

**A TALE OF TWO COMMUNITY HEALTH FACILITIES: EXPLORING  
DIFFERENCES**

by

**NSIZWA ROBERT JONATHAN MOLEFE**

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**SUPERVISOR: PROF. STANLEY LIFSCHITZ**

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## SUMMARY

This study looks at two community mental health facilities. The one setting is that of a state aided organisation, while the other is a non-government organisation (NGO). These two settings are contrasted in terms of how they conceptualise the concept 'community', their physical settings and facilities, and the activities and processes at each setting.

The differences in the day-to-day operational processes, and activities according to their respective philosophies - psychiatric medical model and ecological model - are explored and captured from the participants through utilising qualitative data gathering methods such as interviews, observations and the personal experiences of the researcher. The information obtained from each participant in both settings reflect how they think, feel and behave towards their work. This information contributes to an understanding of how community mental health clinics operate. Finally the recommendations are of how work could be done differently, making them both more community orientated.

### Key Terms

Conceptualising Community

Community mental health clinics

Physical settings in community clinics

Psychiatric medical model

Ecological model

Community ideology

Co-creating a community

Community processes and activities

Qualitative research

Service providers in community clinics

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## CHAPTER 1

### THE BEGINNING AND THE END

#### Introduction

People may break down if the going gets tough enough. When conditions of overwhelming adjustive demands and challenges occur, even a previously stable individual may develop transient psychological problems (Carson, Butcher and Mineka, 1996). The numerous and overwhelming challenges that people face as they go about their daily lives, range from unemployment, poverty, domestic violence, abuse of substances particularly alcohol and physical abuse. There are also the continuous changes in the social, economic, environmental and political landscape which may affect the psychological well-being or mental health of people.

These challenges undoubtedly take their toll, in more ways than one, on human beings. The area of individual functioning that is most vulnerable is the mental health (Bannister, 1983). Mental health is a component of the health system that focuses on the psychological well-being of community members. It arises from the problems in living which are rooted in complex social, environmental and psychological factors (Heller, 1989). As people endeavours to meet all the challenges and demands of daily living they soon realise that their energy levels have limitations and that they can only cope with a certain quantity of demands on a daily basis. These demands of life can lead to stress.

According to Carson et al. (1996) the term stress has typically been used to refer both to

the adjustive demands placed on an individual and to the individual's internal biological and psychological responses to such demands. The adjustive demands of life should not be thought of as only negative. All situations, positive and negative, that require adjustment can be stressful.

Although people's mental health or psychological well-being is most likely to be affected (Bannister, 1983) by the pressures, demands and challenges of living, it tends to receive less attention. The issues of life such as divorce, death of family member or partner, unemployment, rape, and other traumatic experiences tend to be regarded as less important than the biological factors in causing ill health (Bannister, 1983). This is evidenced by the skewed provision of health services which are biased towards primary (physical) or medical health. Primary health care normally receives better and larger financial budgets and allocation which surpasses those allocated to the mental health sector (Bannister, 1983).

In almost all communities in South Africa, whether rural, semi-rural or urban, there is provision of primary health services. This provision can be in terms of permanent buildings or temporary structures, or even mobile facilities. Yet it is a known fact that the mental health services do not enjoy equal provision in the community with their counterparts, primary health care (Gauteng, Department of Health Policy Guideline, 1995). The unequal provision to these two sectors of health will remain a thorny issue to health authorities for some time to come. Bannister (1983) argues that this unequalness in sector provision is partly due to the superior status that the primary health care or the medical health approach enjoys.

It is documented in Department of Health Policy Guideline (1995) that in South Africa, due to low and insufficient state funding, the mental health services in the past were sparsely

distributed. The few state-run mental health clinics did not have sufficient human and material resources. As a consequence various independent groups in the form of non-government organisations (NGO) entered the field of mental health services provision to complement the shortfall resulting from insufficient state provision.

Up to this day, and unlike their counterparts, the non-government community mental health centres do not receive any funding at all from the state. They do not have well equipped facilities but nevertheless help to redress the backlog of community mental health services, and contribute to the lives of many communities.

The legacy of the past imbalances in health care budgetary provision between primary health and mental health has thus resulted in further inequality or discrimination in terms of resources within the mental health sector, between the state-run and the non-government run mental health clinics. The two streams of providing mental health services have resulted in each stream evolving its own ways of doing, conceptualising, structures and procedures. The core aim of this study is to explore one context of community mental health services from each stream - one state-run and one NGO - to discover in which salient aspects they differ.

### Motivation of the Study

The motivation for this study is informed by the researcher's involvement and work experience within both the government and non-government community mental health services agencies. The researcher first worked at Agape Healing Community, which is a non-government community mental health centre. It does not receive any funding from the state. He worked there

as a student therapist for two years to fulfil the practical requirements for a masters degree in clinical psychology with Unisa.

He then worked at Community Psychiatric Clinics or Community Mental Health Clinics. These clinics are state run and therefore receive all financial assistance from the state. The researcher worked at these clinics during his internship towards professional registration as a psychologist.

The researcher's involvement and hands-on experience in these two contexts of community mental health services exposed him to the differences and contrasts between these settings. The differences were not limited to the financial assistance received or not received from the state. But these differences permeate almost every aspect of the work done as well as the thinking in each context. Therefore the researcher was motivated to explore the nature and extent of differences.

The dimensions of the differences are reflected by the differences in physical settings, conception of community, employees or professionals, as well as the processes and procedures in the clinical work done in each context. The researcher wondered if each unique setting does not influence the patterns and processes of working. He was thus ultimately motivated to inquire more in order to increase his understanding of the nature, dynamics and experiences of people, structures and processes within these two contexts of community mental health.

In this dissertation the researcher will give his experiences in and reflections on the two contexts. He will first describe his initial reactions to and expectations about each setting. These

are the experiences which underpin his resultant motivation to undertake the study.

