

**AN EXPLORATION OF HEALTH PROFESSIONALS' PERCEPTIONS
OF THE ROLE OF CLINICAL PSYCHOLOGISTS**

Thesis submitted in partial fulfilment of the
requirements for the degree of

MASTERS IN CLINICAL PSYCHOLOGY

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by

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ABSTRACT

The South African government has initiated the transformation of health services in the country towards primary health care (PHC) in order to provide comprehensive care to individuals and families. The move to PHC involves an increased need for collaboration between health professionals. It is proposed that for effective team-work to take place, an understanding of the roles and functions of team members is imperative in providing quality mental health care. This study explored health professionals' perceptions of the role and function of clinical psychologists working as part of a health care team in a community context.

Three focus groups and three individual interviews were conducted with social workers, nurses and doctors. The data was then processed and analysed using a grounded theory method. The research highlighted the importance of knowledge, and how this affects referrals, perceptions, inter-professional relations and the perceived usefulness of clinical psychology and clinical psychologists. What is of significance is the potential power that the health professionals have as gatekeepers between the general public and clinical psychologists.

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APPENDIX A

PARTICIPANT CONSENT FORM

Dear Participant

My name is Marina Zitianellis. I am a Clinical Psychology Masters student at Rhodes University. As part of my course I am required to conduct a research project. I have chosen to explore “*Referring health professionals perception of the role and function of clinical psychologists working as part of a health care team in a community context*”. In order to complete this study I would like to run a focus group with nurses, social workers and doctors. During this group I will be asking your opinions about issues relating to the research question. The group will be audio taped.

After the focus group, I will approach some of the participants for an individual interview, to gather more information for my research. These interviews will be audio taped.

If you are willing to participate in this study please fill in the underlying form:

I voluntarily consent to being part of this research project. I understand that I will be part of a focus group, which will be audio taped, and that I may be approached for additional interviews after the group session.

I understand that my name and personal details will not be included in the report, and that anonymity and confidentiality will be maintained by destroying the tapes and transcripts once the research is completed.

Signature

Date

APPENDIX B

This is an example of how the data was initially organised for all three groups to give the researcher a clearer idea of what the data had to offer.

Reason for referral:

- ... an overwhelming problem!
- ... the child refuses to talk.

Process of referring:

- ... I have to make sure that the patient I refer to a psychologist can speak English
- ... you take their income into account and where do they live.

Contact:

- ... there is not much interaction
- ... it was only on a referral basis and all that.

Need for education:

- ... I so wish that psychology could be introduced to nurses, then you could really understand
- ... they only know about psychologists dealing with mentally ill people.

Roles:

- ... To myself I would define the psychologist as that person who is there for the other side of the client – other than physical health, which tablets cannot help.

APPENDIX C

A further process of coding elicited different issues within the broad categories. Axial coding was used to interconnect the main categories and sub-categories. This is an example of how the indicators were placed into the refined categories.

Knowledge contradictions

Knowing:

... To myself I would define the psychologist as that person who is there for the other side of the client – other than physical health, which tablets cannot help.

Not Knowing:

... they only know about psychologists dealing with mentally ill people.

Access:

Finances:

... you take their income into account and where do they live.

Accessibility of psychologists:

... there is not much interaction

... it was only on a referral basis and all that.

Cultural issues:

Language:

... I have to make sure that the patient I refer to a psychologist can speak English

CHAPTER 1: INTRODUCTION

1.1 Motivation for the study

The South African government has initiated the transformation of health services in the country towards primary health care (PHC) in order to provide comprehensive care to all individuals and families in the community. In order to provide comprehensive health services to all, community service initiatives commenced in 1998 in order to fill understaffed posts in communities around South Africa.

As part of this initiative, community service for clinical psychologists was officially implemented in 2003. Many of the posts that were advertised are situated in communities, and fewer posts in both general and psychiatric hospitals, and military bases. Many community service clinical psychologists will now be working in contexts that either provided minimal psychological services or none at all. Ignorance about the function of psychology and the poor status of psychology in developing countries within medical health care may prove to be challenging for the psychologists themselves, as they may encounter some resistance to their presence. There has been some international research especially in the UK that looks at professionals' experiences in their Community Mental Health Service (CMHT) as well as specifically looking at clinical psychologists' experiences of working in CMHT's. However, Seedat, Kruger and Bode (2003) stated that in South Africa, "mental health systems research, informing the initiation and integration of psychological services into the PHC is nonetheless sparse" (p. 44).

In this study the researcher's personal experience of working as an intern clinical psychologist on the three-month community rotation was influential in determining the field of study. During this rotation the researcher received many inappropriate referrals from nurses, social workers and doctors. It was presumed that the incorrect referrals, was a result of inappropriate knowledge of the expertise of clinical psychologists and inadequate networking between health professionals. It was believed that a study examining health professionals' perceptions of clinical psychologists may raise awareness of the anomalies between expectations of services and service rendering of clinical psychologists and how psychology can address the changing needs of working in a community setting as part of a health care team.

The move to PHC in the community involves collaboration with team members such as nurses, doctors, social workers that may not have an existing multi-disciplinary teamwork structure that

hospitals might have. An understanding of the roles of team members, as well as the process of inter-professional collaboration should be considered for the provision of quality mental health care.

The study then was an investigation of how health professionals (nurses, social workers and doctors), in the Grahamstown area, perceived the role and function of clinical psychologists. Using theoretical sampling, a group of nurses, social workers and doctors were approached to attend separate focus group interviews. The focus group was conducted to explore their work, the role of clinical psychologists, and referrals. Further in-depth individual interviews were conducted with a nurse, social worker and doctor. The focus groups and individual interviews were audio-taped and transcribed. The data was processed and analysed using the grounded theory techniques of coding, constant comparison and integrative diagramming.

Definitions

- In this study the term *health professionals*, is comprised of nurses, social workers and doctors.
- The terms, *patient* and *client* will be used interchangeably as doctors and nurses speak of patients, and social workers tend to address them as clients.
- In the present study, the term *community psychology* does not refer to clinical psychologists working in a community context. It rather refers to those individuals who have been specifically trained in community approaches and who call themselves community psychologists.

1.2 The structure of the thesis

Chapter 2 provides an overview of the literature thus establishing the context for the research project. In chapter 3 the methodology used in this study is outlined. Included in this is an examination of the grounded theory method. The processes of sampling, data collection, data processing and analysis are discussed. Chapter 4 is a presentation of the results, interpretation and discussion of the data. Chapter 5 concludes the research by reflecting on the research process, and exploring the strengths and weakness. Finally, indications for further research possibilities are suggested.

CHAPTER 2: CONTEXT AND LITERATURE REVIEW

2.1 Introduction

The reality for all clinical psychologists in training is the compulsory community service, which was officially implemented and regulated as from 1 January 2003 by the Minister of Health (Form 160, HPCSA, August, 2003). Compulsory community service is mandatory for those wanting to register with the Health Professions Council of South Africa. Community clinical psychology placements include settings such as Government hospitals [general and psychiatric], military bases, community clinics and others.

Community service was initially implemented in 1998 for doctors, in 2000 for dentists, and 2001 for pharmacists. As from January 2003 the following groups were also included for community service: physiotherapists, occupational and speech therapists, dieticians, radiographers, environmental health officers and clinical psychologists. In 2005, the nursing profession will also be included as candidates for community service. According to the Department of Health, the aim of community service is,

“To ensure improved provision of health services to all citizens of the country. In the process, this also provides our young professionals with an opportunity to develop skills, acquire knowledge, behaviour patterns and critical thinking that will help the in their professional development” (Reid, 2002, p. 1).

Reid (2002) proposed that the universities play a central role in suitably preparing their graduates for the community service year, which he said “can be regarded as a ‘test drive’ of their products, on a challenging test ground” (p. 2). However, he stated that the level of performance, the ability to respond to challenges, and adapt to local contexts as well as contribute significantly in their placements, would be indicative of the individual’s resourcefulness, their education and the context in which they found themselves.

2.2 Primary Health Care

The South African government began initiating policies for a national health system on 1 April 1996 that would result in free primary care to all South Africans (Sidley, 1996). The plan was to convert the then current system into one in which comprehensive psychiatric and mental health care would be incorporated into every primary health care (PHC) setting. The implementation of

community service was initiated in an attempt to combat understaffing in many communities in South Africa.

The primary health care approach, according to the World Health Organisation (WHO) should include the following five concepts (as cited in Sokhela, 1999, p. 230):

- Universal coverage of the population, with care provided according to need.
- Service should be promotive, preventive, curative and rehabilitative.
- Services should be effective, culturally acceptable, affordable and manageable.
- Communities should be involved in the development of services so as to promote self-reliance and reduce dependence.
- Approaches to health should relate to other sectors of development.

Robertson et al. (as cited in Uys & Schene, 1997) noted educational development as important for the effective implementation of PHC. Future health care workers needed to be trained to address their skills and knowledge deficits, and current health care workers also needed to be retrained and updated on all the changes that have been made.

2.3 Approaches to Clinical Training

Psychology as a discipline encompasses a variety of fields, for example, clinical, counselling, research, community, educational, environmental, and organisational psychology. The rubric 'psychologist' is often a confusing one for many who are insensitive to the existence of the diverse fields of psychology as much of the public think that psychology is clinical psychology and that all psychologists participate in psychotherapy (Hartnett, Simonetta & Mahoney, 1989). The HPCSA, however, allows for registration only in the following categories, clinical, counselling, educational, research and industrial psychology (Form 160, HPCSA, August 2003). Each of these fields have their own training and own area of expertise within which they specialise.

Currently there are two different approaches to clinical training. Some academic institutions focus on conventional clinical practice that is based on a medical model, while others have implemented a community psychology framework into their clinical training programme.

There have been many debates about whether community psychology and clinical psychology should be seen as autonomous or integrated fields. Some believe that they are autonomous fields

as they encompass entirely different kinds of activity (Heller et al., 1984; Iscoe, 1984; Sarason, 1976). Gibson, Sandenbergh & Swartz (2001, p. 3) stated that “community psychology invokes empowerment, context, and politics, whereas conventional clinical work talks about patients, boundaries and professional neutrality”. On the other hand, others argued that the clinical programmes should include training in community psychology (Broadhurst, 1980; Gibson et al., 2001; Meisen & Slavich, 1997; Tyler & Gatz, 1976). Gibson et al. (2001) suggested that clinical psychologists “should be able to work, not only in the traditional areas of psychological assessment and psychotherapy, but also be equipped with a flexible repertoire of skills drawn from the field of community psychology” (p. 29).

The above illustrates some of the divergent views of clinical psychology and how those authors would like clinical psychologists’ roles to be defined. The current research will not attempt to explore the merits of these divergent views, as there is already a volume of existing literature on this topic. However, differences in training of clinical psychologists’ needs to be taken into account, as this will have an impact on the clinical psychologist’s experience of compulsory community service.

2.3.1 Community Psychology

The origins, areas of focus, and training of community psychology will be briefly outlined.

At a conference in Swampscott, Massachusetts in May 1965, community psychology as an academic and professional discipline was formed. This arose through the efforts of clinical psychologists who were concerned with improving clinical psychology and effecting social and political change through an ecological perspective and an emphasis on prevention (Edwards, 1996). Duffy (1998) stated that community psychology was born largely because of clinical psychology being unable to deal with the vast numbers of individuals requiring treatment. In 1992 Freeman (as cited in Uys & Schene, 1997) found that the ratio of clinical psychologists to the population was 1:36,000. It was thought that mass intervention was needed to prevent mental disorders altogether and community psychologists would then focus on community level interventions such as education and changing the environment to reduce the probability of mental disorders.

The development of community psychology in South Africa began in the early to mid-1980’s in reaction to the discontent with traditional mental health service delivery. Internationally, the practice of community psychology was concerned with trying to extend traditional mental health

services, using action research programmes focused at organising and changing the community, and in most countries prevention was a significant aspect of community psychology (Wingenfeld & Newbrough, 2000).

Community Psychology focuses on social issues, social institutions, and other settings that influence individuals, groups and organisations. The work of community psychologists is to understand people within their social worlds and to use this understanding to improve peoples' well-being (Orford, 1992, in Cook, 2000). It is an applied discipline where researchers methodically look at the ways in which individuals interact with other individuals, social groups, clubs, churches, schools, families, neighbourhoods, and the larger culture and environment. In other words, community psychology regards whole communities, and not only individuals, as possible clients. It examines a variety of issues such as poverty, substance abuse, school failure, community development, risk and protective factors, empowerment, prevention, intervention, high-risk behaviours, aggression, violence and many other areas (Cook, 2000).

There are a number of different approaches in community psychology, which delineate the role of the community psychologist working from a particular perspective, for example, the mental health perspective, social action perspective, ecological perspective and organisational perspective. However, many community psychologists do not adhere to one perspective and use parts of different theories to inform their practice (Pretorius-Heuchert & Ahmed, 2001) and “there is also no consensus among the different paradigms in the discipline about a single definition for the field” (p. 19). Gibson et al. (2001) agreed with this and stated that “there is dissent and confusion amongst professionals themselves about what if anything constitutes the core sets of skills and competencies in the profession” (p. 30)

Training in community psychology is aimed at equipping students with skills to cope with the multifaceted problems facing communities. Students are educated on how to conduct community research and intervention in a multicultural society. Zululand University offers a Community psychology Doctorate, which focuses on interventions in various health, education and industrial contexts in both rural and urban settings (Edwards, 2001). Most Universities in South Africa have offered a few courses within clinical, counselling and educational psychology since the early 1980's (Wingenfeld & Newbrough, 2000), rather than based on independent curricula.

Many courses are also offered which train students first as clinical psychologists, with skills in assessment and therapy at the individual and small-group level, and then acquire community concepts and skills. Supporters of this view believe that it is important to garner knowledge about individuals and their psychological treatment before undertaking issues raised by communities and the prevention of social problems. However, Heller et al. (1984) believe that this view may be problematic because approaching community work from a clinical perspective could impose “blindness” as students may tend to see social problems in individualistic and remedial terms. These difficulties have resulted in the advocacy for Community psychology to be separate from clinical psychology where community psychologists are not trained first as clinicians.

In the United States, community psychology is a recognised division of the American Psychological Association (APA) and its members are represented by the Society for Research and action (SCRA). In South Africa, the HPCSA and the Psychological Association of South Africa (PsySSA), do not yet have a Community Psychology category for registration.

2.3.2 Conventional Clinical Psychology

Attempting to find a simple overview of clinical psychology was extremely difficult as many of the books go into technical detail, which may be too complicated for the lay person. The researcher thus decided to give a very simple overview of the definitions of clinical psychology as well as outlining some of the main contexts where one could find a clinical psychologist working. It was then deemed necessary to explicate some of the challenges clinical psychologists’ could experience when placed in community contexts.

The HPCSA (FORM 224, Nov 2002) defines Clinical Psychology as the following:

“Clinical psychologists assess, diagnose, and intervene in order to alleviate or contain relatively serious forms of psychological distress and psychopathology, or what is commonly referred to as ‘abnormal’ behaviour”.

The division of clinical psychology of the American Psychological Association (APA) gives this definition of clinical psychology:

“The field of clinical psychology integrates science, theory and practice to understand, predict and alleviate maladjustment, disability and discomfort, as well as to promote human adaptation, adjustment, and personal development. Clinical psychology focuses on the intellectual, emotional, biological, psychological, social, and behavioural aspects of

human functioning across the life span in varying cultures and at all socio-economic levels” (Strickland, 1998, p. 2).

It has been noted that the knowledge base within clinical psychology is so diverse that no individual clinical psychologist can become competent in all areas of clinical psychology (Canadian Psychological Association, 1993). The knowledge base is acquired through undergraduate and post-graduate training, which differs according to the university attended and so each university produces graduates with varying skills and theoretical orientations. However, the HPCSA (Form 160, August 2003) does have policy guidelines, for universities, and training placements for students and interns, which need to be adhered to, prior to independent practice being allowed.

