two whose improvement was not sufficient for them to be considered as adequate counsellors. This raises questions about the selection of trainees. Perhaps trainees need to have certain abilities, such as an ability to listen carefully, be [illegible]standing and respect for the client, in o[illegible]nefit most from the training. If in princi[illegible] practice there is no selection, then perhaps more training and supervision needs to be given to those who are still not adequate counsellors at the end of training. These findings also suggest the need to have some form of evaluation at the end of the training programme to determine whether trainees are competent to be lay counsellors or not.

A particular problem of this study was the low inter-rater reliability. There was greater inter-reliability on the before measures (63,8%) than

on the after measures (33,3%). In the after ratings on scale 1, there was no inter-rater reliability and minimal inter-rater reliability on scales 4, 5, 6, 7 and 9. Of these, scales 4 and 7 are Carkhuff's scales which have been used reliably in the past (Carkhuff, 1967; D'Augelli et al, 1980). The inter-rater reliability was highest on the two subjects that were rated the lowest (trainees 1 and 4). In fact, with trainee 4 there was 100% inter-rater reliability, all of whose abilities were rated 1 with the exception of scale 7 where he received a rating of 2. This suggests that it was easier for the raters to agree on no or very little ability on a particular scale, that is, agreeing on his lack of *ability as a* counsellor than *with some* ability. However, the lack of agreement seemed to arise when the trainee showed some ability in counselling. Almost contradicting this hypothesis, though, is the observation that in the after ratings there was greater, albeit still low, inter-rater reliability with the two trainees who had improved to a facilitative level. Looking at this problem in a different way, and looking rather at the general direction of the ratings (table 3), that is, whether the trainee improved *in a particular* ability or not, then the picture changes. One of the trainees who was considered to be an adequate counsellor improved on all the scales (subject 2)

while the other adequate trainee (subject 3) improved on seven out of the nine scales. The two who were not considered to be adequate counsellors improved on five (subject 1) and four (subject 4) of the scales, and practically all the improvemnt was still below the minimally facilitative level.

The inter-rater agreement on the three Carkhuff scales (scales 4,7 and 8) did not seem to be much different from those (scales 1, 2, 3, 5, 6, 9) devised by the researcher. The scale where there was consistently low inter-rater reliability was scale 5, that is, the counsellor's ability to facilitate problem solving. There was also no improvement on that scale by three of the four trainees and trainee 2 was rated as improved by two of the three raters on that scale. It seemed that that scale did not adequately discriminate between the different levels of ability. Alternatively, the problem solving model was possibly not adequately taught, understood or used (see 4.4.4). In order to use the problem solving model, the trainees have to have listened very carefully and sensitively to their clients, and only once they have identified the main problem can they proceed on to the problem solving model. The trainees experienced difficulties in learning to listen adequately and the problem solving model was introduced to try to solve

this difficulty. While the introduction of the problem solving model seems appropriate, it perhaps avoided the problem of *how to teach and practice effective listening*. Alternatively, the role plays were perhaps not long enough for the counsellor to proceed on to the problem solving model, as the model is implemented only once the problem has been ascertained and explored.

An interesting fact that emerged from the role plays was that each trainee brought the same or similar problem to the role plays, even though they were spaced eight months apart. *This suggests* that trainees *bring problems* that are relevant to themselves and that the role plays may be regarded as realistic simulations of a real counselling session. However, from the interviews it is clear that the trainees feel competent to deal with *issues related* to detention but not *to other problems*, particularly not to relationship difficulties. But, in the role plays, four of the trainees brought problems in relationships, and three of the role playing counsellors had to deal with relationship *problems*. Clearly, all felt *inadequate and* insufficiently *trained* to deal with relationship problems. While one cannot comment on this affecting the role plays due to the small sample size, it might have affected their

ability as counsellors in the role plays. With hindsight, the research could have been better controlled if each trainee (role playing a client) was asked to bring a problem relevant to them but related to some aspect of detention and its effects.

With a larger sample, the following trainee aspects would need to be considered as affecting the outcome of the training:

a) sex of the trainee - in the sample there was only one woman (subject 2) who was also the oldest (16 years). She improved to a facilitative level. In our society women are socialised to be more supportive and nurturing which could affect a woman's counselling ability. It was not possible in this study to have two groups, one of men and the other women. This would have yielded interesting results in terms of pre-training ability, and may have indicated whether sex does in fact affect counselling ability.

b) age of the trainee - the trainees in the sample were all under thirty. In all the groups trained youth organisations have predominated. The recommendation of selecting older members of the community did not happen. Clearly, if the organisation is a youth organization then the older members will be in their

twenties. Age is a variable in ability as a counsellor as life experience can assist the her/him in dealing with her/his client. There is certainly no blanket rule about age, but usually more mature people are preferred as lay counsellors. Some of the trainees in the study felt too young to deal with situations other than what they had experienced, and could not deal with rape and family problems. However, these trainees were particularly knowledgeable about detention, its effects on the families of detainees and relevant referral resources. Perhaps in this instance age might not be a relevant variable in that it is predominantly the youth in the townships who have the most direct experience of detention and its effects. Again this could only be reliably ascertained with a larger sample.

c) Areas of interest and experience - *the trainees* in the sample worked with families of detainees, not only as lay counsellors but in a *supportive and informative* role. Seemingly, their area of knowledge concerns detention, its effects on *families, and on resources* that are available to assist the detainee's family. Perhaps it would have been better to have asked the trainees to bring more focused problems, like one they might be experiencing *in relation to detention*, to the

role plays (see above). This would have ensured that all trainee counsellors would have dealt with problems they felt competent to handle.

Perhaps also knowing that the trainees were members of political organisations, a question which needs to be considered is whether the training programme should be focused more on detention and the effects of detention. Another is whether the trainees actually counsel or whether they act only as information givers, as supports in time of need and crisis and in friendship roles. From the interviews, the trainees seemed to feel more competent in approaching people, particularly if they did not know the person previously, and in providing information and physical assistance. Some did mention having to deal with the anger of the family of a detainee. All felt incapable of dealing with family problems. The answers to these questions effects the content of the training programme. Perhaps the programme needs to be more focused on counselling families or family members of detainees, and on exploring resources for helping detainees and their families.

d) role as primary mental health care workers - after the training, all the trainees in the study expressed increased awareness of the problems and suffering in

their communities and the lack of resources to help people. As political activists they wanted to help people in their communities. They felt that lay counsellors could assist people with their problems and give information and education on problems in their community. Another study could perhaps evaluate the impact lay counsellors have in their communities.