### The Beginning: Reactions and Expectations at the Agape Healing Community

The researcher hopes to journey back in a meaningful way and revisit the events and experiences that led him to undertake the current study. He will reflect on how he punctuated sequences of experiences, aware of the many ways in which the story could have been told. Clearly, this is one version. It is the version that he finds most useful.

The group that the researcher became part of after selection into the MA clinical psychology programme at the University of South Africa was to do its practical training over two years at Agape Healing Community in Mamelodi. Mamelodi is a township east of Pretoria. The supervisor requested the group to visit Agape for the first time on one Wednesday, for introduction and orientation prior to the start of the training in the new year. The group made the arrangements, met in Johannesburg, and arrived safely an hour later with the help of a route map given by the supervisor.

Agape is located in a yard with a big hall surrounded by big blue gum trees dispersed all over the yard. Towards the centre of this yard is a huge gum tree under which many people sat in groups, some big and others small. The place was just busy with people who seemed engaged in some small community projects or self-help schemes of some kind under the tree. The hall is not part of Agape as it belongs to the YMCA. The YMCA is a youth movement that caters for the needs of local youth in areas where possible. It appeared that most activities of Agape took place

under a tree. This place seemed to be a very strange community resource centre with no apparent structure, buildings and proper facilities.

On arrival the researcher felt disappointed that this place with a funny name did not meet his expectations of a proper clinic. He reacted with shock and dismay. How could Unisa hope to train first-world and first-class psychologists in a milieu that appeared so disadvantaged. Agape with its glaring lack of proper buildings, facilities and resources led to a dis-empowering feeling within the researcher.

The researcher wanted a first-world placement boosted with proper facilities for first-world training, such as one-way mirrors and other observational tools. He wanted to be in a placement compatible with technological advancement, and reflecting the latest training trends in computerised psychological assessments. Instantly he felt that he did not want to be there. He felt betrayed by Unisa's selection panel as well as the supervisor because this was not the kind of clinic he bargained for when he subjected himself to the gruelling selection process.

From that moment onwards the struggle began for the researcher. The struggle was about bringing himself to terms with this 'clinic'. He yearned for a proper clinic. In the new year the struggle continued unabated when he began to do a therapy with clients under the tree without any of the first world facilities that normally characterise a Western therapeutic context. However, with time he learned that the work done at Agape was about healing, and that healing was not limited to space or time boundaries. According to Lifschitz and Oosthuizen (2001) healing occurs when people find a safe place where they can share their difficulties and problems of life.

He learned that Agape was a place where everybody brought their own issues and difficulties about life and felt safe about doing so. He learned that it was not a place only for clients to bring their difficulties, but that it was a safe place for all to deal with and face their difficulties. Gradually, he embraced Agape's ideology of healing and he also began to bring his own issues for attention. That brought about a fundamental shift in his view of things and understanding of community work. Consequently the yearning for a 'proper' clinic disappeared.

The researcher's yearning for a 'proper' clinic reflects his initial thinking, which reified the objective existence of things out there as having a true reality (Keeney, 1983). Keeney (1983) aptly states that what one sees will always be shaped by the world in which one is operating. The disappearance of the researcher's yearning of a 'proper' clinic is consistent with Keeney's (1983) assertion that to view an alternative world requires being in that world.

### The End: Reactions and Expectations at Community Mental Health Clinics

The two years at Agape passed so quickly. The researcher did not notice how the time flew and wished he could stay on and on. The researcher had to move on to some strange territory to complete his journey towards becoming a psychologist. The next move an internship of twelve months with an accredited institution. The Internship was split into two equal rotations of six months each. The researcher did the first six (6) months at Tara Moross Hospital in Johannesburg. He did the last six (6) months at the following Community Mental Health Clinics (CMHCs), namely Zola clinic in Soweto and Eaglemont clinic in Hillbrow.

The setting at both Tara and CMHCs were initially quite formal and very intimidating to the researcher. The formality was so thick that he could cut through it with a knife. There were well defined structure and rules. There were buildings and facilities. The atmosphere was very professional and methodical. Paradoxically, all the things that the researcher wanted initially at Agape and which were not provided, were available at both Tara and the CMHCs. There were offices which were fully furnished with tables, chairs, file cabinets, telephones, heater and furn. Furthermore the offices had equipment such as one-way mirrors, test batteries, computers, stationary and toys for play therapy.

Yet, there was a paradox. The paradox was about the pleasure working in an ideal physical working environment, and the discomfort about what 'community' meant here, the way things were done and how people thought about what they were doing. While the researcher thought that working in such settings would be ideal, things did not really turn out that way.

The material comfort of working here was not met by an equal desire to work here. This was due to the different ideologies, processes and practices from that of Agape. Thus the paradoxes, as well as the differences alluded to above, set in motion the drive and the yearning to undertake this study about two different contexts of community mental health service.

### Aim of the Study

The study focuses on both Agape and CMHCs since both settings are contexts that are physically located in geographical communities and offer help to non-hospitalised clients or patients.

Although the two contexts both provide psychotherapy, within their local communities, to people who are afflicted with psychological problems, the approaches are however different in terms of the thinking that informs each context as well as the reality within which each operates. Thus working at both Agape and the CMHCs has provided the fertile ground for the researcher to notice differences and contrasts.

The purpose of the study is to investigate differences and contrasts between the two contexts of community mental health services in terms of their conception of ‘community’ and their physical settings, and how the different conceptions of community and physical settings influence the processes, procedures and activities that respectively unfold in each context.

### A Guided Tour through the Study

It is now time for the researcher to act as a tour guide to lead the reader through the study that has been captured in six chapters. Well, since the study was undertaken for academic purposes the reader may have to follow the order set in this work if he or she hopes to re-create the path that the researcher followed.