Clinical psychologists are employed in a range of settings, such as, psychiatric hospitals, general hospitals, out-patient clinics and private practice and are involved in a variety of activities.

Psychiatric hospitals:

The tasks and responsibilities of individual psychologists will vary according to their training and their role in the institution. The most frequent activities have been the administration of psychological tests [neuropsychological, projective, diagnostic and intellectual testing] for diagnostic and appraisal purposes. Most psychologists also involve themselves to some degree in individual and group psychotherapy.

General Medical Hospitals:

In general hospitals the patients that clinical psychologists encounter are almost solely hospitalised for medical and surgical procedures in contrast to the psychiatric hospital where clinical psychologists encounter mostly psychiatric patients. As a result of the contrast of patient populations, Garfield (1957) suggests that the techniques and procedures used in one setting take on different connotations in a new setting. Although this is an older reference, it is believed that it is still relevant in the present time as each context brings a different set of rules and a different population group, and the psychologist needs to alter her/his working to accommodate this. In the general hospital setting, brief counselling with an individual or groups may be valuable without the need for in-depth psychotherapy. Cognitive behavioural therapy may be utilised to correct misconceptions and to help the patient to express and release anxiety, as well as working with the patient’s family and their perceptions of the illness.

Out-patient clinics:

In South Africa one does not come across many practising clinical psychologists choosing to work in community contexts, such as Primary Health Care Clinics. However, internationally many either work permanently in their national health service community clinics, or as consultants.

The clinical psychologist in the out-patient clinic in many ways has a far greater responsibility than the clinical psychologist in the psychiatric and general hospitals as she/he may be the only person to have contact with the patient once they are in therapy (Garfield, 1957). Many of the duties undertaken in the psychiatric hospital are similar to those in the clinics. However, accurate diagnoses are more essential in the clinic setting. The clinician has to make responsible decisions regarding the need for hospitalisation, suicide and homicide risks, as most patients are not seen on a regular basis and “the clinic does not have the supervisory control over them that exists in a hospital” (Garfield, 1957, p. 392). The clinical psychologists’ activities also include individual and group psychotherapy, participation in community activities relating to mental health, and other social agencies. Currently many intern psychologists (counselling and clinical) work in outpatient clinics on a weekly basis.

Private Practice:

Many psychologists choose to work in private practice, which allows them to be guardian over their work schedules and the types of patients seen. Private practice does not really accommodate the more indigent patients, as they cannot afford private practitioners and private practice psychologists tend to be established in more urban than rural contexts.

2.3.2.1 Challenges in community work for those trained in conventional clinical practice

Challenging issues in Community work:

Community work takes the clinical psychologist outside the structured, comfortable and safe borders of the consulting room and into areas, which are less familiar. Community work may be intimidating for the psychologist who enters a context that is unknown and is faced with daunting tasks. Conventional clinical training does not thoroughly prepare the psychologist for the different work that is expected in these contexts. The anxiety in these situations may evoke confusion about the psychologist’s own skills and competencies (Gibson et al., 2001).

Cultural and Linguistic differences:

Working with people from different cultural and linguistic backgrounds is another issue that arises in community work. Most clinical psychologists are white and speak no indigenous languages except for Afrikaans (Swartz & Gibson, 2001). Language is a key impediment, as psychologists cannot conduct their work effectively if they cannot communicate directly with the client. Research conducted in the UK looked at mental health professionals working in a Child and Adolescent Mental Health Service (CAMHS) that served sizeable minority ethnic communities and who regularly employed interpreters to assist them in their work (Raval & Smith, 2003). Many of the participants in the study experienced that working with an interpreter affected the communication process. The participants felt that they lost much of the emotion that is laden in language, as well as feeling that they were missing information through the translation. The participants also commented on how their therapeutic style, interventions, and style of questioning altered with the use of an interpreter. What was especially noteworthy in the above study, was the importance of there being a good co-working partnership between the practitioners and the interpreters.

In hospitals and clinics in South Africa the nursing staff are primarily requested to assist with translations. The difficulty that emerges with this is that the nursing staff are firstly, not trained to be interpreters and secondly, they have to abandon their own work in order to interpret. It appears that a solution needs to be found for this problem because currently there is an insufficient number of multi-lingual and multi-cultural qualified health professionals, and thus there will be a continuing need for interpreters.

Cultural beliefs and practices of community members has to also be taken into account when working in a community context as this may affect the way in which members respond to the services provided. Petersen (1999) stated that “a comprehensive approach to care demands culturally congruent care which considers the subjectivity of the illness experience for the patient” as it is recognised that culture plays a role in the formation of the illness experience. This is especially important as most of the clients encountered in the community clinics are Black and most of the psychologists working with them are White. There is an implicit need to respect the cultural identity of the patient and to try to assist them in means that are fitting to their beliefs. However, there should also be an awareness that if the cultural belief is harmful to the patient or their family, then a negotiated intervention is necessary for cultural re-patterning (Petersen, 1999). The American Psychiatric Association’s (1994) Diagnostic and statistical manual of

mental disorders, fourth edition, makes provision for culture-bound syndromes, which may assist in diagnoses in multi-cultural environments.

Poverty and Deprivation:

For psychologists trained in secure and protected environments, the poverty and deprivation encountered in many communities may evoke a number of emotional responses that can be exacerbated by a perceived lack of an adequate support basis (Gibson et al., 2001). Feelings of impotence may arise due to seeing the vast complex problems in the community, which may seem insurmountable. This may result in feelings of disillusionment as psychologists feel that they do not possess the necessary skills to handle such issues. Guilt may arise as psychologists compare their own material possessions and that of the community members they work with. Working in communities that are poverty-stricken and deprived may result in them having unrealistic material expectations (Tshemese & Taylor, 2002). This may evolve through the lack of knowledge of the psychology profession and what it is that psychologists can offer them.

Community Awareness:

Hartnett et al. (1989) argued that the public's perception of psychology in general, and especially clinical psychology, vacillates according to a number of factors taking place in society. One factor that they posit, is that the public forms impressions of psychology through information gathered from sources such as newspapers, television, and pop psychology books. The public also forms impressions from interaction with respected members of their community such as doctors and ministers.

The awareness of clinical psychology and psychology in general in the poorer communities is limited. The majority of clients seen in the community clinics are uneducated and deprived and have therefore no real understanding of psychological problems, treatment, or resources as are the better educated members of the wider community. Hollingshead and Redlich (as cited in Bostock, 1998) stated that the stigma associated with mental illness and incarceration is another important reason why patients may not seek help from psychologists.

When attending the clinics to see the doctor the patients tend to assume a passive position in the process. They expect the doctors or nurses to examine them and to identify their ailments (Petersen, 1999) and they seem confident in the diagnosis. However, in psychology there is no physical examination but rather the requirement of active participation in the form of talking. This

may be foreign to them as there is “a lack of congruence between clients’ expectations in a medical setting and the ‘talking cure’ inherent in counselling modalities” (Seedat et al., 2003, p. 49).

Seedat et al. (2003, p. 49) conducted a study whose aim was to investigate the strategic benefits of developing and maintaining a mental health information system. They utilised Soweto-based clients’ counselling records for an 11-year period (1987-1997). One of the findings was that 82% of the clients, who used the service over the 11-year period, used the service for a single session. The analysis from the focus group discussion indicated the following; (a) inappropriate referrals; (b) the social base of many problems (unemployment, housing, disability grant applications); (c) an unstructured booking system; (d) demand for psychometric and cognitive testing and; (e) the long-term therapeutic orientation of counsellors, are among factors that account for the once-off client consultations.

Theoretical confusion:

The SAHR (Reid, 2002) also noted that most graduates entering community service experienced an incongruence between their academic training expectations and the actual conditions in the public health service, which may also affect their confidence. Interns trained in conventionally oriented clinical psychology have not acquired the skills and knowledge of community models and practical approaches needed to work efficiently in community contexts. The difficulty arises when the intern enters the community context and cannot apply her/his knowledge base. Sterling (2002) stated that, “the experience of ‘not knowing’ is always a profoundly frightening one” and “we are perhaps ill-prepared to find ourselves in a situation where our most solid professional container, knowledge, seems inadequate for the purpose of our work”(p. 1). Gibson et al. (2001) argue that without a theoretical framework solid enough to make sense of their experiences interns may feel overwhelmed and may be ineffective in their work environment.

Many clinical psychologists entering community service feel that they have to abandon their, for example, theoretical orientation for something that is more suited to work in a community context. There is also the fear that what they have learnt in the 6 years it has taken them to complete their degree, may not be useful in this context. Sterling (2002) reflected on work that she had done in a community context, which led her to realise that psychodynamic theory could be useful in a community context. In 1991 she worked as a part-time clinical psychologist in Mooidorp, a town 50km outside of Cape Town, providing consultation and training. On reflection

of her experiences her initial concern was that the existing psychodynamic theories were inadequate to make sense of the town. However, she realised that they did aid in providing insights about the community issues and her own relationship with them. Sterling observed that “the challenge then was to create possibilities for psychodynamic thinking in contexts when it is not obvious how to set it up” (p. 30). Swartz, Gibson and Gelman (2002) said something similar to this. They believed that “if psychodynamic thinking is to contribute to mental health in South Africa and other countries experiencing transformation, it is essential that the terrain of this thinking is broadened to reflect the lives and concerns of the population as a whole” (p. 5). The above statements by Sterling and Swartz et al. renews the hope that as clinical psychologists working in community contexts we do not have to abandon our personal theoretical thinking but rather expand it and make it useful to a wider context than just the individual. This does not alter the opinion that community service will be challenging, but it does allow for a different way of viewing it.

Basic differences between clinical psychology and community psychology

- Community psychology emphasises prevention and clinical psychology is aimed at remediation and treatment.
- Clinical psychologists are inclined to react to, rather than initiate social transformation (Holdstock, 2000).
- Clinical psychology is more structured and adheres to boundaries, to protect both the clients and the professionals (Sterling, 2002), whereas the boundaries in community psychology are less clear.
- Community psychologists work with communities and organisations, rather than with individuals.
- Clinical psychologists tend to have an office where clients come to them, whereas community psychology interventions are taken to the ecological setting (Duffy, 1998; Bostock, 1998).
- Community psychologists tend to fight for social reform, whereas the political motives in clinical psychology tend to be more covert.
- Community psychology stresses the fortification of competencies rather than on removing deficits (Heller et al., 1984).

2.4 Referrals

Clinical psychologists receive referrals from a variety of health professionals including doctors, nurses, social workers, and occupational therapists. Referrals are also received from general practitioners, and some patients are even self-referred (Prospects UK, n.d.).

There often seem to be misconceptions about the function of the clinical psychologist, which can result in inappropriate referrals from referring health professionals. Some of the misconceptions may be based on the incongruence between on the one hand how clinical psychologists are perceived, and the expectations of what they can do, and on the other hand clinical psychologists' own training. These misconceptions may also be as a result of inadequate networking as clinical psychologists in private practice often tend to work in isolation, contacting GP's or psychiatrists for medication purposes only. Contact with social workers may occur in custody cases or abuse cases, and nurses are rarely contacted. Compulsory community service alters this, as clinical psychologists are now working in community contexts, which forces inter-professional collaboration.

Peck and Norman (1999) conducted workshops in London, England, that investigated professionals' perceptions of their own and other mental health disciplines in order to explain why professionals working within multi-professional teams often experienced problems in establishing and sustaining inter-professional partnerships in adult community mental health services. One of the findings of the workshops, was that social workers and nurses were confused about what clinical psychologists could and could not do, as well as feeling that they were too autonomous and needing them to be more integrated in the multi-disciplinary team.

General practitioners (GP) are often the first point of contact with patients with psychological problems (Cape & Parham, 2001; Davies, 2000). GP's are often seen as gatekeepers as a result of this, and they are placed in the position of either recommending or not recommending psychological services (Hartnett et al., 1989). Cape and Parham (2001) stated that "this requires some knowledge of the appropriateness of referrals for psychological therapies" (p. 237).

As a result of the range of referral options to different kinds of psychological therapies and the lack of clarity as to which is more appropriate, evidence-based guidelines for GP's on referrals for therapies have appeared in the UK (Cape & Parham, 2001). The guidelines give recommendations as to which psychological services may be suitable for an individual patient.

These guidelines were found to be useful, however, it was found that the resources needed to be adapted to the local context and what services were available, as well as a need for collaboration between psychologists and GP's.

Seedat (2003) suggested that the referral source and location of the psychological service could “impact significantly on the structure, nature, purpose, and scope of a specific counselling service” (p.48). He noted that if the service was located in a Primary Health care facility, this could encourage a stress or somatic presentation. Helman (as cited in Petersen, 1999) stated that in developing countries it was found that patients tended to somatize minor mental illness such as anxiety and depression and according to Swartz (as cited in Petersen, 1999) social and psychosocial problems have been found to be linked to psychosomatic presentations. In many cases when no physiological explanation can be given for these complaints, it was found that the patients would go untreated. This illustrates the important need for adequate mental health knowledge amongst the referring health professionals.

2.5 Health Professionals

As it was noted above, individuals, for example, attending the clinics are usually not self-referred as many do not have the knowledge as to what the psychology profession can offer them and are largely referred by other health professionals such as doctors, social workers and nurses.

Nurses:

In South Africa the psychiatric care system has been moving away from the traditional hospital method of service delivery to a primary health care approach (Petersen, 1999; Sokhela, 1999; Uys & Schene, 1997). One of the difficulties that emerged was of the limited skill and knowledge of nurses, as many had not been psychiatrically trained. According to the South African Nursing Council in 1993 only 12.4% of nurses were registered with the council in psychiatric nursing. It was also noted that many of the psychiatric nurses had completed their training in psychiatric hospitals and their skills in community based approaches were limited. The nurses' negative attitudes towards psychiatric patients, was also a concern. This was corroborated in 1993 when Mavundla (in Uys & Schene, 1997) conducted a survey in general hospitals of nurses' attitudes towards psychiatric patients, and found that 90% held negative views.

Sokehela (1999) discussed a study that was conducted with twenty nurses from 6 clinics in one province of South Africa. The nurses were trained in history taking, diagnosis and

pharmacological treatment and referral. The study found that overall patients care improved and that attitudes towards the psychiatric component had changed and that the nurses were reaching out to the psychiatric patients and their families. The nurses were getting involved in the patients' rehabilitation and they were offering much needed support. Although the researcher stated that the results should be interpreted with caution, it is evident that with proper training nurses can give appropriate psychiatric care and alter their views of the psychiatric patient.

Etzioni (1969) speaks of nursing as a semi-profession. Traditionally nurses, in their workings with doctors, would do their requests with "unquestioning, unknowledgeable-but always reliable dispatch" (p. 59). The doctor was seen as the guardian of knowledge, the one who had specialist information about the patients ailment, thus relegating the nurse to a lower status. Petersen (1999) concurred that the status of nurses in health care is fragile. Nurses were seen as those who provided patient care, listened when the patients spoke and nurtured the patients. This care however "tends to be paid for in the non-negotiable currency of temporary pleasant feelings, not in social recognition that takes the form of a respectable wage" (Etzioni, 1969, p. 67). In a recent study conducted by Peck and Norman (1999), it was noted that "nursing is highly valued by nurses themselves, and by the public but it is under-valued within mental health contexts" (p. 5). Many of the nurses in the study felt run down, vulnerable and worn out and were concerned about being blamed when anything went wrong.

Nursing in South Africa, especially among the African community, has a particularly significant status. This is in contrast to the feelings of nurses in the above study who on the one hand experienced themselves on a lower hierarchy than other health professionals and on the other hand, have a high status within their own profession and with the public.