7.3. PROBLEMS IN THE TRAINING PROGRAMME AND CONSEQUENTLY IN THE RESEARCH PROJECT

Conducting and carrying through this research proved very difficult with many delays and hitches in gaining the research material. These difficulties were part of the problems experienced in the training programme itself. It is important to look at these difficulties in order to understand the problems involved in such a programme.

7.3.1. Effects of the Political Situation in 1988 on the Training Programme.

Early in 1988 the major progressive organisations were banned. Many people were detained and township organisational structures were weakened. Some even collapsed. This had grave implications for the training programme which was dependent on these structures. With the exception of the four trainees in this study, the other groups did not return for training largely because of the breakdown in organisational structures.

With the second group repression as well as problems within the group itself resulted in their not completing the training. For example, some trainees were uncertain about what the training actually entailed. There was clearly not the preliminary work done in organising the group for counselling. In addition, many trainees were not members of any organisation and came as individuals and, hence, were not accountable. For those that were organisationally based, accountability was still a problem because the larger organisational structures were no longer functioning in the township. Although some members of the group were prepared to return for training, the trainers were reluctant for them to return as their

skills would not be disseminated within their community and they would not have the support and back up of their organisations. Organising under such conditions is very difficult and trying to arrange and run training groups dependent on these structures is problematic, to say the least.

What is important to note, is that the group in the study, formed themselves into a counselling group and met together for counselling. However, this is not without its own problems as other organisational structures were not functioning in their area. This raises the question as to whom the counselling group is accountable. What made this group continue to work and what made the others collapse? A further study needs to find those people who came on the training programme and to ascertain why they did not return, and why they too did not form themselves into a counselling group.

Repression, detentions and restrictions form the background to the problems considered below.

7.3.2. Delays, Postponements and Cancellations

The new eight day programme started at the beginning of 1988 when this research commenced. It was expected that the initial training (first three weekends) would be complete for two groups by July where post training recordings could be taken and the final training weekend completed by October. However, this did not happen. Of the two groups, one and a half had two weekends of training only. This meant that the final role plays could not be recorded nor interviews conducted on them. Effectively, this meant losing well over three quarters of the anticipated subjects for the study.

Another problem which affected both the smooth running of the training programme and the research project was repeated cancellations or postponements of training weekends. This non occurrence of training weekends was usually because of the difficulty in getting trainees together for the training. A further reason is a structural problem with the difficulty of contacting trainees because of the adverse conditions in the townships and the large distances between trainees themselves and between the trainers and the

trainees. A solution might be to run the training programmes within the township, close to people's homes. (see 7.3.4.).

7.3.3. Lack of continuity of Trainees

Another problem encountered both in the research and the training programme itself, was the changing population coming for training at each weekend - though certainly some remaining constant. When people start the counselling training programme they are encouraged to make a commitment to come to the full eight day programme as each day builds on the previous one but often this does not happen. Often new people come to the training, or trainees do not come back for subsequent weekends, or miss a weekend of training. This fluctuating attendance was particularly problematic for the researcher as the design of the research project follows each individual subject through the training programme. This factor partly accounts for the small sample size in the research project but also indicates the small number of trainees actually undergoing the complete training.

The final role plays were completed on the third weekend with the possibility of even fewer people coming for the fourth and final weekend.

The reasons found for this variable attendance (obtained in discussions with trainees and the field worker who organises the training groups) have been varied. Firstly, the trainee is an activist and often has other commitments. These commitments might take place at the same time as the training programme and seemingly, the training programme is not given priority. These commitments were usually regarded as more pressing than the training programme and which might have required an immediate reaction to a particular current situation. Secondly, in some instances the trainee had been detained and so obviously could not complete the training. Thirdly, because the majority of trainees are activists and living under severe repression, some are in hiding. However, this is not always a reason for miss g a training weekend as some of the trainees said that they were in hiding but had come to the training programme almost as an escape from the stress of living in such an unsettled way. The likelihood of those particular trainees being able to become effective counsellors is dubious. Other reasons for lack of attendance may include more personal reasons.

What emerges though is that it is difficult for trainees to make a long term commitment to the training programme.

Perhaps part of the difficulty about making a long term commitment to the training programme is that the rewards from the programme are not sufficient. The trainee may gain counselling skills which will be of benefit to her/his organisation and community, and perhaps to her/himself. However, there is no financial gain. The trainees come from working class areas where unemployment is a great problem and many of the trainees themselves are unemployed (see 1.2.). In the Battersea project, Holland (1979) found that using volunteers in working class areas was unsuccessful (see 2.5.1.) and she recommended raising funds to pay them. Paying the lay councellors, for example, would perhaps encourage a greater commitment to the training programme and would ensure a greater involvement of working class people in their own mental health care.

The variable attendance also raises questions about who should be trained and about the content of the training programme. If the trainees are still to be members of progressive organisations with no knowledge about counselling prior to the training then perhaps

more time needs to be spent on the first day of training and revised in subsequent weekends, on the link between politics and mental health. Perhaps also, more time should be spent on discussing what mental health is and not to assume that people know about it (Holland, 1979).

7.3.4. Venues

The training took place in venues in Johannesburg and not in the townships from where the trainees came. The reasons for this were, firstly, that it was safer to use a venue in Johannesburg because it would not draw unnecessary police attention to the meeting of large numbers of activists. Secondly, it was more convenient, as the venues provided food and accommodation and such requirements were not easily obtained in the townships. However, the effect is to take the training out of the place where the training will be used. The venues will also influence how the trainees perceive the trainers and the training. If it is very opulent and bourgeoise then the training will also be perceived in that light. While the venues certainly were not opulent, they provided comfortable accommodation and very adequate catering

services, often better than the trainees were used to. Perhaps this area was not adequately explored in the setting up of the training programme. Another question is whether it is appropriate to train people where there are no structures available to do counselling after their training. It was clear from the functioning group that the lack of a place to counsel was a problem.