The second chapter (2) consists mainly of a literature study. In this chapter the author provides the historical background to mental institutions and the factors which necessitated the transformation of mental institutions into community mental health centres or clinics. Then he also provides the two theoretical models upon which the community mental health clinics operate. In the same chapter he gives a short exposition of the current mental health situation in South Africa.

Chapter Three (3) reports on research. It captures the rationale of the study and also indicates the researcher's own epistemological standpoint about research and therapy. This epistemological viewpoint of the researcher is also captured in the type of methodology and research strategy selected. There are two levels of data collections used in this study. On the first level the contrasting settings which are captured in this chapter are described. These descriptions reflect the differences and contrasts between the two settings in terms of actual physical setting, processes and practices in doing therapy, as well as the activities that take place. Another salient issue captured by this chapter is the typical day at each of these two settings.

The discussion on the second level of data collections has been allocated to chapter four (4). This chapter mainly deals with the analysis of interviews. The analysis of interviews is preceded by the background to the interview procedure as well as the interview processes.

Chapter Five (5) presents the research findings. This chapter looks at what the process of data gathering has yielded. Firstly, there is comparative information of the two contexts in terms of their physical settings. There is table that captures and summarises the differences and contrasts between the two contexts of community psychotherapy services. Secondly, the chapter presents the findings of the analysis of interviews. This is done by way of identifying the common patterns and themes that emerge from the interviews.

Chapter 6 is the Discussion chapter. This chapter begins by reviewing the purpose and expectations of the study and then discusses whether the results are consistent with the researcher's expectations. The chapter also links the research findings with the literature study. The implications of the study are cited in this chapter. The chapter goes further to make

recommendations and also to look at the limitations of the study. Lastly, the chapter looks at the role of the researcher in the study.

## CHAPTER 2

### THE COMMUNITY MENTAL HEALTH CLINICS

#### Introduction

Mental health services come from an era when it was customary and normal to send people with mental health illnesses away from their communities to be treated in institutions. Hamber and Rock (1993) report that up to the period after the Industrial Revolution people afflicted with mental health problems have been treated in institutions as subhuman, without any regard of their human rights and dignity.

Furthermore Hamber and Rock (1993) claim that an examination of the past treatment of the mentally ill reveals a history marked by both state and personal abuse, and neglect of the rights of sufferers. The conditions and treatment in those institutions have since attracted much criticism. Hamber and Rock (1993) argue that instead of being places of care, treatment and rehabilitation institutions have, on a number of counts been found to be abusing their charges.

There is abundant literature evidence of the gross institutional abuse that the sufferers of mental illness were subjected to (Bennet & Morris, 1983; Goffman, 1961; Kanner, 1967, Morgan, 1993; Richter, 1984; ). This was despite the efforts and contributions that the institutions made to ameliorate the mental health suffering of people, through providing rehabilitation and formal care programmes .

The main criticism against mental institutions was that of providing care away from the communities from which the sufferers came (Gruenberg, 1966). Therefore mental institutions could not avoid criticisms levelled against them in favour of the much advocated for community mental health clinics. These clinics were to provide psychiatric and related services in the social and environmental context of the patients suffering from mental problems.

It is for this reason therefore that this chapter alludes to the historical background and reasons that led to the evolution of the community mental health model as the alternative mode of mental health service provision to people suffering from mental illness.

### Historical Background of Mental Health Services

It should be borne in mind that the concern of this chapter is to provide an adequate understanding of the historical development of mental health service provision from the era of asylums up to the era of community mental health services. To accomplish this task it therefore becomes necessary to understand the historical background that informed the evolution and nature of the community mental health services, the issues and events that led to their conception, the theoretical basis underpinning them as well as the practical requirements to be dealt with for the community mental health services to realise their stated goal.

The evolutionary path that led to the establishment of community mental health clinics began around the 1900s with mentally afflicted people who were incarcerated in institutions that were regarded as asylums that placed little or no value on the notion of care, treatment and rehabilitation (Goodwin, 1993).

The different nations of the world have had different ways of dealing with mentally ill people since the beginning of time. In the many different ways there was however (Goffman, 1961) a common trend that characterised the different preferred treatment modalities. This trend was the isolation and banishment of the afflicted from society and community into “total institutions”.

The mental institutions that became especially unpopular for their manner of treating people in desolate and forsaken places were the “total institutions”. This was because of their isolation and lack of any attempt whatsoever in rehabilitating the sufferers (Gruenberg, 1966). People who were afflicted with mental problems would be institutionalised much against their well-being. However, the notion of institutionalization gained much popularity as the preferred means of dealing with those that society labelled as “insane”.

Goffman (1961) asserts that the treatment which the “insane” were subjected to was carried out in less than humane ways and amounted to some kind of banishment and incarceration in “total institutions”. This kind of treatment was dehumanising in that people who suffered the misfortune of mental affliction - unlike their counterparts who presented with physical illness - were physically removed from their communities to remote and secluded institutions where they were left to rot without being provided with formal programmes of rehabilitation (Goffman, 1961; Gruenberg, 1966, Richter, 1984, Scull, 1981).

Goffman (1961) argues that the mental institutions before and around the 1900s were in a deplorable state. It was a question of human warehousing, which defeated the purpose of treatment and rehabilitation. There were many other voices that decried the growing abuses and

inefficiencies in the mental institutions perpetrated in the name of mental health (Cooper,1972; Goffman, 1963; Laing, 1967; Szasz, 1983).

These institutions that harboured the mentally afflicted without making any provision to rehabilitate them and ensure their speedy return to their communities, became human warehouses and were initially called asylums(Gruenberg,1966). The conditions to which mentally ill people were subjected in the asylums were challenged from around the 1900s by various organs of civil society. There was growing insistence that, at least, these institutions should provide for some care and rehabilitation programmes for the afflicted people, no matter how rudimentary this may be (Goodwin, 1993).