Although the views discussed by Etzioni (1969), regarding nurses and further down social workers, appear to be dated, they are still found to be currently valid.

Social Workers:

Social work is mainly a profession where knowledge is applied. Student social workers are taught and trained as practitioners from the outset. They are found in a variety of fields such as, working with children and families, for example, child abuse and domestic violence. They may also be employed in group care settings, or involved in management of care in the community for vulnerable groups such as the elderly, and they may be employed in general and psychiatric

hospitals (Sutton, 1994). Typically the people with whom they work belong to low socio-economic groups and one of the aims is to empower individuals to make them more independent and self-determining.

Community psychology and social work share common values in their concern for social justice, multiculturalism, social welfare, and others (Cook, 2000). Although social work skills overlap with other mental health disciplines, it is their method of applying these skills that is found to be unique. This approach is grounded in the values, knowledge and the theory that underpin social work as practice.

Etzioni (1969) speaks of social work as a semi-profession. This means that it is 'between the full-fledged professions and those occupations which are professionals in name only but do not, in fact, possess any of the attributes characterising the professions (Toren, 1969). At the time that this book was written and for some time later, social work was identified by the public as a feminine profession and associated with the traditional roles of women. It is interesting to note that the occupations deemed 'full-fledged professionals' were doctors and lawyers, all male-dominated. It was also found that majority of social workers in the past came from middle class families and have been in the past number of years been increasingly recruited from lower social strata. Toren (1969) stated that it is for the above reason that social work has gained low prestige as a profession.

The above is reflected in the study conducted by Peck and Norman (1999) where social workers felt that they were not respected by other disciplines within the Community Mental Health Teams (CMHT). They also felt that they needed to defend their positions or compromise in a manner that threatened to undermine the social work culture. A study conducted in Scotland in 1974 examined the relationships between nurses, social workers and general practitioners. This study found that most of the general practitioners did not know what social workers were trained to do, it was a "mystery to them" (Bruce, 1980, p. 80). It was found that lack of communication between the two parties resulted in distrust and poor working relations. Butler (1971) reflected on the social workers role of educator of both the public and non-social-work members of staff in order to enhance working relations.

Social work has changed over the years both in its coursework and the move to community development, as well as more men entering the profession. Although there have been changes, the

lower status of social work seems to have become inherent in the profession and this may take some time to alter.

Doctors:

The word 'doctor' has for a number of years had high status and prestige. There seems to have been an explicit message passed down from one generation to the next that "the doctor knows best" (The Royal Bristol Infirmary Inquiry, n. d.). This message exists not only in the minds of the public but within other health professions as well. There has been a tacit understanding that one does what the doctor has asked, which is evident in the above discussion regarding the nurses. Within the medical profession there seems to be another implicit message that is passed onto doctors themselves – that they do know what's best. Doctors are trained to take charge even when they are uncertain, as this is vital in life-and-death situations (Miller & Swartz, 1990). Macnamara (as cited in Miller & Swartz, 1990) argued that doctors are socialised into the prospect of assuming management and leadership roles, with complete responsibility for patient care. As a result, other professionals are seen to function for the benefit of medicine. This is confirmed with the biomedical culture that is still found in many settings. The move to PHC and a more holistic care for patients may challenge the biomedical model, and could result in conflict among the multi-disciplinary team.

It was noted above that GP's were usually the first port of call for individuals complaining of psychological problems and that they were seen as the gatekeepers to the psychological profession. Davies (2000) reported on a study conducted in the USA by the 'highly-respected' Consumer Reports magazine. The study found that one in four family doctors referred patients to mental health specialists and that medical practitioners tended to respond by prescribing psychiatric medication. In South Africa it was found that family doctors tended to prescribe addictive drugs inappropriately and for a longer period than was healthy. This indicates the importance of collaboration between health professionals in order to provide good service and avoid harmful practice, and the need to offer psychotherapy for patients on psychiatric medication.

Abrahams and Udwin (2002) described a study conducted in an inner London borough that compared referrals to the practice-based child clinical psychology service and the secondary level child clinical psychology service over a 12-month period. One of the findings was that the close contact between the clinical psychologist and the referring agent in the practice-based service

resulted in; (a) greater knowledge and confidence in the quality of the psychological service; (b) the psychologist acted as an accessible information resource and provided advice on clients who may not have needed an actual referral and; (c) the psychologist provided an educational component on general child mental health. Conversely, those referring to the secondary level service found that there was poor communication, unacceptable waiting lists, and a less efficient referral system. This research indicated that closer contact between psychologists and referring agents resulted in better communication, increased confidence of the psychologist and psychological service, and an improved service for patients.

2.6 Multi-disciplinary teams and the Role of the Clinical Psychologist

Low and Heranen (as cited in Miller & Swartz, 1990) stated that the multi-disciplinary treatment team has become the most used approach in providing multiple professional services to the same patients. However, according to Bruce (1980) collaboration between professionals has not been found to occur automatically either from physical proximity or from working with the same patient. He said that in order for teamwork to occur there needed to be a gradual process of loss of stereotypes, frequent contact, a better understanding of each others' roles, and increased mutual trust.

Low and Herranen (as cited in Miller & Swartz, 1990, p. 50) "proposed that teamwork can only occur when it is supported by the environment in which it exists and that the concept of teamwork must be understood and practised in order to fulfil its potential". Payne (as cited in Mistral & Velleman, 1997) agreed with this and stated that team members needed to have a solid understanding of their own occupational role, as well as a clear idea of the roles of the other team members. Mistral and Velleman (1997) stated that each profession has their own academic background, style of training and skills and are socialised into their own group ethos. According to Koch (1986), training in team-building and team-leading skills, and basic individual interpersonal skills is necessary for effective teamwork.

In Britain a number of studies have been conducted on Community Mental Health Teams (CMHTs). Two such studies that focus on the role of the psychologist will be briefly highlighted. CMHT's have become central to the delivery of mental health care in Britain and it was noted that there has been some pressure for psychologists to join them. Onyett, Pillinger and Luijen (as cited in Blumenthal & Lavender, 1997) conducted research on the functioning of CMHTs in general and found differences in the experience of personal and team role clarity between the

professional groups. The study found that clinical psychologists were inclined to have comparatively low satisfaction with work relationships, low team identification (but high professional identification) and low personal and team role clarity. Nurses were found to have a strong sense of professional identity as well as high team identification and clarity about their role. Social workers were more burnt out and less satisfied with their jobs and tended to have low team and professional identification. The study found that the individual professional's role was strongly linked to team role clarity in general.

Blumenthal and Lavender (1997) also conducted a study on the role of clinical psychologists in CMHT's in Britain. They found that psychologists needed to be proactive in raising team awareness regarding what others could expect from psychology services. It was also found that improving communication with other team members would assist in creating a clear role for the psychologist, which could assist team role clarity.

The research conducted by the SAHR (Reid, 2002) for community service doctors found that issues such as attitudes, teamwork, confidence and communication were as important as the technical skills in the delivery of quality medical service. These were referred to as 'soft skills'. The shortage of soft skills in individuals and hospital teams was found to hamper the provision of quality medical services as a whole. It was found that the community service doctors and interns were placed in positions of clinical responsibility without having the personal maturity needed to work as part of a team. Although the research focused on medical doctors in hospitals, this may have an impact on other health professionals entering community service who are also young and relatively inexperienced in working with multi-disciplinary teams.

Referring health professionals perceptions of clinical psychologists and multi-disciplinary collaboration has been well documented in international literature, however little attention has been given to this in South African research. With the transformation of health services in South Africa and the growing implementation of community service to a variety of health professionals, including clinical psychologists, it was proposed that research in this area was important. This study therefore is an investigation into how health professionals, in the Grahamstown area, perceive the role and function of clinical psychologists working as part of a health care team in a community context.

CHAPTER 3: METHODODOLOGY

3.1 Aims of the research

The research aims at investigating referring health professionals' perceptions of the role and function of clinical psychologists. In community settings the main agents of referrals to clinical psychologists are usually nurses, doctors and social workers. Firstly, it is hoped that this study will give a better understanding of health professionals' perceptions of the role and function of psychologists and how this informs the referral process. Secondly, it is also hoped that this may lead to a better understanding and inter-professional collaboration between clinical psychologists and other health professionals.

3.2 Research Question

In an attempt to meet the aims stated above, the following research question was asked: *How do referring health professionals perceive the role and function of clinical psychologists working as part of a health care team in community settings?*

3.3 Research Methodology

3.3.1 Research Orientation

Strauss (1987) stated that grounded theory was a style of conducting qualitative analysis, rather than a specific technique or method. Haig (1995) noted that grounded theory was the most inclusive qualitative research methodology obtainable and is usually presented as an approach to doing qualitative research in that its procedures are neither statistical nor quantitative.

Two sociologists, by the names of Glaser and Strauss, originally developed grounded theory as a methodology. Strauss and Corbin (1990) stated that "the grounded theory approach is a qualitative research method that uses a systematic set of procedures to develop an inductively derived grounded theory about a phenomenon" (p. 24). In other words, instead of testing a hypothesis as other qualitative methods might, the aim of grounded theory is to discover the theory implicit in the data (Dick, 2000).

In grounded theory the process of theory building is dependant on 5 stages, namely research design, data collection, data ordering, data analysis and literature comparison (Pandit, 1996) (see Figure 1, p. 27).

Research design and literature comparison will be briefly described in this section. The other 3 stages will be described further down.

The first step of the research design phase is to design the research question. Strauss and Corbin (1990) stated that the “research question in a grounded theory study is a statement that identifies the phenomenon to be studied” (p. 38). They also believed that it was important to set limits around that which is to be examined, as the researcher could not cover all the features of a problem. Pandit (1996) agreed with Strauss and Corbin (1990) and felt that the research question should be narrowed down to a workable size.

In the present study, the researcher’s interest in the topic arose out of working as an intern on a three-month community rotation. The topic was discussed with colleagues and supervisor, and the research question slowly emerged.

The last stage that Pandit (1996) described was the literature comparison phase. However, before this is described, the use of literature in grounded theory will be outlined. In grounded theory the researcher attempts to engage in the study with few, if any, preconceived ideas and rather allows the theory to emerge from the data (Dey, 1999). Dey stated that a useful method to avoid theoretical preconceptions was to try to avoid the “literature of theory and fact on the area under study” (p. 4). In order to assure the emergence of the theory from the data, Dey thought it was best that the researcher read widely on the phenomena under study so that “the emergence of categories will not be contaminated”. The general sentiment about the literature review was that if the researcher read too closely about the field being researched, she/he would not allow the theory to emerge naturally but would rather force the data to fit preconceived ideas.

Strauss and Corbin (1990) believed that for the analysis to be effective, new categories should emerge that the researcher had not previously thought about. They stated that when this occurred the researcher could go back to the literature to determine what other authors have said about it. In the present study the researcher reviewed the literature quite widely before embarking on the data collection and analysis. During the analysis procedure, new categories emerged forcing the researcher to go back to the literature to find material on the newly emerged category. This process was a continuous one. Strauss and Corbin (1990) noted that in the writing up of the results, the literature could be used as ‘supplementary validation’ of the hypotheses and

propositions made by the researcher. The literature could then be appropriately referenced to validate the accuracy of the findings or how they were different to other authors' conclusions.

3.3.2 Participants

Researchers use purposive sampling to select participants with a specific purpose in mind. In this research, purposive sampling was used in order to identify certain cases for in-depth investigation (Neuman, 1997) regarding health professionals perceptions of the role and function of clinical psychologists. In grounded theory, choosing participants based on their capacity to contribute to the theory, is called theoretical sampling (Cresswell, 1998; Fife-Shaw, 2000).

Theoretical sampling was used to select the organisations from where the sample was drawn and it was comprised of people conversant in English. The nursing sample was taken from nurses working in Community Health Care Clinics and one nurse who had worked in the clinics and who was now working at Fort England Hospital. The social worker sample included one person from Fort England Hospital who had also worked at Child Welfare for a number of years, two from FAMSA, one from Settlers Hospital and one from Child Welfare. Doctors included one General Practitioner working in Grahamstown, one doctor from the military base in Grahamstown, two doctors from Settlers Hospital and one doctor from Fort England Hospital. The individual interviews were conducted with participants who did not take part in the focus groups. These specific samples were chosen because in community settings the majority of referrals to clinical psychologists come from social workers, nursing staff and doctors.

Social Workers Sample:

Social workers working for Welfare Organisations were contacted using the Social services Directory for a listing of the organisations. They were contacted telephonically and the research was explained and they were invited to attend the focus group. This group was more difficult to elicit because of the many workshops and other commitments that they had outside of Grahamstown. The social worker targeted for the individual interview had worked at Child Welfare for a number of years and was now working in a psychiatric hospital as it was felt that she would be able to contribute to the study by providing detailed information.

Nursing Sample:

The researcher contacted the head of Nursing at the Primary Health Care Section in Grahamstown. The study was explained and the researcher was invited to a meeting of the heads

of the clinics in Grahamstown. The researcher attended this meeting where it was decided that each head would go to their respective clinics and invite one of the nurses to attend the focus group. The researcher then contacted the individual nurses and organised for a time to have the focus group. For the individual interview, the researcher contacted a nurse who was known to have worked in the clinics as well as in a psychiatric hospital.

Doctor Sample:

This sample was obtained by contacting two doctors and asking them to recommend another doctor who they thought may be interested in taking part in the focus group. The individual interview was conducted with a doctor who could not make the focus group due to being on-call at the hospital where she worked.

For those who were willing to participate, issues of confidentiality, voluntary participation and time commitment were clarified. Before the start of the focus group and the individual interviews, participants were asked to sign a consent form (Appendix A). The form detailed their willingness to participate in the study, issues of confidentiality and anonymity and that the session would be audio-taped.

3.3.3 Data Collection Method:

The data was collected through two processes, individual interviews and focus groups. In two instances the individual interviews were conducted after the focus groups and the third interview was conducted the day before the focus group. The second form of data collection allowed for richer data to be collected and continuously informed the questionnaire guideline. The questionnaire guideline was modified after reading the literature. Strauss and Corbin (1990) stated that “you can use the literature to derive a list of questions that you want to ask of your respondents or that guide your initial observations” (p. 52).

3.3.3.1 Focus Groups

Focus groups are versatile in that they can be used on their own or in conjunction with other methods. Focus groups can be used to explore people’s opinions, beliefs, attitudes, values and understanding of things (Millward, 2000). Stewart and Shamdasani (1990) stated that focus groups produce a rich body of text that is articulated in the participants’ own words and context. The use of focus groups allows for direct contact between the participants and the researcher and the opportunity to collect data in a group situation. Focus groups encourage the interaction

between all involved, and supports openness and honesty in order for rich data to emerge (Stewart & Shamdasani, 1990). An interview guide is usually used to establish the agenda for discussion and is generally formulated from the research questions that were the impetus for the research. The guide was semi-structured and allowed for changes and digression. Three focus groups were conducted that explored the participants' knowledge. Experience, attitudes and perceptions towards clinical psychologists. The focus groups were approximately an hour each and were audio-taped to assist with the analysis of the data.

3.3.3.2 Individual interviews

Cresswell (1998) stated that interviews are a key function of collecting data in a grounded theory study. The data was collected, by administering semi-structured interviews. The interviews were tape-recorded and lasted approximately an hour each. The interview guide that was used for the focus groups was also used in the individual interview. Semi-structured interviews involve the implementation of preformatted questions that are asked in a systematic and consistent manner, yet, allowing the interviewer freedom to digress (Seidman, 1991). The 'freedom to digress' allows the interviewer to elaborate on the answers given by the participants, by making unscheduled explorations into answers that may need clarification or more detail. Two of individual interviews were conducted after the focus groups. The second interview was conducted before the focus group, due to time constraints. The individual interview allowed the researcher to ask more in-depth questions about issues that arose from the focus groups as well as clarify and expand on various themes.