Primary mental health care essentially involves an emphasis on community involvement (see 2.4.) and by taking the training out of the townships it effectively removed the training from the place where it would be used. In the Battersea project (2.5.1.), a multi - purpose centre was found to be useful as it housed organisations which worked towards improving societal structures affecting people's mental health as well as housing counsellors. It would be advisable for the training programme to run in places where community organisations meet and function and so be part of those structures. However, the feasibility of this would rest on the political climate in South Africa at that time.

7.3.5. Initiating Training

The counselling programme developed as a result of requests for training (see chapter 4). However, as the programme developed and enlarged, it liaised with larger progressive structures rather than individual organisations. The information about the training programme was disseminated through this larger body and a field worker who would contact township organisations. This meant that the organisations were told about the training programmes and then could decide whether they wanted to send members on it or not. The decision to undertake the training was not therefore dependent on a particular felt need. Also, the decreased level of overt state violence in the townships perhaps made the need for lay counsellors less pressing. Furthermore, much greater reliance was put on the field worker to explain the programme and the larger organisational body to inform member organisations of the programme. In a non-repressive and peaceful society, this might work very well, but in South Africa where there is much repression of progressive organisations the discussion of a training programme is probably not given priority. The lack of preliminary work, that is, of informing the

organisations about the training, partly resulted in the failure of the second group to complete their training.

If the need for counselling is not immediately apparent, then more time needs to be spent discussing the link between politics and mental health and on the appropriateness of counselling in different situations and the rationale of counselling. This suggests that the emphasis of the programme might change with the different groups, with some focusing, perhaps, on politics, mental health and more legal issues, and others specifically on counselling skills. The difference in emphasis would be determined by the particular needs of the group.

7.3.6. Trainees

A further question that needs to be considered is whether it is appropriate to train members of political organisations who have no knowledge or perhaps interest in counselling (see 3.3.). In terms of the counselling programme, time had to be spent discussing what counselling is, the use of counselling, why people counsel and what one hopes to

achieve from counselling. While it is always important to discuss these issues in any counselling training programme, it is perhaps better and more useful if the trainee has some knowledge of these issues and has thought about them, preferably based on his/her own experience.

In the small sample, all trainees felt that counselling was useful and an appropriate intervention in their community. It would be valuable to know how the trainees who did not complete their training felt about the importance and relevance of counselling. It seems that the training programme has been considered to be useful by some groups because more training has been requested by groups who have received training over the past three years.

Perhaps the reason for wanting to train people from political organisations is that the material learned in the training programme can be used in these organisations, like the links between social structures and ideological practice, and also that the trainees political activism can be used to fight for adequate mental health care for all (see 3.2.3.).

7.3.7. Language

While all the trainees in the sample said that language was not a problem they all say it was a problem for other trainees. They even had a meeting to discuss the language issue and decided that those fluent in English would translate for those who did not understand. The training, role plays and interviews were all conducted in English which is not the trainees first language and which may have inhibited them in their free expression. Perhaps a much richer protocol would have been obtained if the role plays and interviews were conducted in the trainee's first language. What needs to be considered in the future is the possibility of the trainers learning an African language and doing at least part of the training in an African language.

7.3.8. Social Construction of the Trainee

Perhaps not enough thought was given to the concept of the social construction of the individual and its translation in the training. The trainers have very different upbringings, material environments, education and life experiences from the trainees.

Furthermore, the training programme has a very different approach to teaching and learning to the schools the trainees attend or have attended, which are invariably authoritarian and hierarchical. The following are considered important in the social construction of the individual:

i) Education - Three out of the four trainees in the sample were still at school, and in the other groups most were students or recent school leavers. All had come through the Black schooling system which is generally recognised to be educationally inadequate. The education system is authoritarian and discourages free thought and active participation. This contrasts sharply with the style of the counselling programme where the aim is to have a democratic process of learning and teaching, active participation by all, with extensive discussion and questioning. Perhaps more time or greater blocks of time need to be spent in acclimatising the trainees to the different style of the programme. Greater cognisance also needs to be taken of the educational level of the trainees.

ii) Conception of mental health - Since the start of the training programme it has become clear to the trainers that the trainees usually have little knowledge or understanding of mental health in the way

the trainers view mental health. As Nzimade (1988) has pointed out, one does not enter an empty terrain when dealing with mental health in black communities but one filled with its own practices and conceptions of mental and ill health, all which effects the way conflict and stress is experienced in the townships. More time needs to be spent in exploring the different conceptions of mental health.

While repression is seen as the primary reason for the weakening and breakdown of organisational structures, and hence the failure of the selected groups returning to their training, perhaps mental health itself, is not regarded as a particularly important area of struggle. It also does not seem to be regarded as a priority with other organisational issues taking preference. Seemingly the training programme is not taken seriously enough, perhaps because of the perceived un-importance of mental health generally and counselling in particular.

Perhaps the reasons for the perceived un-importance of mental health are located in our society which splits health and mental health into clearly defined parameters, with mental health services remaining seperated from everyday life (Banton et al, 1985). Furthermore, the concept of 'mental health' may not

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have particular meaning to the trainees and perhaps more appropriate 'language' needs to be developed to explore the different meanings and interpretations given to mental health. Part of this exploration would entail a discussion on traditional healers and herbalists and other people working in the mental health domain and their conception of mental health (see 2.2.). Also perhaps, the richness and variety of people's culture and social history which is essential in understanding the individual and its part in forming their conception of mental health, was not adequately explored and discussed in the training programme. Finally, mental health services need to be moved into the community, with the emphasis on the needs of all community members. Structures, like a community centre (where activist groups could also operate), need to be established to help bring the training and consequent counselling or advice giving or support into the community. (see 2.5.1. - the Battersea project).

7.3.9. Theory and Training

A fundamental tenet of the theory informing the training programme is the unconscious and the

ideological unconscious. This implies that often a person's actions are beyond her/his immediate consciousness and that people are unconsciously motivated. A person's actions and feelings become understandable when the unconscious dynamics are uncovered, and the person can gain greater understanding about her/himself and more control over her/himself and her/his world. The way this can be done is through in- depth psychotherapy and also through knowledge and understanding of the influence of ideology and social forces on the individual. Some attention is given in the programme to the effects of the ideological unconscious on the individual by discussing the trainee in her/his socio-political environment, by linking this to his/her and their community's mental health. Certainly, a lot of time is spent on the contextualisation of mental health. Discussion of how the socio-political and economic conditions directly affect the trainees, and what the psychological effects are, is encouraged. The effects of racism and class are also discussed which promotes a better understanding of mental health.