The years that followed after the 1900s saw the proliferation of policies that called for the transformation of institutions for the mentally ill. The policies focussed on the funding and provisioning of programmes within institutions that would emphasise care and treatment. Simultaneously there was improvement in medical sciences that brought with it the introduction of medical treatment intervention to mental health sufferers (Gruenberg,1966). It was upon the provision of some improvement of formal care, treatment and rehabilitation programmes that these institutions subsequently transformed into what became known as mental hospitals (Goodwin,1993).

The paradigm shift in mental health provision from isolated “total institution” or asylums that merely harboured patients, towards treatment oriented mental hospital was not only brought about by new policies, but was also accelerated by the medical advances in the treatment of mental illness (Gruenberg, 1966). However despite the new policies, medical advances and huge

funds that were allocated for the refurbishing of the “new” mental hospitals their patterns of working largely resembled those of “total institutions” (Goodwin, 1993).

Goodwin (1993) argues that the only change brought about by “new” mental institutions was a change of name. This made the “new” mental institutions attract much criticism like their predecessors, the “total institutions” or asylums. Furthermore, the fact that they still remained outside and far from the communities from which their patients came, they carried the stigma of confining their patients, and the perception of perpetuating the dehumanising conditions that patients were subjected to in the asylums.

It was this type of confinement, and the conditions at the mental hospitals that did not seem to yield any positive outcomes for the patients, which triggered the debate that eventually ushered in a move towards community provision of mental health or psychiatric services. It was argued that institutional care in mental hospitals not only did little to help the mentally ill but actually produced the opposite and negative effects, to the further detriment of the patients (Goffman, 1963; Morgan, 1993; Richter, 1984).

This gave impetus to the movement towards community mental health care, thus anticipating the demand that the services should be accessible to members of community without them having to be sent far away. It was believed that the establishment of the community mental health clinics would address and accelerate the process of bringing patients out of the “total institution” and treating them more proximally in their community. This was with the aim of improving people’s rights of self-determination and control over forces affecting them through improved opportunities in the communities (Richter, 1984).

Goodwin (1993) supports this argument by stating that mental hospitals were less beneficial than once thought as places of therapeutic intervention, and that people experiencing mental illness benefit from being supported in their normal environments. Therefore the community mental health movement was born as a consequence of the negative impact that “total institution ” had on the patients (Richter, 1984).

### Towards Community Mental Health Clinics

In an attempt to lessen the negative effects of “total institution” efforts were made to transform mental hospitals from rigid institutions of incarceration to therapeutically healthy person-oriented community centres (Goffman, 1963). There was a growing outcry due to awareness of the changes affecting people who were spending much of their adult lives in psychiatric institutions. There was loss of drive, loss of personal identity, loss of dignity as well as a diminishing of ability in daily living skills (Richter,1984). This paved the way for the birth of community mental health services around the 1950s.

With the birth of community mental health services substantial humanistic concerns about the plight of patients in mental hospitals began to emerge and society advocated for psychiatric service delivery along the community mental health model. Mann (1978) sees the community mental health model as based on the explicit intention to provide mental health services to a defined catchment population with the aim to increasing the coverage and impact of services, and the possibility of more people receiving help sooner within their local communities.

The agencies of the model are called the Community Mental Health Clinics. Bean and

Mounser (1993) define Community Mental Health Clinics as locally based centres for the delivery of psychiatric and related services to people with mental health problems, who are no longer treated in the mental hospitals. Heller and Monahan (1977) describe these clinics as centres that provide a base outside the hospital for the multi-disciplinary team and the provision of a wider range of services than those of the more traditionally structured day-care facilities.

This means that the purpose and mandate of the model is carried by the community clinics. When community mental health clinics were built within the catchment areas nearer their consumers it was hoped that they would enhance the attainment of the purpose to alleviate the ever increasing pressure on the mental hospitals.

The historical development of mental health institutions and the evolution of community mental health clinics have enjoyed broad documentation and publication and reflects the developmental trends both from the United Kingdom and the United States of America. The decades of the 1950s and 1960s witnessed the emergence of community mental health as a major focus of the mental health care delivery system (Richter, 1984). In the United States of America the new era of mental health care delivery system was ushered in by the passage of the Community Mental Health Centres Act of 1963 (Gruenberg, 1966; Schulberg and Baker, 1975).

The Act provided for the establishment of a national network of community-based mental health clinics intended to bring adequate care to all. It was argued that when these community mental health clinics were situated in target populations they would have the potential to keep patients in their natural settings, and thereby foster rather than disturb social relations (Bloom, 1984; Mann, 1978; Murrell, 1973). This meant that, for instance, family members could not be

separated through one member - the patient - being incarcerated in an isolated institution.

Another developmental milestone of community clinics came through the Joint Commission on Mental Illness and Mental Health, established by the USA congress (Heller and Monahan, 1977; Sarason, 1974). The commission recommended that a vast array of flexible and needs-based services be situated in the environmental context from which significant patient communities tended to be drawn (Heller and Monahan, 1977; Sarason, 1974). Heller and Monahan (1977) state that the ultimate intention of the commission was to table the research findings which indicated that there were too few community mental health clinics.

Richter (1984) argues that the birth of the community mental health movement was met with many opposing views and debates about the efficiency or lack of it in caring for patients with long term mental illness. Proponents of the status quo argued that people with long term severe mental distress could best be treated and cared for in the psychiatric hospitals rather than in the community based facilities (Richter, 1984).

The historical developments referred to here above are of American origin. There is also work that came from the United Kingdom, explaining how and why community care for mentally distressed people developed. The USA and the UK led the trend for the development of community services, and much of what unfolded in these two countries had an impact on and is more generally applicable to the Western world.