3.3.4 Data Processing:

The data was processed by transcribing the interviews and analysing the data using a grounded theory approach. "The purpose of grounded theory is to build a theory that is faithful to the evidence" (Neuman, 1997, p. 334). The research project makes use of the grounded theory techniques of coding, constant comparison and integrative diagramming (Strauss, 1987).

The initial coding of the data is accomplished by examining the text 'line by line, or even word for word'. Everyday practical knowledge as well as the theoretical knowledge the analyst brings to the study influences the process of coding (Van Vlaenderen, 1999). Coding is based on a concept-indicator model that involves the constant comparisons of indicator to indicator. Indicators, which are words taken from the text, are chosen according to their relevance to the analysis. The indicators are compared with each other (constant comparison) and this forces the

analyst into “confronting similarities, differences, and degrees of consistency of meaning among indicators” (Strauss, 1987, p. 25). The method of constant comparison entails the constant questioning of gaps, oversights and discrepancies (Van Vlaenderen, 1999). Indicators that are similar are coded into conceptual categories. The categories are then examined to ensure the indicators fit best into the categories they have been placed into. Indicators are moved around and category labels are changed until “the codes are verified and saturated, yielding nothing much new” (Strauss, 1987, p. 25).

The final stage involves diagramming the results of the coding process. This entails presenting the coded categories in a diagram format (Strauss, 1987).

3.3.4.1 Analytical Procedure:

The transcripts were examined and the text was divided separated into crude categories, for example, work settings and responsibilities, roles and perceptions, and others. Fragments of the text were then placed into these categories for the social workers, nurses and doctors. This initial phase of the analysis is termed open coding, where initial categories are formed, enabling the researcher to develop a clearer idea of what the text has to offer (Cresswell, 1998) (Appendix B). Strauss and Corbin (1990) stated that creativity is a vital component for the researcher to fittingly name categories and to make associations necessary for producing exciting questions and coming up with comparisons.

The indicators within the various categories were then carefully examined and sub-categories were identified and labels were attached to them. The text was read and re-read and the indicators were placed into these new refined categories. This stage is referred to as axial coding and occurs interchangeably with the open coding process (Strauss & Corbin, 1990). Axial coding allows for the researcher to go deeper into the data by making connections between the categories and sub-categories. Pandit (1996) stated that “axial coding refers to the process of developing main categories and their sub-categories” (p. 8). During the open and axial coding the researcher makes use of memoing, which are notes to the self about ideas, thoughts, and hypotheses that arise from the data collection and coding procedures (Dick, 2000). The use of memos assists the researcher “in the formulation and revision of theory during the research process (Strauss & Corbin, 1990, p. 10). (Appendix C).

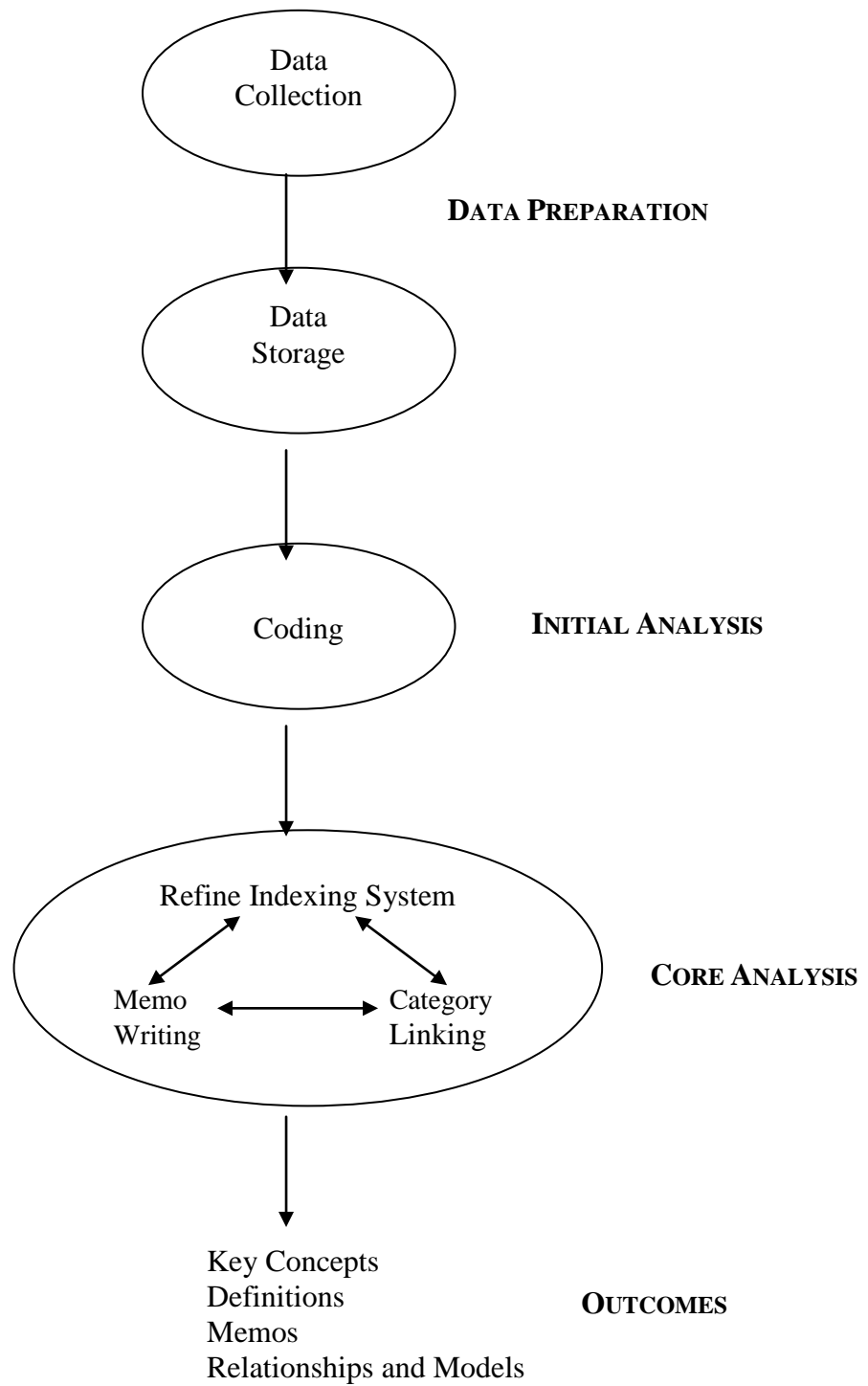


Figure 1: The Grounded Theory Approach
(reproduced from, Pidgeon & Henwood, 1997, p. 259)

Finally selective coding is the final phase of coding the data. Selective coding was used to integrate the categories that have been developed to form the initial theoretical framework. In this phase the researcher takes the core category and systematically relates it to the other categories, validating the associations and filling in categories that need further refinement and development (Strauss & Corbin, 1990). The various coded categories were then examined and an integrative diagram was finally designed.

The process of constant comparison was done by carefully scrutinising the categories and the indicators to see if they could fit better into other categories or if more appropriate category labels could be found. Data analysis and theoretical sampling ends when theoretical saturation is attained. Theoretical saturation occurs when there is no longer any new information to add to the understanding of the categories (Cresswell, 1998).

3.4 Ethical considerations

Ethical principles were considered in all areas of the study. The participant's confidentiality and anonymity was assured, and each participant signed a consent form. On completion of the study, it was conveyed that the record sheets and audio-tapes would be destroyed.

3.5 Internal and external validity

In qualitative research knowledge is accepted as constructed and therefore is open to a number of interpretations. In an attempt to ensure the validity of the current study, triangulation in the form of two methods of data collection and analysis was utilised (Banister, Burman, Parker, Taylor & Tindall, 1994). Literature can also be used as supplementary validation to verify the accuracy's of the findings or to note any differences and the reasons for these (Strauss & Corbin, 1990).

CHAPTER 4: RESULTS AND DISCUSSION

4.1 Orientation to the chapter:

The results and discussion of the results will be presented in this chapter. It was decided to combine the results and discussion chapter, which is often done in qualitative research (Banister et al., 1994). The nature of qualitative research makes the separation of results and discussion very difficult as they are intertwined, and a separation of them could result in vast amounts of replication.

The overall analysis yielded 5 main categories (see Figure 2, p. 30). These were (1) Knowledge contradictions; (2) Perceived ‘usefulness’ of clinical psychologists; (3) Access; (4) Inter-professionals relations and (5) Community issues. These 5 categories will be interpreted and discussed in detail. Before this takes place, an example of the framework of the chapter will be shown, to give the reader a clearer understanding of what to expect from this chapter.

EXAMPLE:

1. Knowledge Contradictions [example of main category]

A brief explanation is given for this heading

1.1 Social workers:

Knowing: [example of sub-category]

A short explanation was given of what the researcher thought that the data was reflecting

Quotes chosen from the data pertaining to the sub-category ‘knowing’.

Not Knowing: [example of sub-category]

A short explanation was given of what the researcher thought that the data was reflecting

Quotes chosen from the data pertaining to the sub-category ‘not knowing’.

1.2 Nurses: [The same format as above]

Knowing:

Not Knowing:

1.3 Doctors: [the same format as above]

Knowing

Not Knowing

Discussion

To conclude this category a discussion of the results for all three groups was conducted focusing on overlaps and differences between the groups as well as proposing a number of possibilities for the findings.

This format was utilised for all five main categories.

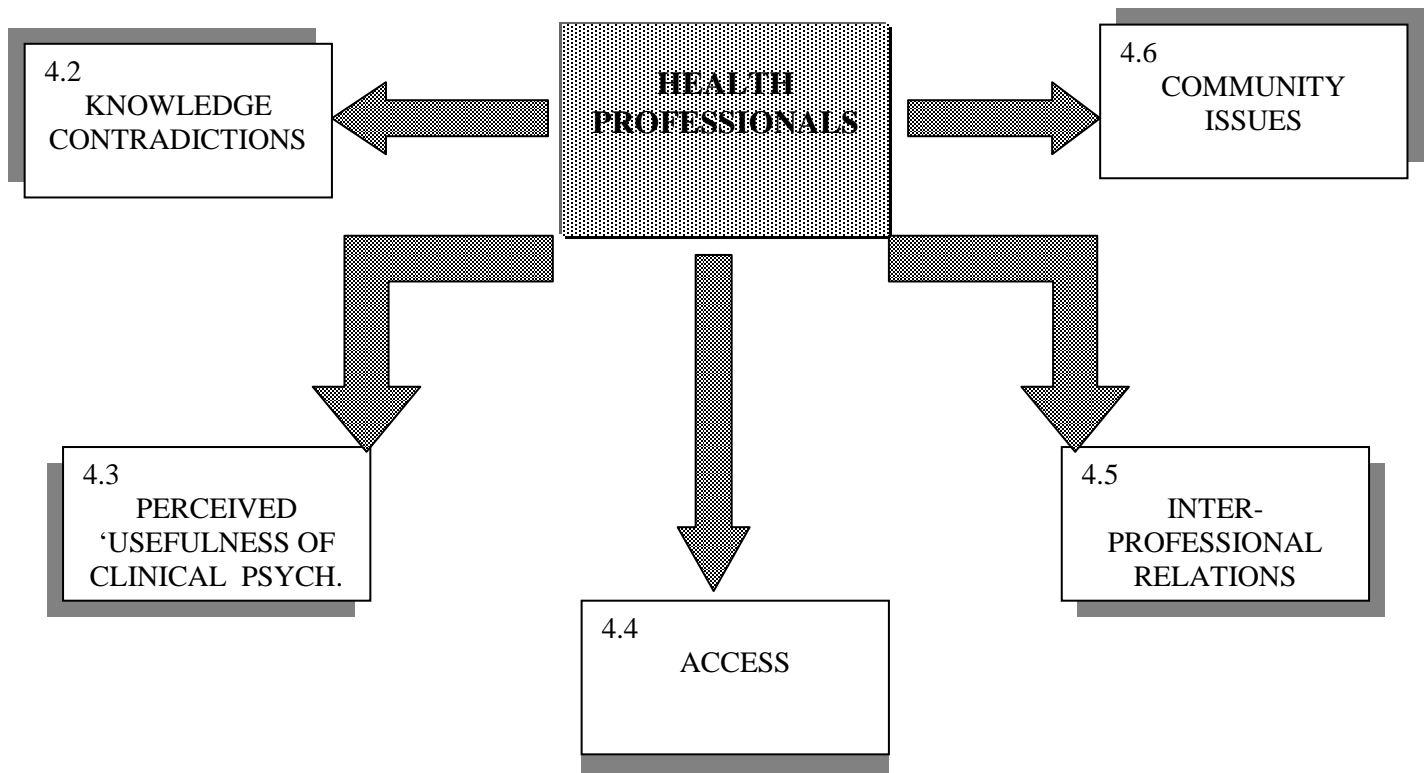


Figure 2: A representation of the 5 main categories that were generated through the analysis procedure

4.2 **Knowledge contradictions:**

From the data it is apparent that knowledge is a key feature of health professionals' understanding of the role of clinical psychologists. There are certain contradictions in the nature of the knowledge between what they feel they know and what they think they do not know.

4.2.1 **Social Workers** (see Figure 3, p. 32))

Knowing:

Social workers were able to demonstrate their basic knowledge of the role of psychologists by giving an explanation of how they think a psychologist could be helpful. This is reflected in the following statement:

“With my limited knowledge I think generally the role of the clinical psychologist is to help one to see life in perspective, because I think one goes to a psychologist when he or she feels that there is something that she can't put her finger on in her life, even though a psychologist won't prescribe and say 'do this and do that'. I find that they have some skill and know how of how to get one to come to their senses and learn to cope with whatever that person was not coping with”.

Not Knowing:

They appeared to have an intrinsic lack of confidence in their knowledge, which they revealed in comments such as:

“Is this their role (psychologists) or is it not? Is it my role or is it somebody else's role? It would help if they (psychologists) can make themselves clear”.

“I feel I don't have sufficient information”.

“And I don't want to ask (about the role of psychologists) because I feel now I'm sounding really stupid”.

Their lack of confidence in the knowledge they had gained about clinical psychology could be because it was attained through experience and not through formal education. Statements such as the following reflect this position:

“In community development [social work] training I didn't do psychology, so that removes the knowledge and skills from the social worker”.

“I used to think it was my confusion alone, because I thought maybe there's something I missed at school”.

It appears that because the majority of social workers do not have a clinical psychologist as part of their team to interact with, and from whom to obtain first-hand information, their knowledge has not been validated and they do not feel confident with the knowledge that they have. Whereas the one social worker interviewed, who has a clinical psychologist on her team, appeared to feel more confident in her knowledge and understanding of clinical psychologists.