A person grows up within ideological relations which affects her/his perception of the world, consciousness, hopes, desires etc. The training programme does not train the trainers to uncover

unconscious material, but rather to make them aware of how forces beyond their immediate control affect their clients. The distress their client experiences is then located within its political and social context. Perhaps the trainees perception of mental health could have been more fully explored in the interviews.

7.3.10. Power Relations

In confronting power relations within a relationship, awareness of it becomes evident and hence can be dealt with. There are certain inherent power relations in the training programme, namely, between the trainers and trainees by virtue of the trainers privileged backgrounds, education, professional qualifications and present living arrangements. There is an attempt to make these relations conscious by open discussion and seeing its roots in the socio-political situation in which both trainers and trainees live. An attempt is made to share skills and knowledge to change the power balance between trainers and trainees. However, it seems that gaining counselling skills within the

theoretical framework discussed in previous chapters) is a long term and intensive project which requires commitment and favourable political circumstances.

The power relations between the trainee and her/his client would also need to be addressed. Hopefully, the modelling of the trainers in dealing with the power relations in the training would assist the trainees in dealing with power relations in the counselling relationship.

Perhaps the trainees were empowered in the sense that they felt that they could offer assistance in their community, and were seen as being able to help. Personal empowerment can also be seen in the expansion of consciousness through increased knowledge of one's own environment and the development of a critical consciousness (Lazarus, 1985).

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CHAPTER 8

CONCLUSION AND RECOMMENDATIONS

8.1. SUMMARY AND CONCLUSION

Of the four groups planned to be trained in 1988, the only group that completed its training was the one used in this study. This group grew with new people coming on the second and subsequent weekends, but those trainees could not be used in this study. The remaining groups are unlikely to complete their training in 1989 (see 7.3.).

One must accept that in a repressive society, such as South Africa, the smooth running of a training programme like the one described in chapter 4, which is linked to progressive organisations, is very difficult. From a theoretical viewpoint, the training programme appears appropriate and useful. The small sample size and the limited scope of the research project does not allow one to comment on the effectiveness of the programme or its impact in the

communities from which the trainees came. This would have to be ascertained when the programme is used with other trainees.

If the aim of imparting skills to assist in the functioning of a particular organisation and the community which it served is retained, then perhaps the training programme itself needs to adapt to the present repressive situation in South Africa. This could be done, for example, by revising skills learned in every training weekend to accomodate to the changing population of trainees, to more actively work in creating stuctures in the townships where the training and subsequent counselling could take place and to spend more time on the links between politics and mental health. Moving away from the above aim suggests another, perhaps more effective solution which would be to train groups who are already doing some sort of counselling or advice giving and who have the existing structures in which to counsel. These would include advice officers, field workers in the health area or field workers in the rural areas or church groups who as part of their work might work with ex- detainees and their families. A research project would have to determine the effectiveness of

the programme discussed in chapter 4 using people who are already doing some form of counselling or help giving.

Finally, it must be recognised that in the three years of the training programme's functioning, the political situation has changed greatly as did the needs of the trainee's organisations. From responding to specific requests by organisations, the programme expanded and was offered to organisations. When this happened great effort needed to be made to determine the needs of the organisation and the ways in which the programme could contribute to the strengthening and functioning of that organisation. It seemed that this did not always happen. The importance of preliminary work in discussing the training programme, its relevance and use became evident and needs to be considered in the future operation of the programme.

The need for mental health workers, particularly in the townships, is great. While the training programme under evaluation did not contribute greatly to the numbers of skilled mental health workers, it did illuminate the kinds of problems that future training programmes might encounter.

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8.2. RECOMMENDATIONS

8.2.1. Recommendations for the Lay Counselling Training Programme

1. Under present repressive political conditions, individual organisations should be contacted and informed about the training programme. Requests for assistance from particular organisations should be responded to without being reliant on the larger progressive structures.

2. In-dept' preliminary work should be done to determine the needs of the organisation and the consequent focus of training. The educational level of the prospective trainees should also be established so that the level of the training is appropriate for the trainees.

3. The counselling training programme needs to be flexible to the particular organisation's needs. Specific counselling related to detention and its effects, for example, might be the focus. At other times educational material and resources may be stressed.

4. The trainees conceptions of mental health should be explored as well as the ways they have of dealing with strers and distress in their lives.

5. Creative and imaginative ways need to be developed to talk about 'mental health'.

6. The programme should be organised in such a way that there is on-going revision of material taught and practised. This would counteract the difficulty of trainees missing sessions or coming late into the programme.

7. New and imaginative ways need to be developed to teach and practice effective listening.

8. Venues are important in terms of the way the programme is perceived and how it is integrated into the community. Therefore, if possible, the venues should be in the townships where other community organisations are based. Counselling should also then take place at these venues after the training is complete.

9. The training weekends should be spaced at monthly intervals for training and ongoing supervision.

10. The trainers should be able to understand the language of the trainees so that role plays and some of the instruction can be conducted in that language.

11. The feasibility of paying lay counsellors should be investigated.

12. There needs to be some form of evaluation at the end of the training programme to determine who needs further training and supervision and which would be able to identify potential counsellors.

13. The counselling training and counselling service should work actively with community organisations to work for the redistribution of mental health services *and to take up the struggles that influence the* quality of mental health of the people.

8.2.2. Further Recommendations

1. People who are working in areas where counselling skills could be useful should be trained. These include people working with the families of detainees, *like the Dependents Conference, Detainee* Advice Committee; field workers from church organisations like the South African Council of Churches who deal

with a wide variety of problems of people in both urban and rural areas; advice officers serving township residents and certain employees of progressive organisations, for example, employees working at Detainee clinics.

2. There should be continuous evaluation of the training programme to determine its effectiveness and its impact on the community from which the trainees come.