Further debates about the development of community care services originating outside the USA have been generated. It is argued that the origins of community mental health care can be

identified within 'three revolutions' that occurred in the 1950s, namely; the pharmacological revolution, the administrative revolution, and the legislative revolution. While no claim is made regarding exactly what the influence of each was, it is nevertheless argued that between them they caused the development of a more community based system of treatment and care for many mentally distressed people (Bennett and Morris, 1983; Jones, 1972, Bloom, 1979).

### The pharmacological revolution

In the early 1950s a range of psychotropic drugs were developed, that were utilised by psychiatrists in the mental hospitals from the mid-1950s (Bennett and Morris, 1983; Jones, 1972; Bloom, 1979). Bennett and Morris (1983) state that these drugs were developed with the purpose that they would ameliorate mental distress, therefore resulting in more patients who were previously condemned to "total institutions" being de-institutionalised.

Little doubt is left as to the importance of this development in prompting the change from institutional to community forms of care (Bennett and Morris, 1983; Jones, 1972; Bloom, 1979). Jones (1972) argues that the newly available drugs enabled psychiatrists to control the more florid behaviour patterns:

“ .....it meant that patients could go home sooner: once a condition was stabilized, there might be no need for further hospitalisation provided that the patient had home support, and the doctor could be sure he would take his pills. It also meant that some patients did not need to come to hospital at all, because their symptoms could be controlled and the

illness treated while they remained at home. Imperceptibly the emphasis began to shift from talk of 'after-care' to talk of 'alternative care'" (Jones, 1972, p.252).

### The administrative revolution

During the 1950s a series of administrative changes were made in the way services for mentally ill people were provided (Bennett and Morris, 1983; Jones, 1977; Bloom,1979). These changes resulted in the 'open door policy' which was widely introduced in the mental hospitals (Bennett and Morris, 1983; Jones, 1977; Bloom,1979). This policy meant that mental hospitals moved away from lock-up wards where patients were kept for most of the time in isolation. Jones (1972) states that with this policy patients gained some freedom to be in the opened wards where recreation activities took place.

The policy meant more interaction among the patients through participating in activities. Bloom (1979) argues that the policy meant that formal programmes of rehabilitation were put in place. The main principle of the policy was to reduce the length of stay in hospital. For patients whose stay could not be shortened the policy usually encouraged weekend visits to family members outside the hospital. However, such visits were carefully considered.

Consequent to the introduction of the 'open door policy' the number of people seen at out-patient clinics rapidly increased and varied new systems were experimented with, such as the

therapeutic community, day hospital, social clubs and community psychiatric clinics. Jones (1972) contends that these changes reflect the move from an institutional to community base service.

### The legislative revolution

According to Goodwin (1993) the Royal Commission on Mental Illness and Mental Deficiency was set up in the United Kingdom by the state to respond to the changes in mental health that were going on. The changes were mainly about patients being sent to desolate and secluded institutions. The report of the commission paved the way for the promulgation of the Mental Health Act of 1959. The major theme of this Act was a change in emphasis towards community based services. The Act also provided for financial as well as logistical support towards this end.

Although there were similar trends and patterns elsewhere outside the United Kingdom that led to the birth of community care, different scholars provide different reasons due to different contexts in which the changes towards community care took place. According to Morgan (1993) the origins of community care lie in the increased sensitivity to social issues and increased intervention in the social affairs by the governments that arose during the Second World War.

Goodwin (1993) maintains that the egalitarian philosophy associated with the emergent welfare state, together with changes in psychiatry towards recognising the importance of social factors in the creation of mental distress, were the major impetuses behind the community care movement.

In the final analysis, it should however be noted that the move away from “total institution” is less the experience of a single process and a coherent philosophy than the outcome of a number of trends that have different objectives, emphases and intellectual foundations (Bennet and Morris, 1983). This sentiment is best captured by Martin (1970) :

“ The promotion of ‘care in the community’ for the mentally ill flowed from the convergence in the 1950s of several different trends and developments. Clinical innovations, administrative and legal changes, advances in professional and in public attitudes played parts which are separately identifiable, even though it may be impossible to assign a precise weighting to the influence of any one of them.”  
(Martin,1970,p.1).

And finally, in the light of the above debate, the issue regarding psychiatric services provision is not one of “either or” between mental hospitals and community mental health clinics. The issue is also not about whether mental hospitals are less favoured than the community mental health centres and vice versa .

The question is about which mental health agency is best located, useful, suitably capable and has resources sufficient for the provision of services in the best interests of the consumers or patients. A valid consideration would be the one that embraces a “both and” position about the provision of mental health services, depending on the nature of the illness or distress as well as its of severity and the kind of intervention that would be appropriate, all in the best interest of the patient.

## Community Mental Health Clinics: South African reality

The above discussion pertains to the historical background of the community mental health clinics abroad, which have a decidedly far reaching bearing on the community mental health policy in this country. Notwithstanding the poor state of mental health provision in this country, the theory and practice upon which the local mental health service is based, mirrored the influence and direction provided by the industrialised Western countries of the north. However the pace and momentum of development of community mental health services in South Africa fell behind that of its counterparts internationally (Gauteng, Department of Health Policy Guidelines, 1995).

According to Mental Health Report (1993) South Africa emerges from a period in history where mental health was ignored and marginalised. The report states that the biggest blow to mental health in this country was dealt by Apartheid policies that fragmented service delivery in this sector along racial lines. According to the report the worst affected communities were the black (Africans, Coloureds and Indians) working class communities in both the metropolitan and rural areas.

Since the 1970s a few community psychiatric clinics have evolved along and within both psychiatric teaching departments of universities and psychiatric departments of large hospitals. However, their efforts remained uncoordinated, sporadic, scattered, minimal and isolated as the health department lacked particular commitment to such services (Mental Health Report, 1993). Up to this present day the community psychiatric clinics provide an inadequate service in those few communities (Gauteng, Department of Health Policy Guidelines, 1995).