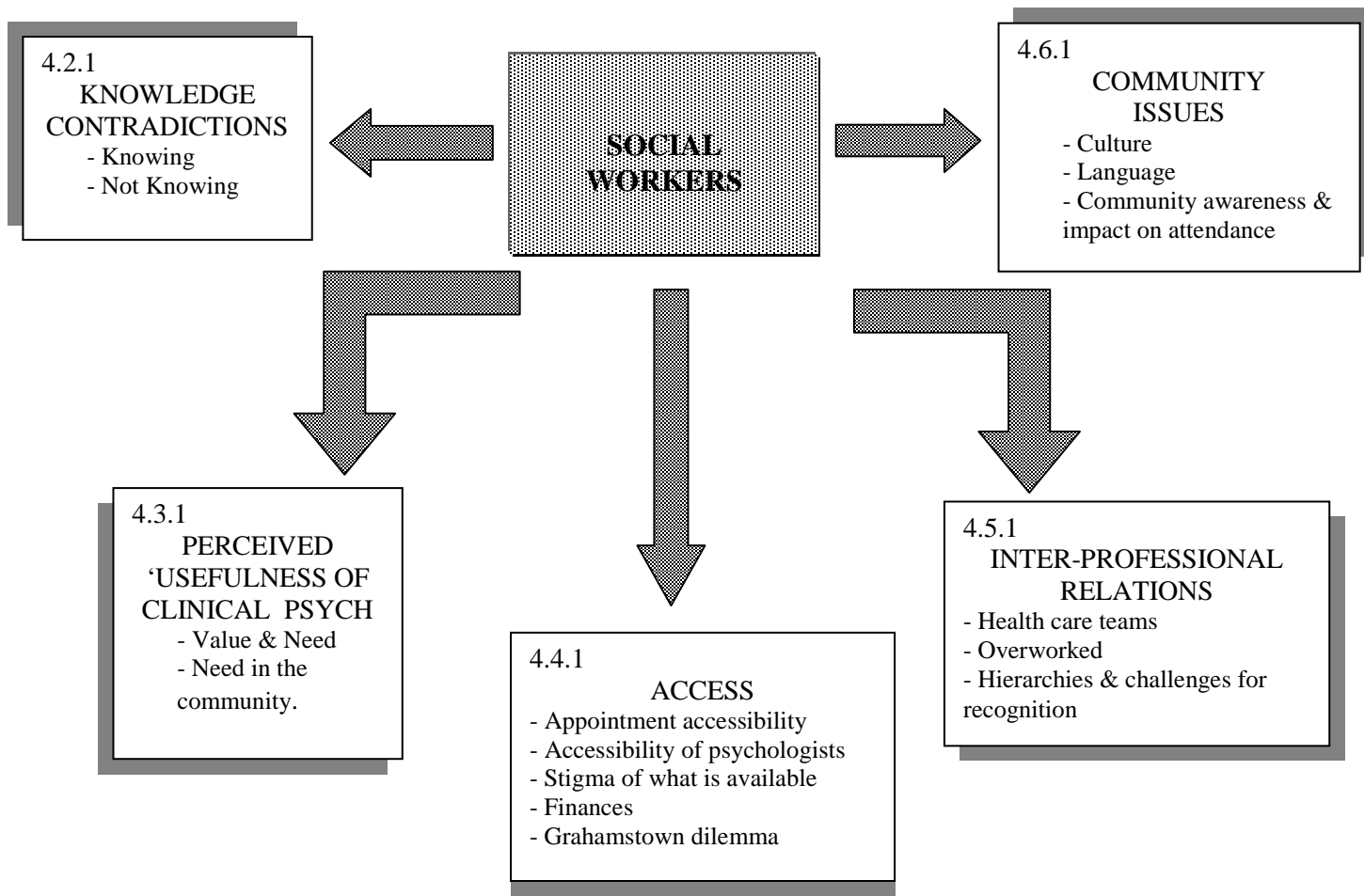


Figure 3: A representation of the 5 main categories as related to the Social Workers

4.2.2 Nurses

Knowing:

Nurses seemed more confident in their knowledge of psychologists and were able to give good concrete examples of how psychology could help, as indicated by the following statements:

“To myself I would define the psychologist as that person who is there for the other side of the client – other than the physical health, which tablets cannot help”.

“I also view the role of the psychologist as someone who assesses the psychological, emotional well-being of the person, who can identify the stress levels around the patient and the origin of the stressors. Someone who can actually give them the necessary interventions according to the identifying stress that is around the patient”.

Not Knowing:

Although nurses felt confident of their knowledge, they still had some misgivings. What could have affected this was that the newer graduates have completed a course in psychology during their training, whilst the older nurses have not. This correlates with the social workers, who it was surmised did not feel confident due to not acquiring their knowledge through formal education, and may not have believed that their acquired knowledge was accurate. What is also evident from the data is that some nurses see psychology and psychiatry in the same category. The conclusion that seemed to be drawn by them, was that if a psychiatrist worked with mentally ill patients, then a psychologist worked with mentally ill people as well. The above was noted in the following comments:

“They only know psychologists dealing with people who are mentally ill. We don’t know the difference between psychiatrists and psychologists. To us it’s mad people, and there’s a stigma now attached to referring people to the psychologist. It means they are mentally ill”.

“I so wish that psychology could be introduced to nurses, then you could really understand. So that we pick up the problems at a very early stage and refer at a very early stage”.

What was also apparent from the nurses, who had worked in a psychiatric hospital, was their need for a more intricate understanding of psychology. They were exposed to case conferences where the intern clinical psychologist would present findings on psychometric and projective testing and conclude with a psychological formulation. This is reflected in the following comment:

“When it comes to case conferences we switch off. We only understand when the doctor and social worker are speaking. But when it comes to the psychologist presenting their findings we don’t understand. Your language is far, far from what we know. It increases the gap even within the same institution. We work together but there is that big gap because we don’t understand what you are saying. When we sit there as nurses we think we are the only ones who don’t understand what they are saying. We think we are the only ones”.

4.2.3 Doctors

In this group there is a split between those who genuinely do not know much about psychology and admit this, others who do know and demonstrate their knowledge accurately, and others who say they know but do not give concrete examples of how their knowledge is put to use.

Knowing:

The doctors demonstrate their knowledge of the role of psychologists through their reason for referral and definitions, as indicated by the following comments:

“I utilise the clinical psychologist for assessment of intelligence. For example, head-injured patients that come looking for a disability grant”.

“I would see it as engaging in a more longer term and in a deeper, more thorough way with the patient to try and effect the healing process of the underlying disease or whatever, psychological distress”.

Not Knowing:

What is interesting about this category is that the doctors who really did know the role of psychologists were saying that they needed more information, this includes the doctor who admitted to not knowing much at all. The other doctors, who said they knew but could not really demonstrate their knowledge as accurately, did not really respond within this category. This is reflected in the following statement:

“Especially not really knowing quite what would be better to refer to a psychologist than to a social worker or to the psychiatrist – or it would be nice to have a personal contact or more of a knowledge about what’s going on and where to refer to, or how to refer, if we do”.

For the doctor who did not have a clear idea of what psychology is all about, said the following:

“A psychiatrist does psychotherapy. Why do you guys do psychotherapy too?”

“We’ve been through 6 years of training, We’ve now been working for how long, and we still don’t have a clear cut view of what psychology does, the psychologist does”.

“I do feel that there should be more – okay they cannot teach us full psychology, but it should be more of an awareness of who the other part of the team is. I mean we get told, this is what a physio does, this is what an O.T. does, you know. Why not tell us the help we can get from a psychologist?”

The doctors who say they know, gave quite uncertain explanations about what psychology was and also seemed to connect it with what they were struggling with in their own work, as reflected in the following comments:

“I actually look at this and think, ‘oh this is going to be a long story’”.

“Lots of fertility issues or infertility, which is also in the world of AIDS becoming a problem because you’re talking about people who are at the fertile stage of their lives and suddenly you know they’re both HIV+”.

“But I really think that AIDS is a disease for psychologists, very much so”.

“In an ideal situation then we would then refer for many other things, not just psychotherapy, but also for counselling, discussion of issues”.

Traditionally, doctors have been the ones that the public and other professionals look up to and expect them to have all the answers, and psychologists are perceived to work with mentally ill patients and have therefore acquired this stigma. One statement sums this up:

“I think in many communities it’s acceptable to see the doctor and then they expect the doctor to be able to help them with everything – social work, psychology, everything. That is the expectation of the people and whereas they might not want to see the psychologist because of the stigma attached to having a psychological problem”.

4.2.4 Discussion

The results highlight a number of important issues. Firstly, all three groups were able to communicate their knowledge regarding the role of psychologists to differing degrees. The nurses’ examples of ‘knowing’ were a lot more concrete and descriptive than the other two groups. The social workers appeared to be hesitant in their explanations, seemingly with a fear of making a mistake. The doctors were less descriptive but gave the impression of knowing. In these professions a minimal amount of psychology is introduced into their coursework and thus the knowledge obtained is generally through practical experience, television, pop psychology books and conversing with colleagues as noted by Hartnett et al (1989).

The relegation of social workers and nurses to a lower status denotes that there is always someone above them who has more knowledge (Etzioni, 1969). This may account for their lack of confidence and contradictions of their ‘knowing’ because there has been an implied feeling that they should appear to know less than they do, as they are not seen to be the guardians of this specialised knowledge. Psychological jargon may have also affected the various groups ‘not

knowing’ as they may not be versed in the ‘language’, which could make them feel more separated from psychology. Doctors, on the other hand, have been indoctrinated into believing that they know more than they do (Miller & Swartz, 1990). This may account for their comments of ‘knowing’ that were more global rather than specific. Out of the three groups, the doctors were the least able to provide concrete examples of their knowledge, yet were the most confident of their knowledge.

The stigma associated with psychology and psychologists was especially noted in the comments made by some of the nurses of how some did not want to have any connection with psychology and psychiatry. This correlates with the finding in 1993 by Mavundla (cited in Uys and Schene, 1997) that found that 90% of nurses held negative views towards psychiatric patients. This finding confirms the need for nurses to be given appropriate psychiatric training, which was found to alter nurses attitudes of psychiatric patients for the better (Sokhele, 1999), which ultimately will assist in their perceptions of clinical psychologists as well.

Knowing and not knowing plays an important role when it comes to referring patients to psychologists. Reliable knowledge of psychology will result in accurate referrals and efficient service, however, wrong referrals may result in frustration for the patient as well as the psychologist who may have to refer the patient back. Although the data revealed that some of the health professionals had a solid understanding of the role of clinical psychologists, there is still an immense need for further education. A need for education is necessary for health professionals to feel confident in their own working with clients, as well as knowledge for referrals.

4.3 Perceived ‘usefulness’ of clinical psychologists

The data revealed that the doctors’ perception of the ‘usefulness’ of psychologists is different compared to what the social workers and nurses believed. However, they all felt that psychologists should be placed in community contexts, such as primary health care clinics.

4.3.1 Social Workers

Value and Need:

There was a definite sense that the social workers believed that psychologists were needed to assist with in-depth psychotherapy, diagnosis and assessments and that these skills were valued. This was reflected in the following statements:

“I have confidence in them. Yes they can make mistakes or whatever, but I know they are one of the people that I know that they can do the job”.

“If the baggage needs unpacking more than we feel we can unpack in counselling”

“So if there was no psychologist there to assess and do some tests and all that, those patients would be misdiagnosed”.

“If we can’t manage then it gets referred to the psychology department”

Need in the community:

The need for psychologists in the community or as part of the social workers’ teams was highlighted. They felt that this would give better access to the patients as well as giving them the opportunity to follow-up on referrals. This was emphasised in the following comments:

“The weakness is that we’re not in the same physical space, and so it’s more difficult to follow up and check on patients”.

“It would make our lives a lot easier to have a psychologist here, or better access to a psychologist”.

“So I feel that in a hospital like Fort England, they need them, they can’t do without them”.

“To me I think it would be very important to have a psychologist in the community because during the referral process you lose many clients and so it’s better when there’s a nearer source”

4.3.2 Nurses (see Figure 4, p. 38)

Value and Need:

The nurses believed that there is a place for psychology in the community, as not only the individual patients were helped but their families as well. The nurses also seemed to benefit themselves from having a psychologist at their clinics. The nurses tended to refer from a more medical perspective. That is, if a patient presented with a physical complaint that was noted to be psychosomatic in nature, they would then refer the patient to a psychologist. The nurses found that after psychological treatment, the patients did not present with those symptoms again. This helped to lessen the burden of numbers at the clinics. This was indicated in the following statements:

“What I discovered without being given the feedback by the psychologist, I’m seeing that the patient is now on psychiatric treatment. It shows that on those frequent visits there was an underlying problem”.

“So whenever you refer to the psychologist you knew that you would get advice on further management of this patient, and also it helped in the management of the whole family because

usually when a patient is not well and keeps on coming back, you realise that he is not the only one affected”.

“In a way the psychologist helped us, because they even counselled – we got counselling at the same time. And while we were interpreting, you took some of the things for yourself, like their techniques”.

Need in the community:

Nurses seemed to feel that having a psychologist in the community clinics would make the service more accessible to patients, which would help decrease the number of psychological presentations at the clinic. This was reflected in the following statements:

“It would help a lot because the person doesn’t have to travel far. Even if it’s once a week, at least it’s more accessible to the patient”.

“I think the service of the psychologist are very vital in the communities. I think it can prevent some of the problems to the extent that the clinics wouldn’t be so full”.

“I never knew the impact of the psychologist in the community but I realised that, when they [community] wrote a letter to the District Office asking for the ‘Doctor of worries’ to come back”.

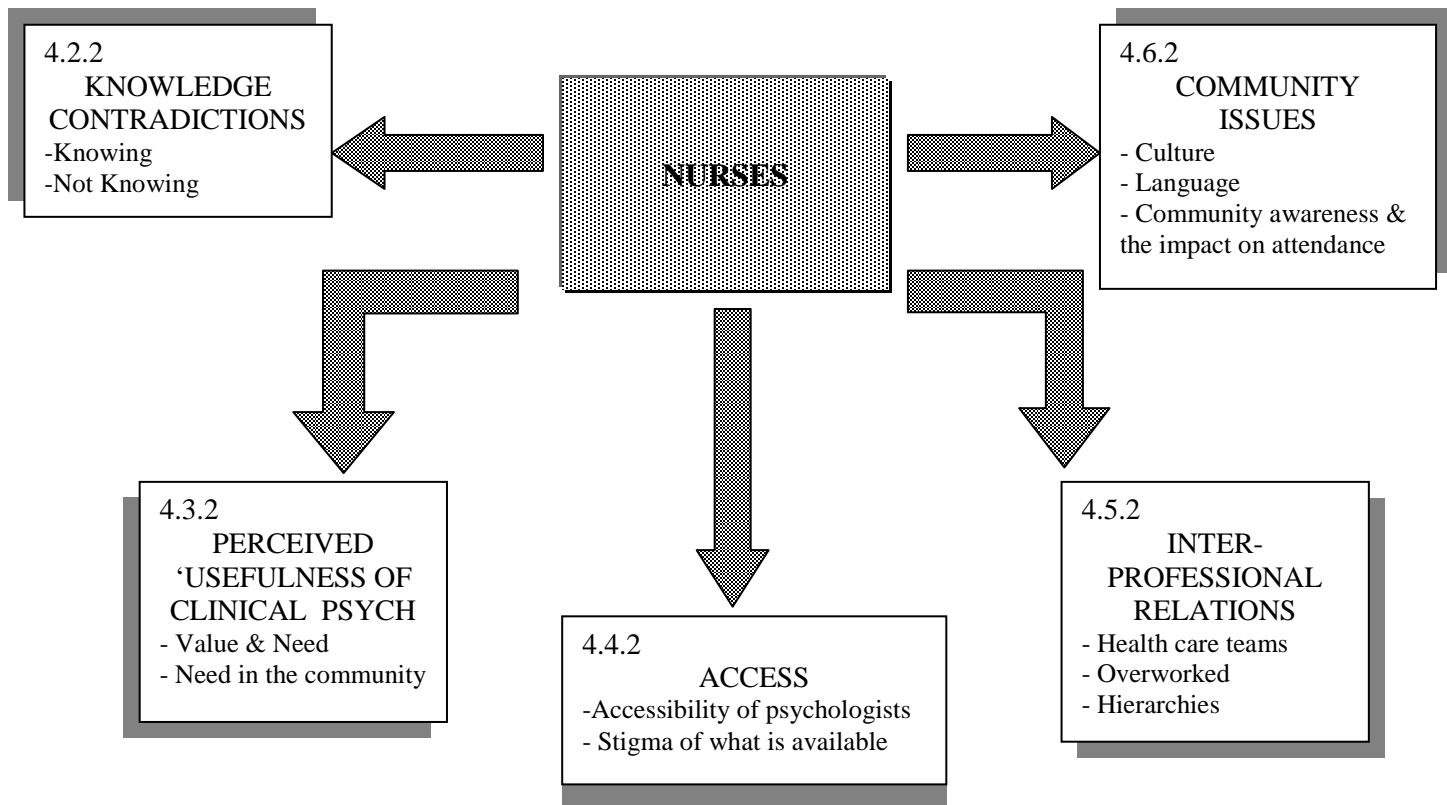


Figure 4: A representation of the 5 main categories as related to the Nurses

4.3.3 Doctors

Psychology as a luxury:

Some of the doctors seemed to view a visit to the psychologist as a luxury and a chore for more destitute people. This is illustrated in comments such as:

“Then to get to somewhere, find transport, pay a taxi, especially if they don’t have their own transport, it becomes a luxury you know in comparison to the rest of their life, and it’s the first thing that’s going to be cut out when there’s stress and that’s it because the psychologist it’s just talking or whatever”.