3. Recognising the need for mental health workers, the training programme should continue both for members of political organisations and for people in helping roles, (see 1. above).

8.2.3. Research Recommendations

1. Further research needs to be carried out to determine whether the trainees actually gain counselling skills that the trainers try to impart. This would require sufficient subjects to be able to use appropriate statistical tests.

2. Once the training is complete, the impact of lay counsellors in the townships and their effectiveness needs to be researched.

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APPENDIX A

RATING SCALES

Please rate the taped sessions on the following variables using a 5 point rating scale. As a general guide the following numbers mean:

1 = no skill or ability on that variable
2 = minimal amount of skill or ability on that variable which hinders the counselling process
3 = some skill or ability on the variable with the effect of some facilitation of the counselling process. This is the minimal facilitative level.
4 = adequate ability or skill on the variable which facilitates the counselling process but with some lapses
5 = A very good grasp of the skill or ability and a smooth and uninterrupted counselling session.

Scale 1:

The counsellor's facilitative ability to allow the client to tell her/his story.

1 = Impedes the telling of the story by inappropriate responses, avoids the main problem, misinterprets what is said.
2 = Moderately hinders the telling of the story by not following leads and not staying with the topic.
3 = A moderate ability in allowing the client to tell his/her story unhindered. There may be some gaps in the story as not all the leads are taken up or explored.
4 = A good facilitative ability in allowing the client to tell his/her story, some leads not taken up but an adequate story told, few inappropriate questions.
5 = Facilitates the full telling of the story so that the client seems to have told all that s/he wants to say, a full exploration of the story.

Scale 2:

The counsellor's ability to uncover the client's main concern/problem:

1 = The main problem is not dealt with at all and the client only hints at the problem. The counsellor does not allow the client to speak about his/her problem either because of his/her lack of interest, lack of respect or other reason.

2 = The main problem is mentioned briefly and superficially but not adequately explored either because the counsellor did not facilitate the exploration or changed the topic.

3 = The main problem is spoken about and the counsellor assists the client in speaking about her/his problem but misses some leads or does not take up issues. The problem is explored on a factual rather than a feelings level.

4 = The main problem is fairly fully explored and the counsellor has a good idea of the problem, a few leads are not taken up but both the main problem and the feelings associated with it are discussed.

5 = The counsellor uncovers fully the client's main problem or concern and follows all leads and stays with the client fully.

Scale 3:

The counsellor's ability to understand the client's problem:

1 = The counsellor shows no skill or ability in understanding the client's problem, the counsellor misinterprets what the client says and does not stick to what the client is saying.

2 = The counsellor shows minimal skill or ability in understanding the client's problem. Some aspects of the problem are discussed but are not taken further because the counsellor tends to block the communication.

3 = The counsellor has some understanding of the client's problem and some time is spent

exploring the problem. Some leads are not taken up and some aspects of the problem need to be further explored.

4 = The counsellor has an adequate understanding of the client's problems and is able to identify what the problem is so as to start the steps to solving it. A few areas still need to be explored.

5 = A very good understanding of the client's problem and a smooth facilitation of the client speaking of his problem. The counsellor responds with accurate and appropriate responses to the client.

Scale 4:

The counsellor's ability to understand the client's feelings.

1 = The counsellor's verbal and behavioural expressions do not attend to or detract significantly from the verbal and behavioural expressions of the client in that they communicate significantly less of the client's feelings and experiences than the client has communicated him/herself. The counsellor communicates no awareness of even the most ovcious, expressed surface feelings of the client. The counsellor may be bored or disinterested or simply operating from a preconceived frame of reference which totally excludes that of the client. The counsellor does everything but express that he is listening, understanding or being sensitive to even the most obvious feelings of the client in such a way as to detract significantly from the communications of the client.

2 = The counsellor rarely mentions feelings or shows an understanding of the client's feelings. When the counsellor responds to the expressed feelings of the client, s/he does so in such a way that s/he subtracts noticeably from the client's communications. The counsellor may communicate some awareness of obvious, surface feelings of the client, but his/her communications drain off a level of the

exploring the problem. Some leads are not taken up and some aspects of the problem need to be further explored.

4 = The counsellor has an adequate understanding of the client's problems and is able to identify what the problem is so as to start the steps to solving it. A few areas still need to be explored.

5 = A very good understanding of the client's problem and a smooth facilitation of the client speaking of his problem. The counsellor responds with accurate and appropriate responses to the client.

Scale 4:

The counsellor's ability to understand the client's feelings.

1 = The counsellor's verbal and behavioural expressions do not attend to or detract significantly from the verbal and behavioural expressions of the client in that they communicate significantly less of the client's feelings and experiences than the client has communicated him/herself. The counsellor communicates no awareness of even the most overtious, expressed surface feelings of the client. The counsellor mat be bored or disinterested or simply operating from a preconceived frame of reference which totally excludes that of the client. The counsellor does everything but express that he is listening, understanding or being sensitive to even the most obvious feelings of the client in such a way as to detract significantly; from the communications of the client.

2 = The counsellor rarely mentions feelings or shows an understanding of the client's feelings. When the counsellor responds to the expressed feelings of the client, s/he does so in such a way that s/he subtracts noticeable affect from the client's communications. The counsellor may communicate some awareness of obvious, surface feelings of the client, but his/her communications drain off a level of the

affect and distort the level of meaning.The counsellor tends to respond to other than what the client is expressing or indicating.

3 The counsellor's expressions in response to the expressions of the client are essentially interchangeable with those of the client in that they express essentially the same affect and meaning. The counsellor responds with accurate understanding of the surface feelings of the client but may not respond to, or may misinterpret the deeper feelings. In summary, the helper is responding so as to neither subtract from nor add to the expressions of the client. S/he does not respond accurately to how that person really feels beneath the surface feelings but indicates a willingness and openness to do so. This level constitutes the minimal levle of facilitative interpersonal functioning.

4 The counsellor's responses add noticeably to the expressions of the client in such a way as to express feelings a level deeper than the client was able to express him/herself. The counsellor's responses add deeper feeling and meaning to the expressions of the clients.

5 The counsellor's responses add significantly to the feeling and meaning of the client's expressions in such a way as to accurately express feelings levels below what the client himherself was able to express. The counsellor responds with accuracy to all of the client's deeper as well as surface feelings.