It should be noted that the academic and hospital psychiatric departments played midwifery to community mental health services in this country following a common trend in Western countries (Mental Health Report, 1993). The report argues that it is therefore anticipated that the community mental health services in South Africa, as is the case abroad, would be largely influenced by the dynamics and politics that prevail and predominate within the psychiatric institutions.

Mental health care services in South Africa, and particularly in the former homelands, are inadequate both in terms of their failure to meet the needs of the majority of the population and in terms of the nature of the service provided (Zwi, 1993). The nature of the community mental health services are mainly psychiatric emphasising the view of the medical model on which psychiatry is based (Zwi, 1993).

The nature of service delivery in the mental health system in South Africa has tended to ignore the non-psychiatric services needed in the community and placed much emphasis on the curative approach of the medical sciences. The inadequacy and failure of the mental health care services is a consequence of Apartheid socio-economic policies, the damaging effect of the enforcement of these policies and a generally low prioritisation of mental health (Mental Health Report, 1993).

With the dawn of the new political and health dispensation the health department is beginning to usher in a new policy framework, infrastructure and resources to revamp the current state of national mental health provision. The new mental health policy has warmly embraced the provision of community mental health services and has approved and endorsed their provision

within the primary health clinics (Gauteng, Department of Health Policy Guidelines, 1995).

The community clinics which generally focus on primary health will be empowered to provide a wide range of services in line with the international trend of one-stop health service centres (Gauteng, Department of Health Policy Guidelines, 1995). The top priority alongside primary health will be provision of community mental health services from both a preventative and curative point of view.

The mental health policy with its emphasis on the community clinics came at the right moment to deal with the ever escalating violence both on women and children as well as other mental health problems that are afflicting and traumatising communities around the country (Gauteng, Department of Health Policy Guidelines, 1995).

### The Theoretical Models of Community Mental Health Clinics (CMHC or CPC).

It has been mentioned in the preceding paragraphs that the evolution of CMHC or CPC has international roots traceable mostly to the USA and UK. Most of the literature about the theory and practice of the community clinics come from these countries. Therefore it is against this international background that the theory of the CMHCs will be discussed here.

According to Bennet and Morris (1983) the evolution of the CMHCs around the 1960s represented a new beginning that had the intended purpose of making psychiatric or mental health services accessible to people in their local communities or catchment areas. To be able to realise

this noble and ambitious goal the thinking and practice of CMHCs had to be rooted in some solid theory.

The two main theoretical approaches that have tended to guide how things are thought about and done at the CMHCs are, the mental health model (Mann, 1978) and the psychiatric model (Basaglia, 1990). These two models have been considered to be the most appropriate and relevant towards explaining the processes that unfold at community mental health clinics (Basaglia, 1990; Mann, 1978).

### The Mental Health Model

According to Seedat, Cloete and Shochet (1988) the mental health model is based on the explicit objective to prevent mental illness and its consequent disruption of the pattern of living of the individual within his environment. Their reference to the environment is implicitly indicative of the new conceptualisation of mental health services. This means that the mental health services has the intention of providing services in the local catchment area targeted at a specific population of the afflicted people.

These authors contend that the new definition of mental health does not simply equate mental health with the absence of mental illness. Instead, the new definition moves beyond individuals so as to take cognisance of the broader social and economic stresses created by their contexts (Heller & Monahan, 1977; Mann, 1978).

This means that the model does not place emphases and foci solely on the internal illness

of the individual. The model does not see illness from the view that it resides only within the patient, with the implication that it could be removed if so wished . Therefore pathology cannot be attributable to the individual without considering his or her wider context of living (Heller & Monahan, 1977).

In keeping with the definition Mann (1978) states that the mental health model attempts to understand people within their total personal and social environments rather than as isolated human beings. He further states that the new conceptualisation of mental health served as an impetus that fuelled the establishment of many community clinics. This is so because mental health is seen as connected and interacting with and within community patterns.

According to Mann (1978) the Mental Health Model 's conception of 'positive mental health' represented a clear attempt to consider not only the individual's relation to his or her "self", another and significant others, but also his or her relation to the world. It means that the model seeks to incorporate such context-related considerations as the material and social conditions with which individuals have to contend. These considerations, according to the model, enable psychologists to assess the fit between the functionality of the individual's behaviour and personality and the social context in which he or she lives (Sarason,1974).

The Mental Health Model is inherently underpinned by an exclusively geographic conception of community (Mann, 1978) and is committed to the development and implementation of psychotherapeutic strategies and mental health service delivery in and to particular catchment areas.

The geographic conception of community is manifest through the creation of separate self-contained and self-sustaining community clinics in the different geographical settings. Mann (1978) argues that when these clinics are situated in the relevant catchment areas they are seen as having the potential logistical capacity to provide a wide variety of services to a relatively large catchment area.

Originally when the Mental Health Model's agencies, the CMHCs, were conceived it was due to the desire to deal with the effects of social variables like poverty, homelessness and alienation on mental health (Iscoe, Bloom & Spielberg, 1977). This conception was intended to characterise a meaningful epistemological shift, from those traditional models which equate mental health model with individual intrinsic psychopathology.

Contrary to the mental hospitals that based their understanding of mental illness on the psychiatric philosophy, Iscoe et al. (1977) argue that the CMHCs sought alternative understanding to that of the intrapsychic causation of mental illness. This alternative understanding was to be found in the social and economic environment of people. It was believed that the CMHCs would find solutions to many mental health problems related to social variables such as substance abuse, crime, violence against children and women and unemployment (Iscoe et al., 1977).

Seedat et al. (1988) state that during the conception of the mental health model it was believed that the model, by increasing the coverage and impact of services through the establishment of CMHCs, would result in more people receiving help sooner within their local communities. The ever-mounting pressure on the mental hospitals would be alleviated. This means that people with mental health problems related to their social environment and not necessarily

suffering mental illness would receive help locally in community clinics.