“I think it’s just the grind of life. If you’ve got less grind in your life, and that’s when you mostly need a psychologist probably, that’s when you least inclined to go because there’s too much pressing, urgent matters”.

Need in the community:

However, some of them do envisage a need for psychologists in the community for education, group therapy as well as a need in non-psychiatric hospitals, as indicated by the following statements:

“I think we should flood them, train them and just send them out – like the doctor’s community service. Eventually the message will have to get through. I mean initially there will be a bit of a stigma maybe, but I think that in the end - because it’s a resource and it’s there”.

“I mean helping one person per hour, then you can only do that much per day and there are not that many psychologists. So I think there needs to be more education and possibly more things like group therapy and that type of thing”.

“There’s still a need for psychologists, even in a government hospital that doesn’t do purely psychiatry, because emotions, social problems, emotional problems, whatever one is feeling about things, impacts so heavily on how one fares physically”.

4.3.4 Discussion

The data reveals a difference between the doctors’ perceptions of the ‘usefulness’ of psychologists, with the nurses and social workers. With the doctors there is an impression of psychology being a luxury rather than a necessity. Doctors tend to deal with symptoms that can generally be treated with medication, however, psychologists don’t prescribe medicine, but rather talk with the patient in their specialised manner in order to alleviate the symptoms presented. It is suggested that ‘talking’ may feel like a luxury to doctors, as this takes up about three times the

time that they tend to spend with patients and they may thus come to the conclusion that poverty stricken people may not find this necessary.

Helman (as cited in Petersen, 1999) stated that in developing countries minor psychiatric disorders have been linked to the manifestation of physiological complaints and that because no physiological explanation can be found, the problem is ignored and often goes untreated. This finding indicates the important need for psychology, so that these complaints do not go untreated. Doctors' belief of psychology as a 'luxury' is therefore contradicted by the above finding. Many indigent patients continuously present with the above physiological complaints at the clinics, which without a psychological explanation may never be resolved. This reflects that psychology is not exclusively for more affluent individuals, and calls for doctors to revise their thinking of psychology as a 'luxury'.

Nurses and social workers on the other hand perceive psychologists to have an immense usefulness. They feel that psychologists are able to 'solve' problems that they are unable to with their own skills. Nurses tend to encounter many psychosomatic complaints and have found that after a psychology consult the people do not present with these problems again.

The differences between the three groups may be because the nurses and social workers have spent a lot more time with patients in the community. They are more likely to have seen the results of psychological intervention even with the more destitute people, and thus can value the work psychologists are able to.

What is clear however, is that the perceived 'usefulness' could have an impact on referrals and the resultant patient care. If psychology is considered a luxury, then it can be surmised that only patients from a more middle-class and above bracket will be considered for a psychology referral. This leaves out a vast majority of the population that will not be considered for psychotherapy and who may benefit from it the most.

Although most of the health professionals interviewed felt that psychologists would be needed in the community, many of them felt that they would be doing one-on-one-work with patients reporting to community settings. There were very few who thought that a more 'mass intervention' should take place such as group therapy. It is interesting to note that the health professionals felt that the work that should be done in the communities was more on a reactive

than preventive basis. In other words, clinical psychologists would mainly concern themselves with symptom relief, rather than play an educative role in the community.

4.4 Accessibility

The term ‘accessibility’ encompasses many areas in the study, such as appointment accessibility, accessibility of psychologists, the stigma of what service is accessible, and others. Many of the health professionals felt that there are not enough resources to cope with the number of people requiring psychological assistance in Grahamstown, as well as there being inadequate interaction between psychologists and the respective health professionals.

4.4.1 Social Workers

Appointment accessibility:

Appointment accessibility refers to referring agents being able to secure a time for their clients to be seen by the psychologist. There seems to be a lack of appointment accessibility due to a lack of resources and waiting lists. Even though Grahamstown is fortunate to have Fort England Hospital, a psychiatric hospital, that has a free psychological service, and the Rhodes Psychology Clinic, which negotiates the fees, it appears that it does not fulfil the need that there is in the town. The social workers indicated their concern with this in the following statements:

“Fort England is full, there’s a waiting list. Rhodes also – and these children are left without having any therapy”.

“There are waiting lists and it might have been available for emergencies or whatever but not for ordinary referrals”.

“I’m saying that the resources are not enough to cater for the needs in this town”.

Accessibility of psychologists:

It seems as though there is not a lot of interaction between social workers and psychologists, and psychologists are perceived to be inaccessible. The one social worker, which had direct contact with a psychologist, found it easier to communicate, make referrals, and receive feedback. This is reflected in the following comments:

“I see sometimes the social worker as the step-child, where the psychologist is the hidden child, you know, is that we don’t know where the psychologists always are. At the end it seems that they are hidden, they are away, they are not there”.

“When I was at Child Welfare it was easier because I knew who to talk to at FEH, because then you can follow up. I never had problems because I even used to get feedback from the psychologist”.

Stigma of what is available:

The data revealed that the stigma of going to a psychiatric hospital to see the psychologist has an impact on clients, as they seem to be afraid of the psychiatric population. The enormity of the psychiatric stigma is clear in the following statement:

“Fort England has such a stigma – he just ran away from her [mother] and said that he couldn’t go to that place where the mal mense are”.

Finances:

The social workers take the clients’ finances into account when referring. If the client is financially able to see a private psychologist this is preferred, as they are usually able to get an appointment immediately rather than having to be placed on a waiting list. This is reflected in the following comments:

“For psychology we take into account the income of people, because if they can afford a private psychologist we normally recommend that. It would be easier to access, easier to get an appointment”.

“You take their income into account and you take where they live and how easily accessible [it is]”.

Grahamstown dilemma:

What seemed to be frustrating for the social workers, was that most of the private clinicians are on leave from around the end of November to late January. This results in there being a non-existent psychological service during this time. Even though the Fort England service is still running, interns are replaced each year and there is consequently a lack of continuity for the clients. The other difficulty was that mainly intern clinical psychologists conducted the free services available in Grahamstown. This seemed to have an impact on referrals, in that the interns only have one-year experience of psychotherapy and assessment. This frustration is summed up in the following statements:

“Round about November / December then that service is non-existent. So what we are talking about here is about three months that there is a non-existent service”.

“It’s difficult to access and even the private psychologists were full last year”.

“Sometimes we think ‘Oh we stick with it ourselves because maybe with out 4/5 years experience, we can cope maybe as well as them’” [psychology masters students].

4.4.2 Nurses

Accessibility of Psychologists:

Due to a lack of resources only three of the clinics in Grahamstown have a psychologist that attends the clinics once a week or every second week. Many of the nurses who do not have a visiting psychologist refer their patients to one of the three clinics the psychologist does visit or to the Community Psychiatric Services at Fort England Hospital (FEH). This results in many nurses not having direct contact with the clinical psychologist they refer their patients to. The above is reflected in the following comments made by the nursing participants:

“Like in town clinic there’s no psychologist, so when the doctor, nurse, sister want to refer a patient, then I make a booking to see the psychologist at Fort England CPS or one of the other clinics”.

“We have got that referral system in which case the psychologist leaves a book at the clinic, so that you put the name of that person you feel the need to be assessed by the psychologist”.

“There’s no interaction between the nurses and the psychologists. You will find that we don’t interact the way we do with doctors and social workers”.

Stigma of what is available:

The nurses also noted the stigma that exists regarding the psychiatric hospital and how it would be more useful for the psychologist to visit the clinics so that there would be no need to refer the patients to FEH. Statements such as the following reflect this position:

“Because they thought that if you refer them to the psychologist at FEH they are mad. They will be coming back with packets of medication. They will be laughed at now at school, when they will have to now and again go to the psychologist”.

“Stigma at Fort England. That is why it was much better when the psychologist now visited the clinic”.

4.4.3 Doctors (see Figure 5, p. 45)

Appointment accessibility:

The doctors agreed with the social workers about the lack of resources in Grahamstown to accommodate their patient’s needs, especially for those who did not have medical aid, as reflected in the ensuing comments:

“Say you have a private patient who is not on a medical aid and you want them to get some psychological help. You phone around and the Rhodes Clinic is booked for some months and FEH doesn’t take a lot of things anymore, it seems you know there’s nowhere to go”.

Accessibility of Psychologists:

The data revealed that there is not much contact with clinical psychologists. It was also noted that because of the lack of resources for referrals, they tended to medicate their patients instead of referring them for concurrent psychotherapy or psychological assessments. The above is indicated by the following statements:

“Majority of cases are just through a piece of paper. Every now and then we interact, say over the phone, that’s the only interaction”.

“We tend to just then medicate ourselves, and maybe over-medicate when you should be using other interventions, because it’s just quicker. You do a bit of sort of like intervention and it’s just then and there – then after the patient is back to it’s own coping resource which is probably inadequate”.

Stigma of what is available:

There seems to be an agreement between the health professionals about the stigma associated with referring to psychiatric institutions, as indicated by the following comments:

“Fort England tends to be a problem actually, because when you say to somebody, ‘I’m going to send you to FEH’ – ‘you really think I’m cuckoo, no’, and I try to explain that I’m going to send you to a section of Fort England”.

“There’s a big stigma attached to it. When you’re talking to a para-suicide and say ‘go and see the psychologist’ – ‘no, I’m not going there, it’s a mad place’”.

Finances:

Doctors feel that they are left with the burden of having to assist patients when they are unable to refer them for psychological assistance. They also seem to feel that the patients need to ‘fit’ a specific category before referring them to a psychologist. This position is reflected in the following statements:

“But often then you know, if your patient doesn’t fit into the right category, financial or demographic or whatever reasons, you just end up being the only person that can try to help the patient and actually it’s not good enough”.

“Tend to refer through a private network or a government network, depending on what the patient can afford”.

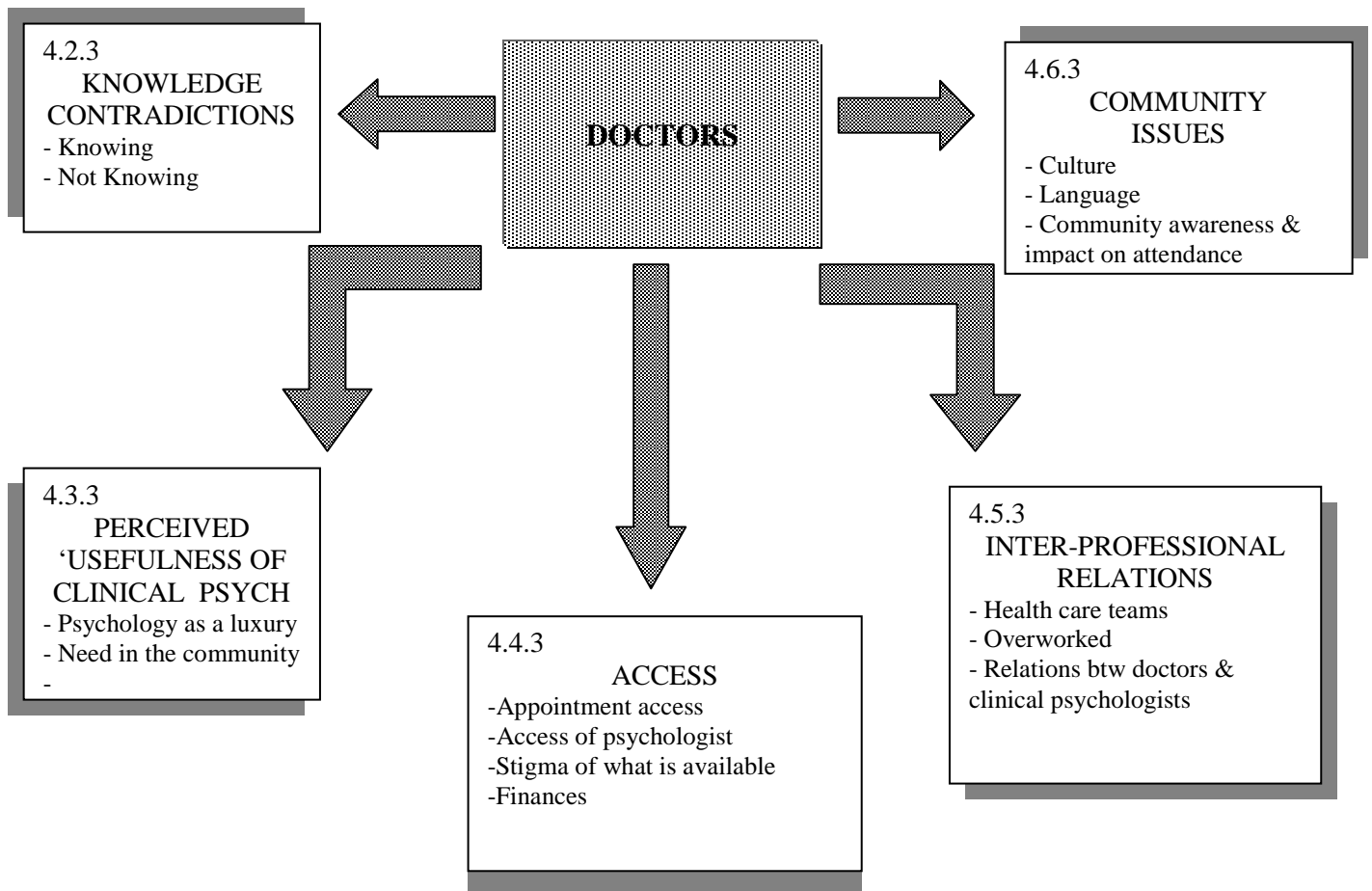


Figure 5: A representation of the 5 main categories as related to the Doctors

4.4.4 Discussion

The limited interaction between psychologists and the other health professionals is largely evident in the data. The contact that does take place is generally through a referral letter or a report. Both the social workers and doctors highlighted the lack of availability of psychologists and their concerns that there were not enough resources to accommodate their patients' needs. This is similar to the study conducted by Abrahams and Udwin (2002) that found that second level referrals included poor communication, long waiting lists and an inefficient referral system.

The results indicated that there were not enough psychologists to deal with the amount of people requiring psychological intervention. This feeling corresponds with Duffy's (1998) view that community psychology was born largely because of the inability of clinical psychology to deal with the vast numbers of people requiring treatment. Whether this treatment will be left to the

devices of community psychologists or not, cannot be surmised. However, with the implementation of community service and the move to primary health care, there is a growing need to increase the number of psychology graduates to accommodate the growing number of people needing psychological interventions.