Scale 2:

The counsellor's ability to facilitate problem solving.

1 There is no attempt to follow the steps of the problem solving model and no problem solving occurs.

2 There is a rudimentary identification of the problem and an attempt to solve it but the problem may be too vague to adequately do so or there is not an adequate resolution to the problem, for example the counsellor solving the problem.

3 = The problem is identified sufficiently to try to find a workable solution for it. There is some discussion about ways of resolving the problem in terms of options available and appropriate activities.

4 = The problem is identified and fairly thoroughly explored as are ways of resolving it, namely, exploring more than one way of solving it and more than one way of going about it.

5 = The problem is clearly identified and thoroughly explored. A number of possible options are discussed as a means of solving the problem and a number of possibilites of action are also discussed. The final action decided upon is appropriate.

Scale 6:

The counsellor's ability to allow the client to make her/his own decisions.

1 = The counsellor makes all the decisions for the client and tells the client what to do and how to solve her/his problem.

2 = The counsellor makes most of the decisions for the client but does allow some leeway for the client to do what s/he wants to do. When the counsellor tells the client what to do, there is some consultation with the client.

3 = The client encourages the client to make her/his own decisions but does make some decisions for her/him. The counsellor may push the client to make the decision that s/he feels the client should.

4 = The counsellor encourages the client to make her/his own decisions and resists telling the client what to do or making her/his decisions for him.

5 = The counsellor encourages the client to explore as many possibilities as s/he can and on the basis of a thorough exploration of all aspects of the problem, the client is able to make her/his own decisions. The counsellor never tells the client what to do or makes his/her decisions.

3 = The problem is identified sufficiently to try to find a workable solution for it. There is some discussion about ways of resolving the problem in terms of options available and appropriate activities.

4 = The problem is identified and fairly thoroughly explored as are ways of resolving it, namely, exploring more than one way of solving it and more than one way of going about it.

5 = The problem is clearly identified and thoroughly explored. A number of possible options are discussed as a means of solving the problem and a number of possibilities of action are also discussed. The final action decided upon is appropriate.

Scale 6:

The counsellor's ability to allow the client to make her/his own decisions.

1 = The counsellor makes all the decisions for the client and tells the client what to do and how to solve her/his problem.

2 = The counsellor makes most of the decisions for the client but does allow some leeway for the client to do what s/he wants to do. When the counsellor tells the client what to do, there is some consultation with the client.

3 = The client encourages the client to make her/his own decisions but does make some decisions for her/him. The counsellor may push the client to make the decision that s/he feels the client should.

4 = The counsellor encourages the client to make her/his own decisions and resists telling the client what to do or making her/his decisions for him.

5 = The counsellor encourages the client to explore as many possibilities as s/he can and on the basis of a thorough exploration of all aspects of the problem, the client is able to make her/his own decisions. The counsellor never tells the client what to do or makes his/her decisions.

Scale 7:

The counsellors communication of respect towards the client.

1 = The verbal expressions of the counsellor communicate a clear lack of respect for the client. The counsellor communicates to the client that her/his feelings and expriences are not worthy of consideration or that the client is not capable of acting constructively.

2 = The counsellor communicates little respect for the feelings, experiences and abilities of the client. The counsellor may respond mechanically or passively or ignore many of the feelings of the client.

3 = This level constitutes the minimal level of facilitative interperpersonal functioning. In many ways the counsellor comunicates the possibility that who the client is and what s/he does matter to the helper, at least minimally.

4 = The helper clearly communicates a very deep respect and concern for the client. The counsellor's responses enable the client to feel free to express himself and to feel valued.

5 = The counsellor communicates the very deepest respect for the client's worth and helps the client to act constructively.

Scale 8

The counsellor's personally relevant concreteness or specificity of expression in interpersonal processes.

1 = The counsellor appears to lead or allow all discussions with the client to deal only with vague and anonymous generalities. The counsellor makes no attempt to lead the discussion into the realm of personally specific situations and feelings.

2 = The counsellor frequently appears to lead or allow even discussions of material personally relevant to the client to be dealt with on a vague and abstrct level. The counsellor does

not elicit discussion of most personally relevant feelings and experiences in specific and concrete terms.

3 = The counsellor is open and at times facilitative of the client's discussion of personally relevant material in specific and concrete terminology but sometimes these are not always fully developed.

4 = The counsellor appears frequently helpful in enabling the client to fully develop in concrete and specific terms almost all instances of concern, by guiding the discussion to specific feelings and experiences of personally meaningful material.

5 = The counsellor appears always helpful in guiding the discussion so that the client may discuss fluently, directly and completely specific feelings and experiences.

Scale 9

Overall evaluation of the counsellor's ability

1 = The counsellor shows no ability to facilitate the discussion of the client's problems and difficulties, seems not to understand the person and may even have a negative effect on the client. The counsellor appears to feel inadequate about his/her ability as a counsellor.

2 = The counsellor shows a small amount of facilitative ability to allow the client to discuss her/his problems or difficulties. The encounter is not regarded as therapeutic.

3 = This is the minimal level of the encounter being helpful or therapeutic.

4 = The counsellor shows adequate abilitity to facilitate the counselling process.

5 = The counselor shows a good ability to facilitate the counselling process.

APPENDIX B

INTERVIEW SCHEDULE

1. Personal Information:
   name:
   age:
   sex:
   educational level:
   employment:

2. Why did you come on this training programme?

3. Do you think counselling is important? If so, how?

4. Why did you choose to do counselling training rather than first aid and legal skills training?

5. Do you feel you have gained counselling skills? If so, what kind?

6. Have you gained or learned anything else? If so, what?

7. Have you used your counselling skills? If no, why not? (go to 14)

8. If yes, how have you used them? (one-to-one counselling, family situation, in organisation)

9. How many people have you counselled?

10. What was your relationship with the person you counselled? (relation, friend, etc)

11. Was there any difficulties with the place or time *when you counselled?*

12. What type of problems do you have to deal with?

13. What did you do to help them?

14. Do you feel competent to counsel? Explain.

15. Why do you want help other people with their problems?

16. How has the counselling training helped you?

17. Does the training programme fit into the broader political struggle? If so, how?

18. Was there a link between the person's problem and her/his political and social conditions? If so, how?

19. Did the trainers give you enough support in your counselling?

20. Was language a difficulty in the training?

21. What was the most useful part of the training programme?

22. What was the least useful part of the training programme?

23. What were your problems or difficulties with the trainers? Explain.

24. Was the programme useful? If so, how?

25. What suggestions can you make to make the programme better and more useful?

APPENDIX C

INTERVIEWS

Trainee 1

Trainee 1 is a 23 year old man who is at school in standard nine.