Caplan (1974) takes the point further to say that the mental health model, in line with its emphasis on the social environment of people, does not target people identified as suffering from mental illness as the only recipients of treatment efforts. It also targets people who may be regarded as healthy and yet experiencing difficulties and problems from their social and economic environment.

However Caplan (1974) notes the inherent contradiction that is found when this argument is taken further that while, on the one hand, the mental health model wants to accommodate those who are healthy and yet experiencing problems of living from their social environment, on the other hand, the agencies of this model (CMHCs) use a common stereotypical language of 'patients' which labels every person who utilises their services. The term 'patient' pathologises individuals regardless of their state of mental health and therefore marks a serious departure from the mental health model.

The mental health model's agenda of psychological intervention is designed towards human capacity building, both on an individual and group levels, to alleviate harmful environment conditions, to avoid unnecessary psychic pain and to strengthen the resistance of communities to inevitable future stressful experiences (Caplan,1974).

This capacity building implies that various intervention strategies have to be sought for which will free people from their 'patient' role towards a role that will empower them with life skills and survival skills (Caplan, 1974). Thus people can be engaged in activities that will

positively reinforce their self esteem and self image. This has further implications that medical treatment will have to be balanced against the psycho-social interventions.

The hallmark of the CMHCs ` treatment and staffing in line with accomplishing the stated goals is an interdisciplinary team of usually about ten (10) professionals including a psychiatrist, psychologist, social workers, psychiatric nurses, and occupational therapists (Basaglia, 1990). The team work together in a collaborative effort and employs two main intervention strategies namely, the mental health consultation and crisis intervention.

Caplan (1974) defines consultation as the provision by an expert from within the agency, of technical or professional assistance or guidance on issues in relation to which they are regarded as having expertise. Usually the experts that provide services to the clinics see themselves as outsiders who may come and go anytime and who, besides their occupations, do not have any common agenda with the clinic.

Basaglia (1990) states that mental health consultation entails pharmacologic treatment, individual counselling, group counselling, psychological support to individuals and their families, occupational rehabilitation and social support and network skills.

The crisis intervention approach used by the mental health model focuses on the incentives for constructive change and growth opportunities, that crises are seen as presenting. The goal of crisis intervention is therefore “ to aid in the resolution of crises towards growth and development, towards a higher level of functioning that improves the individual`s ability to deal with subsequent crisis situations” (Mann, 1978, p.88).

Mann (1978) argues that crisis intervention is regarded as relatively permissive in practice and the theoretical justification for its permissiveness is located in its adopting of three major epistemological assumptions. The first assumption is that one needs to mobilise patients` cognitive resources. This is done for example, by talking through the crisis (Mann, 1978), as well as by presenting alternative scenarios and perspectives (Caplan, 1974).

The second assumption is that one needs to mobilise human resources such as family, friends and welfare agencies (Mann, 1978) outside of the individual. Caplan (1974) asserts also, that by incorporating family members into interviews, the approach can support the integrity and functioning of the patients` family.

The utilisation of support external to the family, such as friends, clergy, colleagues and so on is also encouraged. In particular the community members should be brought to awareness of psychological tasks that are involved in ameliorating specific crises (Caplan, 1974).

Lastly, there is the assumption that the disequilibrium experienced by people in crisis often facilitates a greater capacity to both accept as well as to respond positively to therapeutic intervention.

In concluding the discussion on this topic, it should however be noted that this model is theoretically ideal and that there has never been a matching practice on the ground, whereas the application of the model in the CMHCs has been deeply entrenched in the psychiatric ideology which looks for remedies of social problems in biological causes (Pilgrim, 1983).

## The Psychiatric Model

Ironically the state-run community mental health clinics in South Africa are referred to as Community Psychiatric Clinics. The irony arises from the fact that when these agencies of the mental health model were conceived, the conceptualisation of mental illness was deliberately located outside the body of an individual somewhere in the social environment and yet the individual has been stigmatized as pathological.

Although the community mental health model seeks to go beyond the individual's personality in locating and dealing with his or her problems and embraces contextual issues, (Mann, 1978; Seedat et al., 1988), however its agencies (the CMHCs) are married to the psychiatric philosophy of conceptualising mental illness as based on the biological assumptions.

Basaglia (1990) confirms that up to this day the community clinics function according to psychiatric ideology founded on the medical model. He states that the psychiatric philosophy together with the medical model see any deviation in behaviour as a function of biological factors and compares emotional or mental distress to biological illness.

The prime consideration of the psychiatric model is the intrapsychic and internal biological functioning of the individual and it views the individual in isolation from his social and other contexts of living (Basaglia, 1990). The primary mode of intervention is pharmacological drugs through which the patients' behavioural problems are "corrected" to some limited extent psychotherapy could be considered at the discretion of the psychiatrist (Goudsmit, 1989).

Persons who visit the CMHCs are regarded as patients whose state of psychological and social well-being is linked to their physical state. Once people are identified as patients, the assumption is that the seat of illness can be found within the individual (Bannister, 1983). This is an indication of the acceptance of the medical ideology in mental health which as Bannister (1983) says, leads inadvertently to the acceptance of a body-mind dichotomy.

This means that the person is then fragmented into different independent parts whose functioning are not integrated. This fragmentation may be manifest in mental health where human problems are attended to by different professionals, for instance a social worker, occupational therapist, psychologist and psychiatrist, each dealing with particular needs of the patients under the guise of "specialisation" (Bannister, 1983).