The inadequate resources that the health professionals comment on, seems to indicate a need for a more 'mass intervention' in the communities, rather than individual psychotherapy, to alleviate psychological presentations. However, currently this does not seem like a viable strategy. It is suggested that the previously disadvantaged communities are slowly coming into their own and are no longer as passive as they used to be. The words, 'mass intervention' evokes passivity where the people receive, while others give. One of the concepts included in the PHC approach stated that "communities should be involved in the development of services as to promote self-reliance and reduce dependence" (Sokhela, 1999, p. 230). It is proposed that the implicit need for 'mass intervention' is to take away the problems of society in order to pacify our own needs rather than those of the communities.

Psychology is a relatively new profession and there are not as many psychologists practising in South Africa that would account for the apparent need. Most Universities only enrol between 7-12 clinical psychologists into the masters training. If you multiply that by the number of universities that accommodate clinical psychology, it will not amount to a very large number. However, the limited number of psychologists does not always account for the inaccessibility of psychologists. Traditionally trained clinical psychologists are aware of boundaries and usually do not participate in activities where they may meet other health professionals. One example is the Journal Club that FEH has once a month where there are very few psychologists in attendance. A suggestion for this non-attendance is not possible, however, with the changing context in mental health, this definitely needs to be addressed.

The doctors commented that the unavailability of psychologists for referral purposes, resulted in them medicating patients, without a psychological assessment or concomitant psychotherapy. This finding corresponds with Davies (2000) who stated that consulting a GP was more likely to result in a medical response to the problem without the patient being offered ongoing counselling.

All three groups commented on the stigma of referring patients to a psychiatric institution where the psychologists were situated. This psychiatric institution offers free services and many of the

patients referred are unable to afford private practitioners. However, only limited amounts of people are assisted due to resources, which results in long waiting lists. Many people are also afraid that by going to the institution for psychological assistance, suggests that they are mentally ill. This is one of the reason why the nurses and social workers believe that having a psychologist as part of their team, or attending the clinics more regularly, may eliminate the fear of this stigma.

4.5 Inter-professional Relations

4.5.1 Social workers

Health care teams:

Some of the individuals work as part of a multi-disciplinary team and others work with people within their organisation and within their profession related groups. Those who work within their profession-related teams seem to be quite isolated from other professionals, thus having to refer externally, which makes it difficult for them to follow up on patients. However, when they work within their own teams, they appear quite efficient, as they know what each team member is capable of and what their individual expertise is. Those that are in multi-disciplinary teams experience some difficulty in that they sometimes have to 'educate' others on their role, as well as having to negotiate the hierarchy they find themselves experiencing. These points are reflected in the following statements:

"I have very much a team in the hospital and then I see myself as a team with the other social workers in this area, and that's another team. The social worker one, and then I work in a multi-disciplinary team with the doctors, the nursing staff, the OT's, the physiotherapists, the radiographers and the pharmacist. So I've got two settings, you know and I try to bring the two groups [together]".

"At FAMSA we see ourselves as a team. We're not a multi-disciplinary team in that we're all doing similar things. We have different levels. We've got development workers who are the life skills facilitators, we've got auxiliary workers, we've got social workers. But we're working as a team there."

"We work also with the Department of Social Development, with FAMSA and any you know social workers forum, with the Magistrates Court and also with social workers within Child Welfare".

Overworked:

Social workers have vast amounts of cases to deal with as they work in a variety of settings. They deal with many destitute people and have to labour through red tape in order to get things done.

Their work is often tiresome and in many cases thankless and disheartening. They deal with people at a grass roots level and are involved with things such as, the increase in unemployment and therefore poverty, domestic violence, child and women abuse, and substance abuse. The following comments reflect their workloads:

“I work very closely with all sorts of problems, social problems, abused children, suicidal attempts and counselling and assessment of suicidal attempts and any social problem that the doctor picks up during his medical examination – that is social related. So to make his work easier the case gets referred to me, and I take it further from there”.

“We look after children between zero and thirteen. All have caseloads say up to two, three hundred, and you know because there’s so much to do, you can forget”.

Hierarchies and challenges for recognition:

There seems that within the multi-disciplinary team, the social workers experience some kind of hierarchy that creates a need in them to ‘fight’ for their profession, their status, and need within the team. This experience was noted with one of the social workers that worked as part of a multi-disciplinary team in a hospital context.

Hierarchy:

The hierarchy experienced is summed up in the following statements:

“Ja, when you say doctor its up there and you can’t oppose a doctor. They know everything, even if they don’t sometimes”.

“Meanwhile sometimes if I have to go to a doctor, ‘how do I approach this one?’, because there is always this thing that they are high up there”.

Challenges for recognition:

The experience of being on a lower rung of the hierarchy ladder resulted in a need for recognition, which was indicated in the following comments:

“Social work is secondary. When you talk about a hospital, people always think about doctors and nurses – there’s a tendency sometimes where especially the people who are supposed to be in a hospital is a doctor, they tend to want to prescribe and they tend to think that they know what you are supposed to be doing as a social worker. Now as a social worker you have to put the whole team into perspective as to what is your role there”.

“So those are the difficulties sometimes that one finds herself in having to fight for one’s profession so that they can also see that it’s needed. Without it as much as the other professions – I mean the patient won’t be serviced as a whole’.

4.5.2 Nurses

Health care teams:

Nurses seem to work mainly within their profession-related groups as well as relying on community health workers and volunteers. The community health workers are extremely valued as they take some pressure off the nurses, by talking to the patients about health issues and by following up on patients who have defaulted on their TB treatment. Other professionals such as doctors, psychologists and dentists come to the clinic on a weekly or monthly basis. The above is reflected in the following statements:

“At the maximum security unit we worked as a health care team but in the primary health care setting, sort of you were almost on your own, but you could refer but there was no close contact between us as a team. Each one was treating the patient differently, and you didn’t know what the other one based their decisions on”.

“Can also include the doctor, because we’ve got days where the doctor and the psychologist come to the clinic. We also have an oral hygienist that comes once a month”.

The nurses in the clinics seem to have a lot more responsibility and have to at times perform multiple roles that they are not trained to do. One statements sums this up:

“But now I can really appreciate the fact that I was on my own because in primary health care you learn through trial and error and you develop such a skill on a lot of things. You had to be a social worker at times, a psychologist, a pharmacist – you just play a lot of roles at the same time without you knowing it, and at times you get it right. But here the fact was that you sort of learnt from other disciplines”.

Overworked:

Although the above comment from one of the nurses showed that working at multiple roles was beneficial to her learning, this was only acknowledged with hindsight after she no longer worked in the clinics, as was indicated in the following comment:

“Frustrating. Having to be the jack-of-all-trades, I mean really we have not been trained to be pharmacists, to be psychologists, to be social workers. At times you really ask yourself, did I make the right decision? Did I say the right things to this person? Sort of at times you are left with a guilt, ‘Did I do the right thing? Could I have referred this person?’ But you know that if I do refer I would never get feedback, or the patient does not want to be referred. So those were the situations when you felt very helpless”.

Nurses are also faced with many difficulties due to the type of illnesses that they deal with. The nursing profession was dealt a knock with HIV/AIDS, as they were not trained to deal with people who were going to die. Before, this was left with the Hospice nurses but with the ever-increasing number of people that are HIV+ in the communities, this is falling to the clinic nurses as well. The enormity of the situation is apparent in the following statement:

“At the primary health care there was a time that I could not cope with the workload and especially HIV/AIDS. The patients were coming in and out of the clinic, they were really sick, and having to take blood, to do counselling. And it’s not only the patient, it’s the family, you know. Nursing never prepared us, you know. Those that were trained a long time ago, that we have to take care of the family. And we were never trained to take care of people who are going to die. We are used to making sure that somebody gets well, and now all of a sudden we are nursing people who are dying. It was a lot of strain on me and I couldn’t handle the patients too, because you had to have time and the skills now to sit and talk to them”.

Hierarchies:

The nurses did not seem particularly confident of their value in relation to other health professionals, and seemed surprised when they became aware of their own worth in the team. The following statement reflects this position:

“And I realised that the nurse is an important part of the health team, other disciplines really depended on you. You are the one to give the report because you are with the patient 24 hours. The team really respected me”.

4.5.3 Doctors

Health care teams:

Some of the individuals work as part of multi-disciplinary teams and others work with people within their profession related groups. Those who work within their profession-related teams seem to be quite isolated from other professionals, thus having to refer externally, which makes it difficult to then follow up on patients. What is also apparent is that although they are working as part of a multi-disciplinary team, they do not necessarily have sufficient contact with each other, in order for true group-work effectiveness. The above is reflected in the following statements:

“I definitely work as part of a clinical team at FEH. I’m with a social worker, a clinical psychologist, and a specialist psychiatrist consultant and also the OT and especially the nursing staff. And it’s also quite a lot of training, so there are intern psychologists and medical students as well”.

“We also the GP’s work as a team. It’s less structured in that we don’t have boards and that but there are systems”.

“In general the team that I work with at Settlers, basically consists of nurses, social workers and then the other doctors. I don’t think we really work as part of a team, there’s no coming together as such, of the group, and actual discussion”.

Overworked:

Doctors have sizeable patient loads, which do not afford them time for themselves, nor the ability to follow-up on patients, as reflected in the following comments:

“I must say we do get stuck, I’ve got so much to do. I’m getting home late, work through lunch there’s too many patients to see each of them. It’s just a nightmare to be able to get information out, so a lot of the time you do, you just leave them and carry on with your regular work”.

“I’m working at Settlers Hospital and basically everyone presents there with – it’s the first point of contact with the health services in Grahamstown”.

Relations between Doctors and Clinical Psychologists:

There seems to be a lack of tolerance and flexibility between the professions, which was indicated in the following comments:

“I think one of the things as well though, is mutual tolerance and that type of thing. I mean there have been a lot of clinical intern psychologists in the last 5 years and some of them have an unbelievably negative attitude that they have to fix the patient after the doctor has seen them because the doctor has stuffed them up psychologically – that type of thing is, I find a bit of a problem”.

“But I have noticed, which surprised me I think – particularly about *confidentiality*, whatever happens between them and the patient is a confidentiality issue and they don’t even report back to us which coming from the doctors of the medical profession we tend to respect confidentiality”.

4.5.4 Discussion

The data revealed that some of the health professionals work in multi-disciplinary teams and that others work within their own professional groups. What is evident is that those working within their own disciplines are more effective in their work. This may be because they are aware of each other’s roles and there is no confusion as to who should be doing what. For those working in multi-disciplinary teams it is evident that there is often no ‘real’ teamwork. Although there are multiple professionals assisting a single patient, there is not always communication between them.

Many of the health professionals working in Government institutions and primary health care are enormously overburdened. They have to attend to vast amounts of patients in a short period of time. This seems to not allow them the opportunity to discuss with other professionals specific cases or problems and each professional may write out a referral for the patient to be seen by another professional, and their hope is that the patient follows this up. What is also difficult is that the patients are not always seen by the same health professional and so as one professional said, “the patients then get lost in the system”. This is quite an overwhelming problem in the health care in developing countries, which the government is seemingly trying to alleviate with the initiation of community service.

The question is, is how can understanding and knowledge of the different members of the health care team be improved if there is such a lack of time? Lowe and Herranen (cited in Miller & Swartz, 1990) state that “teamwork can only occur when it is supported by the environment in which it exists and that the concept of teamwork must be understood and practised in order to fulfil its potential” (p. 51). Bruce (1980) said that teamwork does not occur automatically, but rather through a gradual process of frequent communication, a better understanding of each other’s roles and loss of stereotypes. This becomes a difficult task when one looks at the community service implementation. Health professionals and specifically clinical psychologists will be entering a context and a team for a one-year period. It is difficult to expect the permanent staff at these differing contexts to adjust to a new professional group, with different personalities and training, every year.

The hierarchical structure experienced by nurses and social workers and the seemingly lack of tolerance between clinical psychologists and doctors, may make teamwork an even more difficult concept to achieve. Both nurses and social workers experienced having less authority and confidence in their respective teams. The social workers felt that they had to fight for their profession and educate others on their role. They also experienced doctors as being above them and having to submit to the doctor’s knowledge. This is consistent with the study conducted by Peck and Norman (1999) that found that social workers needed to defend their positions or compromise in a manner that threatened to undermine the social work culture.

The nurses in the current research seemed surprised to find that they were an important part of the health care team in giving feedback on the patient. This is congruent with the lower status of nurses and their subservience to doctor’s more specialist knowledge (Petersen, 1999). However,

nurses seem to have counteracted this with them having a high status in the community and within the profession themselves. There also seems to be an embedded hierarchy within the nursing culture, which may have risen out of the low status amongst other health professionals.

The conflict doctors experience with clinical psychologists may be explained in a number of ways. Psychology and medicine both have a healing component to them. Doctors give patients medication and within a few days or weeks their symptoms tend to be alleviated. In psychology there are no guarantees, and usually the patient will get 'worse' before they get 'better'. This may evoke frustration in doctors who may perceive that the psychological interventions as not working when they are called out at '3am' to assist in crises and this may affect their confidence in the profession.

In their education many doctors did not acquire much knowledge of psychology, which may have limited their understanding of the profession. It is possible that because doctors are socialised into assuming management and leadership roles with complete responsibility for patient care (Macnamara, cited in Miller & Swartz), they are perturbed when faced with a profession that may have a more intricate understanding of the patient.

Doctors are used to knowing everything about the patient and the psychologists' patient confidentiality is not appreciated, as they feel excluded and not trusted. This may have the effect of poor interpersonal relations, as there is a perception of mistrust. This, coupled with limited knowledge may result in a lack of faith in the profession and therefore a low rate of referrals for patients who may need psychological assistance. Generally, it appears that doctors do not have a very positive perception and confidence in psychologists, which is a concern as it was noted that they are often the gatekeepers to psychological assistance. This however, may be resolved through increased communication, tolerance, and flexibility from both sides.

4.6 Community Issues

4.6.1 Social Workers

Culture:

The data revealed that even though it was felt that psychologists were currently more aware of cultural issues, such as culture-bound syndromes, clients would rather see someone who was of

the same culture as them who might have considerably better understanding of them. This was reflected in the following comments:

“So if maybe they could choose, these people who are deep into culture and all that, they would prefer to go to one of their own culture who they think will understand them”.

“It was very difficult for psychologists to help the people from other cultures who believe in those things, while now, if I come to you and tell you about ukuthwasa you will know what is going on, and you will know if I am really twasing or schizophrenic or anything”.

Language:

The social workers felt that working through a translator may result in an inadequate understanding of the patient as many words and phrases could not be translated into English. As a result of this they would generally choose not to refer a client to an English-speaking psychologist but rather help the person themselves, as they could communicate directly with the patient. The following statements reflected this:

“The terms that Xhosa speaking people use sometimes – they tend to have a different meaning in English and it’s easy to misinterpret what the other person is saying”.

“We don’t just refer. Sometimes we decided that, Z has decided on occasions this is a little bit out of my depth, but she would not cope with English so I will support her and stay with it”.

Community awareness and the impact on attendance:

The data revealed that there is a need for education about psychologists in the community as the public seems to believe the myth that psychologists only deal with psychiatric patients. This belief has an impact on attendance and the social workers refute the myth by giving them explanations of why they are being referred, what to expect, and listening to their feelings about the referral.

Awareness:

The social workers felt that community members are not aware of the role that psychologists could play in their lives and they felt that increased knowledge of psychology could result in assisting many more people. This lack of knowledge also seems to impact on what is thought to be best for them. The above are reflected in the following comments:

“If you go to a psychologist that means you must be mad”.

“People would be sort of enlightened as to the fact that there are other people, I mean who can help them. I think we wouldn’t be having so many people taking their lives unnecessarily, especially the young kids”.