He realised that a lot of people were suffering, both physically and mentally and he wanted to be in a position to help those who are suffering. He therefore decided to attend the counselling course. He said that alcohol and drug abuse were common problems in his township. He felt he was able to give help and advice and educate people about these problems. He also spoke about the possibility of detention for those involved in the struggle to bring about change and the difficulties this posed for them and their families.

He felt that counselling was important in dealing with all these problems, particularly as he felt that people were not aware of their 'mental' problems.

He felt that he had gained counselling skills. He felt that he could approach a person and understand him/her, and deal with a wide variety of problems. He spoke of how he had successfully counselled someone who was thinking of committing suicide. However, he felt that he needed more skills and saw counselling as a process. Towards the end of the interview he said that he was not convinced that he could counsel on his own and that he still struggled. He said he often doubted whether he had done anything for the client and found it difficult to find out what the client really wanted.

Since his initial training in February he has seen four families of detainees. He said he had spent time with these families. He spoke of an incident where a person was shot and how all the trainees had gone to the family, spent time with them, helped in the home, even did gardening - "anything to help the person who has lost their child". He also provided information where needed and discussed issues with people. He

helped them cope with detention and in the above incident, with the death of their child. He counselled the families in their homes.

He felt that the training had given him the confidence to approach strangers and to know what he was going to do. He said that the training had made him more aware of the conditions in the township and had taught him to be a counsellor. He found learning to understand the feelings of the client and his/her feelings about his/her problem to be the most useful aspect of the training course. In fact, he said he found everything useful, that it was an education for him and gave him what he needed to know. He also liked the contact with other people from different regions and organisations.

This particular trainee had been on the training course in 1987 when the training took place over two days. He found the emphasis of the new training different from the old in that the former stressed problem solving rather than just listening to and understanding feelings. Also the trainers were different. He seemed most appreciative of the training and apologised for the difficulties of the

weekend where people had not arrived. He also wanted more contact with the trainers between the training weekends.

Trainee 2

The second trainee is a 25 year old woman who has a part time job in an office.

She came to the counselling training programme as she is committed politically and wants to help the community in which she lives. She said that there are frequent and many detentions but with few people who can help the families of those detained. She said she was interested in the training and wanted to help families of detained people. She said she wanted to help others because she did not want to see someone suffering.

She felt that she had gained counselling skills. She said that she had learned about feelings, about how to control them, examine and understand them. She said that she has also learned and was made to think about the stresses in the townships, about poverty and

alcoholism. She felt that she was more aware of where the problems came from. She said that counselling was not separate from politics.

Since her training in February she said that she had counselled four people, two parents, a mother and a family. All were parents of children who had been detained. She had helped these parents to cope with their child's detention and and informed them of the resources available to them. She also physically assisted them in seeking out those resources, like arranging lawyers. It seems her help was largely supportive and she spent much time with those she counseled She also told of an incident where all four trainees had gone to counsel the parents of a young man who had been shot dead by the police. This incident was also related by the first trainee and is discussed more fully above.

She spoke of the difficulty of starting an office where they could offer a service because of police harassment and the fear of closure by them. The second difficulty in such a venture was the financial expense. She said that she counselled in the 'clients' homes.

She said that initially she and perhaps others were not used to the trainers and so people were scared to say things. She did not think language was a problem as most were students who learned and spoke English. She found the role plays to be the most useful part of the course as she felt they trained her how to go back into her community to be a counsellor. She found it a very practical method of learning the skills. She felt that the gaps between the training weekends were much too long and that the trainers did not offer support during those times. She suggested that the trainees and trainers meet at least once every month. She said she had used the counselling manual which she had found very useful.

Trainee 3

The third trainee is a twenty year old man who is presently in matric.

The reason that he came on the counselling training programme was because of the recognition that psychologists cannot come into the townships during a crisis or when people are picked up. Furthermore, he sees the need to talk to people, like parents whose

child has been detained, and he likes to talk to people who are having problems. By learning counselling skills he felt he could help in these situations. He thought that there was a great need for counsellors in the township.

He felt that he had gained counselling skills, particularly about how to approach and speak to a person. He felt this was particularly important in dealing with an injured person who does not want to go to the hospital or seek medical attention, and that the counselling skills enabled him to calm the person down and to encourage him. He felt that he had learned to give the 'client' a chance to say what was important for him/her which enabled him to better understand that person. He said that he had learned not to decide for a person. He said that he had also learned from his experience in dealing with people experiencing problems. Although he felt competent to counsel he felt he had still much to learn. He felt competent to counsel parents of detainees only, and to deal with the problems related to detention only and not problems like rape or family problems which he felt needed to be dealt with by a professional.

Since February till October he said that he had counselled approximately thirteen to fifteen people, two or three who were friends and the remainder were parents of detainees. He said that so many people had been detained, and when he heard of a detention, he would approach the parents who usually did not know what to do. He would help the parents to organise study material for their child, explain to them how to get a lawyer and would himself organise a lawyer or assist in a way that they needed. He would find out if they were experiencing financial problems and refer them to the appropriate resources and generally explain what was going on.

He had experienced problems in his work as a counsellor. Firstly, he had been harassed by the police. Even during the counselling sessions he was scared of the police coming and never felt completely free in his counselling. Secondly, he found parents were often difficult to deal with as some did not like their child being part of an organisation for fear of their detention, and would question who the struggle was for. He was not always welcome in their houses. He found that he had to deal with their anger at his counselling them while their child was detained. Thirdly, he felt too young to deal with problems like rape or family disturbances. Finally, the venue was a

problem and he used his house or his 'client's' house. He said that it was very difficult to find a room in which to counsel. However, he said he was known in his community for providing counselling and that when people were detained, people would come to his house at any time of the day or night.

The counselling training programme was important for him as he has always been aware of the problems related to detention but felt ignorant about what to do when a person was detained, how to approach the families, how to deal with their anger. It seemed that he felt empowered by the training as he felt competent to deal with those matters. He also mentioned the number of problems in his township and the inadequacy of resources and felt that he could offer some help and advice as to appropriate referral sources. He felt that the training fitted into the broader political struggle as the trainees used their skills with people who had problems and who were members of political organisations. Furthermore, he said that all those who had been helped by them would become aware of the problems in their community and perhaps better able to deal with them.

He commented on the inferior education that the trainees had experienced and the different methods used in the training programme, some of which were new and quite surprising to him. For example, one of the trainers seemed quite strange in his manner, and it was only after a while that the trainee realised that he was deliberately acting in such a way so as to evoke a particular response from the trainees, which they then discussed. He felt that the trainers were patient, tolerant and explained what was going on. He felt that language was not a problem for him but said that it was for other trainees which made them slow to speak out. He said the most useful aspect of the course was the discussions about feelings. While he recognised the difficulty of accurately understanding another person's feelings he thought it very important. He said that he had not been aware of other people's feelings and that he had learned much. He also found the brainstorming of ideas very useful. Although he felt that he had learned much about counselling, he said that he needed more practice. Counselling was new to him and he said he needed *lots* of time and practice to gain proficiency. He said it was difficult to put theory into *practice and very* difficult to teach others counselling skills.

Trainee 4

Trainee 4 is a 20 year old man who is attending school and is in standard nine. He is an active member of a counselling group which was established after the initial training.

He decided to attend the counselling training programme as he wanted to gain more skills so as to be able to help his community. He recognised the lack of skills and resources in the township for helping people. He chose to do the counselling training as he felt it was important and that he felt he was good at counselling as it was "in his heart". He said that counselling was important as it helps people with their many problems, it enables people to share problems and there was a possibility of finding solutions to those problems.

He saw counselling as first understanding a person and his/her problem and then coming up with a solution. He felt that the counselling training enabled him to understand a variety of problems and to find appropriate solutions to those problems. He felt that he had gained counselling skills, and that he was a good counsellor as he "feels from his heart" and that

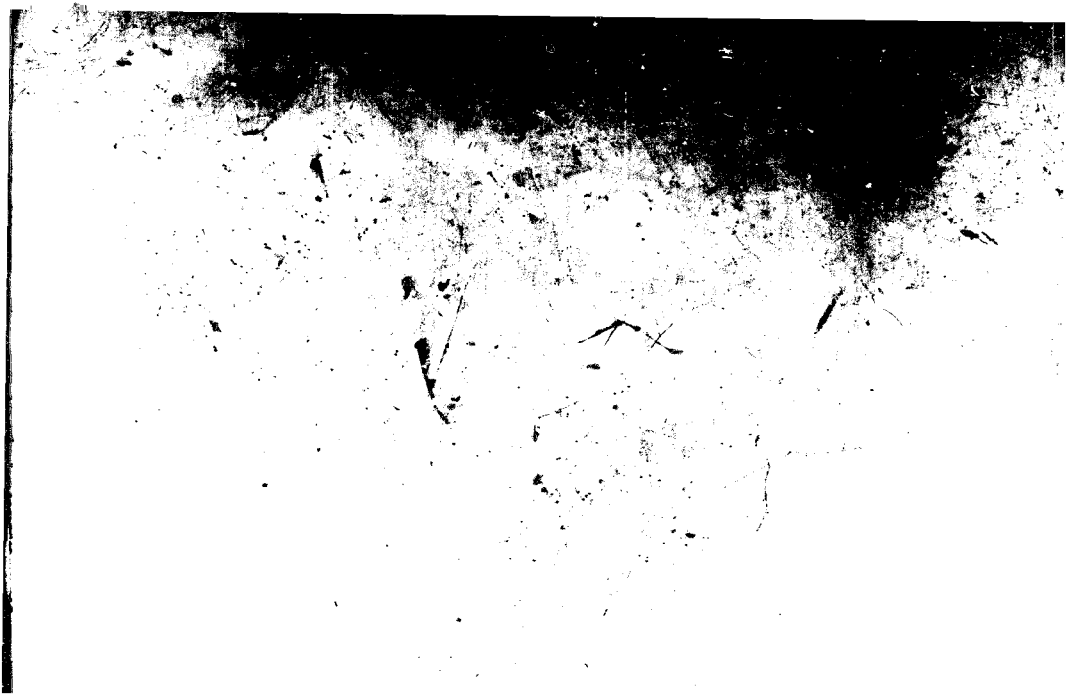
he was able to understand a person. However, he felt he wanted more counselling skills. As a counsellor, he felt that he needed to be always available.

During the period from February when he had the first counselling training weekend to mid October he said he counselled from ten to fifteen people. He found counselling his friends difficult and preferred to counsel people he did not know. He said he had counselled at the client's house or at school and when it was needed rather than at specified times. His 'clients' included the parents and family members of detained people. He seemed to serve a largely supportive function to these families by speaking to them of their problems and difficulties and then referring them to the appropriate resources. He cited the example of the breadwinner being detained and the family not knowing what to do or how to be assisted. In this case he referred them to the Dependents Conference where they would be entitled to some monetary support. If children had been detained or had left the country he would counsel the parents.

He said he wanted to help people because of the need for help. He said he did not want them to make mistakes in their lives.

He felt he had gained personally from the training programme by learning more things about life and by making him think of new things. Learning about counselling and the existence of counsellors was something new for him and which he regarded as important. He felt that the counselling training programme fitted into the broader political struggle by teaching him how to help those involved in the struggle who were in need, to continue their political activity. He also felt that most people have problems and need counselling.

He felt that the trainers co-operated with the trainees. He found that they made him think and that he felt free to say anything. Language was not a problem for him. He found the training programme very useful in that he gained much knowledge that he did not have before. He also commented on the role plays, particularly one where a problem had been about divorce from which he had learned much. He said he found the programme useful and interesting and felt that he had made use of the training. He also found the manual on counselling (which was produced by the trainers and given to all trainees) very useful in helping to identify problems and learning appropriate solutions.



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