“What we think the clients need they don’t think they need”.

Attendance:

The awareness and knowledge of the psychology profession was thought to impact on the individuals’ attendance at the psychologist. It was believed that a thorough explanation of what a psychologist does and what they should expect from the psychologist, would assist in their attendance at the psychologist. This was reflected in the following statements:

“Because if the client doesn’t understand, the chances are he or she might not go there”.

“It’s important for a person to know when she is going and why she is going there”.

“It’s also important to hear the feelings of the client about the referral”.

“But you’ve got to explain to them – the client, what you are going to get and why it’s necessary’.

4.6.2 Nurses

Culture:

The nurses felt that culture plays a role when someone who does not belong to the same cultural group is attending the patient. This may affect the patients’ honesty in the session, as they would not want the psychologist to think they are ‘mad’ when presenting with culture-specific problems. The following statement sums this up:

“Culture does play a part, especially now when the patient is being seen by a psychologist and then you realise at times that this according to us is normal, but for you to tell a psychologist that according to our culture, this is accepted. What he or she is saying is not a sign of mental illness, it is normal in our culture”.

What is also interesting is that within the Black culture there are many sub-cultures, which are not understood by all Black people, as indicated by the following comments:

“For someone to learn the details of it because even with us, in our culture it’s very different. I am shocked at times by what people say. Then when one has gone I start asking ‘is it really true that this is what happens with other clans?’ then they say, ‘no it’s normal, there’s nothing wrong with that’. It shocks us, how much more with somebody else”.

“With us Blacks, we are divided in clans and each clan has got its own sub-culture. Then we differ also within our culture”.

Language:

Language is a complication when it comes to working in communities. Psychologists tend to use translators, who are generally the nurses, when working with the patients, whether it is testing or counselling. What stands out the most is that the nurses felt that they could not accurately translate what the psychologist or the patient was saying. They also felt that the patient would not be forthright about their problems in front of them, as this would encroach on confidentiality issues. The other problem was that psychologists were taking away a nurse from their work in order to translate. The above issues were reflected in the following statements:

“But you could feel at times that the language – because I would not be able to say exactly what the patient is saying to the psychologist”.

“Nurses complain of workload, having to take one now where you are already overloaded and you are taking one of them to sit with the psychologist for plus minus an hour – it would be too much”.

“With the part of the language, the psychologist asks for help. Maybe some of the things the client would say, will not say in front of this person who is an interpreter”.

Although the above was a problem, the one clinic had their own solution to the problem and came up with ways to combat the confidentiality issues and to deal with the loss of a nurse who was translating. A long-term solution was also considered for this problem. This was reflected in the following comments:

“Language was the problem because at the times the patient couldn’t open up right in front of you, but we had a system in the clinic that, if I’m the one who thinks that I need to refer the patient to the psychologist, I must be the one to interpret because the patient at least trusts me, so we sort of solved the problem with language”.

“The long-term solution is to make Black pupils interested in studying clinical psychology”.

Community awareness and the impact on attendance:

The data revealed that there was generally a lack of understanding of the role of clinical psychologists. It was also felt that the community that the nurses worked with had a lot of faith in doctors and Sangomas who were able to tell the patients what was wrong with them rather than being asked what they are struggling with, which is what a psychologist tends to do. As a result of this, the nurses appear to give detailed explanations of what a psychologist does in order to ensure their attendance.

Awareness:

The data revealed that there is inadequate understanding and false impressions of what psychologists do. What is also interesting is that the patients would like psychologists to be like doctors and Sangomas, who tell the patient what is wrong with them rather than being asked what is wrong. They appear to have more confidence in those who are able to tell them what is wrong. The above are highlighted in the following comments:

“They get very pleased for being told what’s wrong with them without being asked much questions. That goes back to the Sangoma thing. The Sangoma tells you what’s wrong, why you are visiting, so with the doctors as well”.

“It’s normal with social work, but with psychology – no it has to do with the person being mentally ill. But that’s how us nurses and the patients take psychology to be all about”.

“You have to explain what it is that is going to happen when he gets there. Because they don’t know, but they think it’s something to do with their minds. He or she is reading their mind and he thinks they are crazy”.

“Then they will say, ‘but I was always talking. The psychologist does nothing because I have done all the talk. She has done nothing to me’”.

Attendance:

What was evident when listening to the nurses, is the amount of explanations they give to patients when referring them to a psychologist. It seems that because of the lack of awareness of psychology and the ‘mental illness’ stigma, they try to give a step-by-step explanation for the reason for referral to ensure the patients attendance. The above are reflected in the following comments:

“Even with the patients you have to explain when you refer them to psychologists. I am not referring you to a psychiatrist, this is a psychologist. You will not get medication from her or him, but she may refer you to the psychiatrist who will give you medication”.

“Then I explain to the person what is a psychologist and then they are grateful, because some of them – it’s the first time they hear about a psychologist. Then they are very grateful”.

“I say that we are referring you to someone who is specially trained to attend, to help you with your problem. This will also make your body feel better too because I’m not trained to do that type of work”.

What made an impression during the data collection was the term “doctor of worries”. Some of the nurses use this term to explain to the patients about psychologists. Firstly it seems to take the stigma of mental illness away and secondly it seems that ‘doctor’ gives the patients some kind of

assurance that we can help them because that's what doctor's do, they cure their ailments. One statement summed this up:

“It was difficult even to then explain to the patient what is a psychologist and then people used to laugh because I even said that it's a doctor who is going to deal with the worries that you have. I cannot help with tablets. Then at least the client understands – when she comes she says, ‘I've come to that doctor of worries’”.

4.6.3 Doctors

Culture:

One of the doctors noted that within the Black culture 'talking' is done differently than what psychologists are trained to do and that this might impact on the therapeutic process. The following statement sums this up:

“I think there is a methodology with Western psychology that leaves a huge gap for the Black person to jump over – to be able to actually say what is wrong with them. I suspect that part of it is because the psychologist is trained to try and get out of you what is the problem, whereas I think within the conventional African counselling situation is that you begin by going .. ahhh ... you know what I mean, and then starting the whole thing yourself and in a conversational kind of way and I also think the language actually probably does become a barrier and the culture and everything else’.

Language:

Language was noted to be a problem as there were not many psychologists, training or private, in Grahamstown that were able to speak a Black language, therefore limiting their referral options. This was reflected in the following statements:

“The majority of patients that I refer to a psychologist are either White or Coloured because of the language basically. I think part of the problem – even if you could understand the language in a non-Afrikaans or English speaking patient, there aren't people that could speak to them in that language. At Fort England there are very few. I'm talking about Fort England, and in fact psychology in general”.

Community awareness and the impact on attendance:

The data revealed that the patients' have limited understanding of psychology and the role it could play in their lives. The doctors stated that many of the patients do not attend the psychology sessions and return some time later with the same complaints.

Awareness:

The doctors felt that there was a limited understanding of the role of psychology and that many are not aware of its availability to their communities. It was also felt that patients would agree to see the psychologist but would then not attend their appointments. The following statements indicated this:

“The majority of the patients have no idea what psychology is there for and what they can gain from it, so most of them don’t go to their appointments that we make for them at all - they just don’t realise what the benefits would be”.

“I think that in many communities they don’t know enough about it as a service that’s available”.

Attendance:

It was believed that the lack of attendance might be due to the psychiatric stigma attached to psychology as well as ignorance of the psychology profession. This was reflected in the following statements:

“Might not want to see the psychologist because of the stigma attached to having a psychological problem”.

“I usually in fact offer it to them and most of them agree it’s not a problem, they’ll go, but the vast majority of them don’t. And then in a few weeks time they’ll pitch up again with the same problem. You ask if they saw the psychologist, and there’ll be a reason why they didn’t go”.

4.6.4 Discussion

Many issues arise under this category. The majority of clinical psychologists are white English-speaking individuals who are entering deprived and impoverished communities that contain a different racial background, a different language, a host of cultural norms and practices, which are for the most part foreign to the psychologist. These differences not only make it difficult for the psychologists to be effective in their work, but also complicated for the referring agents as they do not have adequate referral resources for their patients.

The long-term solutions to relieving the above difficulties may involve encouraging young Black students to enter the psychology profession, however, this does not alleviate the current situation. What seems to be of current importance is that psychologists are continuously aware of the cultural differences and read and enquire before making assumptions, which may be harmful. What is useful to psychologists is the chapter on Culture-Bound syndromes included in the DSM-

IV (APA, 1994). Although this chapter consists of broad categories, there appears to be an effort to be more sensitive to various cultures.

Language is an immense obstacle both for the psychologist, the patient and the translator to overcome. The basis of psychology is talking and being able to understand the patient and the problems presented. When the psychologist is unable to understand the psychologist, this hinders the therapeutic process. These factors correspond to those of Raval and Smith (2003) who found that working with translators affects the communication process.

Acting as a translator when one is not trained to do so, as the nurses are frequently requested to do, puts them in a compromising position. Firstly, they are taken away from their own valuable work, secondly, they are out in a position to translate words that cannot always be explained in English, thirdly, the patient may not feel comfortable speaking in front of the nurse due to confidentiality reasons. What is also difficult is when the nurse is not psychiatrically trained and does not understand the terminology being asked by the psychologist. There does not seem to be an easy solution to these problems. However, what may be suggested is that the psychologists' and nurses reach some kind of compromise, which would require effective communication. The psychologists should also take into the account the probable limited psychological knowledge of the nurse and therefore she/he should be briefed before each patient is seen. Debriefing the nurse after the session should also be done as the nurses hold a lot of the emotions released by the patient. These tentative suggestions may result in better patient care and enriched relations between nurses and psychologists.

Patients' understanding of psychology, as well as the referring health professional's own understanding and perceptions, can have an impact on the patients' attendance. It is suggested that if the referring professional has limited knowledge of psychology then the patient will not be given an adequate explanation of what to expect.

The limited public health education may account for the publics' lack of knowledge and misconceptions of psychology. The most common myth is that "if you go to a psychologist that means you must be mad". This myth correlates with Hollingshead and Redlich (cited in Bostock, 1998) who stated that the stigma associated with mental illness and incarceration is an important reason why patients may not seek help from psychologists. This may also account for patients who agree with the health professional on the referral, but then do not go to the psychologist.

Doctors referring patients to psychologists may produce another reason for the patient's non-attendance. Many patients assume that 'doctor knows best' and so when the doctor cannot assist them, this may result in despair as the doctor is referring them to someone who is not necessarily a 'doctor' and to a profession that is stigmatised. They may fear that the doctor thinks they are 'mad'. It may be this fear as well as the despair of the doctor, 'who knows best', not being able to help them that may result in their non-attendance. The perception of 'doctor knows best' is especially significant when compared to the concept raised by the nurses of the 'doctor of worries'. This concept firstly, seemed to diminish the stigma of mental illness from the word 'psychologist' and may have given the patients the reassurance that if they were going to be seen by a doctor, then they would be helped.

Many patients' who do attend the sessions usually do not go for their follow-up appointments. The following is suggested to account for this. Patients' are used to going to doctors who examine them and ask specific questions about symptoms and duration, and who then give them medication that relieves their complaints. When patients go to psychologists they talk, but with the process of therapy or counselling it is a different kind of 'talking'. However this does not seem to be entirely understood with health professionals in general, let alone the public. They do not understand how the 'talking' is important and when asked why they did not go back, some say it was because they did not know it was important. This validates the importance of mental health education and especially education of what to expect from psychological interventions.

In summary:

The data yielded five main categories with a number of sub-categories. These categories and sub-categories were then interpreted under the headings of social workers, nurses and doctors. Each main category was then concluded with a discussion tying together the findings for all three groups by focusing on overlaps and difference between the groups as well as suggesting a number of possibilities for the findings.

Chapter 5: CONCLUSION

5.1 Reflections on the study

This study was an investigation into health professionals' perception of the role and function of clinical psychologists. The researcher drew on available literature on the topic in order to be familiar with the research area. This was an arduous process as there was not much literature on the research topic, especially in South African literature. The grounded theory approach was utilised to process and analyse the data from three focus groups and three in-depth interviews. Insights into the data were then formulated into an integrative diagram, and discussed by drawing on the relevant literature.

The study revealed the importance of 'knowing' and 'not knowing' and how this affects; (a) perceptions of clinical psychologists; (b) the perceived 'usefulness' of clinical psychology and clinical psychologists; (c) referrals made and not made to clinical psychologists; (d) inter-professionals relationships and (d) community awareness of the role and function of clinical psychologists. What is significant about the findings is the potential power that the other health professionals have as gatekeepers between the general public and clinical psychologists, since psychology is seldom the first port of call.

5.2 Contributions of the study

The transformation of PHC in South Africa and the advent of community service has had and will for some time have, an enormous effect on health professionals. These changes in health care seem to indicate a need for a modification in the current educational curriculum to accommodate the health care changes. A number of debates concerning this have already arisen within medicine and psychology, and finding an adequate solution may not be easy. What does seem significant however is the perception of each health profession involved in this transformation and how they can adapt their knowledge in a manner that can help them to conduct their work to the best of their ability.

These changes do not only affect the individual health professional but the health care teams that they work in. Many authors cited above, stated that for effective teamwork to occur, health professionals needed to have a solid understanding of their own profession and role, and an adequate understanding of the function of other team members. In this changing context it is difficult for both to take place. The current study highlights the important need for education

about psychology, as knowledge affects referrals, inter-professional relationships, patient awareness, and the 'usefulness' of the profession. It is proposed that the necessity for education becomes a two-way process. The need for constant communication between professionals cannot be stressed enough to assist in the process of personal and professional adjustment. Tolerance, understanding and openness between professionals can go a long way to creating healthy working relationships and providing communities with health care that is holistic and professional.

5.3 Strengths and limitations of the study

Cresswell (1998) stated that in order to undertake qualitative research, "the researcher must invest a strong commitment to study a problem, which demands a lot of time and resources" (p. 16). As a clinical psychology masters student under time pressure to complete the research in order to commence compulsory community service, time and resources were lacking to produce the kind of study that Cresswell spoke about. However, it is believed that this small study was able to contribute to a body of knowledge. The scarce literature available on the research field indicates that there is a lot of scope for study in this area. The current study was a small study that used a small sample and therefore the results cannot be generalised to the wider population. However, it is hoped that this study provides a basis for further larger studies to be initiated.

The data collection process was a difficult hurdle to overcome. The low numbers in the focus groups resulted from participants not arriving and cancelling at the last minute. The focus group literature suggests that the researcher should recruit extra participants in order to combat these problems. The researcher was unable to do this due to a number of factors and thus had lower numbers than expected. However, it is believed that valuable data was collected from these groups and it seemed that the smaller groups assisted the participants in relaxing and contributing in the discussion. The smaller groups also assisted the researcher who had not run a focus group before. The smaller group was easier to manage and thus everyone had a chance to participate.

There are a number of factors that may have contributed to the participants not arriving for the focus groups. Firstly, many organisations are short-staffed and may realise that they could not afford to lose a worker for the morning. Secondly, the participants have been included in numerous studies and may feel that they are always giving and not getting anything in return. In the current study it was gratifying to hear some of the participants say that they had learnt something new at the end of the focus groups, and that it was enjoyable to get together with their co-workers as they usually do not have time to see each other.

5.4 Suggestions for further research

There are many areas within which this study could be continued. This was a very small exploratory study and it is suggested that a larger more extensive study could be conducted in order to be able to generalise the results. A similar study looking at health professionals' perceptions of each other could be useful for understanding inter-professional relations. A study looking at permanent staffs' experiences of working with community service professionals as part of health care teams and the dynamics that exist in these teams could be explored. There are many studies that could be conducted and it is hoped that the current study may inspire other researchers to pursue these questions in greater depth.

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