According to Goudsmit (1989) medical concepts and language have been adopted at the CMHCs due to the dominant position that psychiatry plays at these clinics. The language used in the treatment processes entails concepts such as psychiatric interview, diagnosis, and symptoms, just to name a few, and this in a small way shows, the power of the medical model at the clinics. Goudsmit (1989) illustrates the powerfulness of the medical model by alluding to the fact that the model uses a diagnostic tool such as the DSM-IV, which is extensively used to diagnose and categorise the patient.

People who visit the CMHCs presenting with psychological problems embedded within a particular social context often find themselves diagnosed according to the DSM-IV. The sad thing about this is that, as Keeney (1983) states, once people are diagnosed as such a label is being affixed on them, for instance when patients are labelled as schizophrenic or having a personality

disorder, it is as if they no longer have issues to talk about, or no longer have different identities than the ones affixed on them.

Unfortunately such patients end up being given medication with little or no psychotherapy work being done. Medication often serves as the first line of intervention at the CMHCs. Once patients are given drugs this method of intervention is akin to one of mass repairs with the minimum human involvement and interaction (Bannister, 1983).

Goudsmit (1989) argues that mental illness, according to the medical model, is manifest through symptoms which are grouped or classified together to formulate a diagnostic category. He further argues that in working according to this model the psychotherapist is not regarded as being able to affect the illness since it (the illness) is seen against a scientific background and as needing scientific intervention.

In other words, the model's functioning is based on the objectivity principle wherein the symptoms are objectively observed and can be only objectively treated using standard or universal procedures and strategies. Furthermore, the vigorous scientific standards applied in the medical model do not permit the therapist to deviate from the norms of diagnosing as the categories of classification of the patient's illness are provided before hand. What has to occur is to match the patient's complaint against the symptoms provided by the category (Goudsmit, 1989).

As far as the staff complement is concerned the hierarchical structure and power relations ensure that the psychiatrist is one who holds sway through the power of his medical background (Bannister, 1983). Usually it is the psychiatrist who confirms diagnosis as well as important

decisions about the patients. The psychologist, together with other professionals are, according to the dynamics at play at the clinics, expected to play second fiddle to the psychiatrist (Bannister, 1983).

### Linking Literature with the Study

The researcher has provided the historical background of the development of community agencies or clinics. It was done so in order to give the reader a theoretical perspective from which he could see the transformation of asylums into the current community clinics. However, reference to the South African context indicates that much more work still needs to be done in addition to current efforts to redress the past imbalances and to deal with the legacy of the past.

To repeat: in the South African context there are two streams of mental health provision wherein the one stream is made up of the state-aided community clinics. These clinics to some extent have adequate resources. The other stream consists of voluntary and privately run clinics which do not receive any funding from the state. These clinics came to being due to the shortage of community clinics, lack of mental health professionals and wanting to make a difference to the communities that they serve.

The two theoretical approaches referred to may serve as broad guidelines from which the community clinics draw their frame of reference in terms of how they want to work. This means that these approaches may provide direction and impetus as to how services should be delivered, and also inform the thinking and working of the agencies of community mental health services. The decision to embrace any specific approach to serve as a guideline lies with each community clinic.

Thus the study looks at the clinics from two different streams. Firstly, two clinics from the same stream, the mainstream (state-aided), shall be studied together since there is great overlap in their conceptualising of phenomena as well as close similarity between their processes and procedures. These clinics provide almost the same context for service provision and differ mainly because of their location.

Both clinics are serviced by the same staff members in terms of professional and administrative services. The staff members rotate between the clinics. The researcher has decided to study both clinics because of their almost similar contexts that should yield almost same outcomes. Also when studied together they should yield much more information that will help the reader understand and appreciate the functioning of mainstream community mental health clinics.

The mainstream clinics are Zola clinic in Soweto township and Eaglemont in Johannesburg. For the purpose of the research these clinics shall be seen as one and jointly called the Community Mental Health Clinics (CMHCs) or Community Psychiatric Clinics (CPCs). This means that the study will compare CMHCs or CPCs with one NGO clinic - Agape Healing Community. Therefore reference to the two clinics or contexts or settings in the study pertains to CMHCs and Agape.

The Agape Healing Community in Mamelodi east of Pretoria is the only known mental health centre in Gauteng province that functions differently from mainstream clinics or that provides an alternative approach or service. Besides being different or providing an alternative approach, this clinic is not sponsored or supported materially in anyway whatsoever by the state or the private sector. The clinic survives due to the generosity of its members. The clinic does not

seek to be funded by any person since it does not want to serve the interests of the funders at the expense of the community it co-creates with the people who come to it. This clinic called Agape Healing Community is in Mamelodi a township east of Pretoria.

The study provides descriptions of the contextual background of each clinic setting within each stream. The study wishes and endeavours to look at the differences and contrast between the clinics located in the different streams. These differences are formulated in terms of how each clinic conceptualises community, how the clinics differ in terms of their physical setting, and how the conceptualisation together with the physical setting influence what happens and how it happens in each clinic. The aim of this study will be clarified further in the next chapter.

## CHAPTER 3

### THE RESEARCH

#### Introduction

A qualitative research approach has been selected as method of choice for this present study. Qualitative research means different things to different people and also means different things at different times, however Denzin and Lincoln (1994) offer a generic definition:

“Qualitative research is multi-method in focus, involving an interpretive, naturalistic approach to its subject matter.”

This means that in qualitative research subjects (humans) are studied in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings that people generate among themselves. Furthermore, the multi-method nature of qualitative research involves the studied use and collection of a variety of empirical materials - such as case study, personal experience, introspective life story, interviews, observations, historical, interactional and visual context (Neuman, 1997). These reflect routines, processes and problematic moments and meaning in individuals lives.

Qualitative research is not about numbers and averages about human behaviour, nor is it

about correct and exact measurement, proof and verification of human personalities. Rather, the keywords and central aspects of qualitative research are process and meaning arrived at through human interactions without any independent existence outside of a social context. Hence Denzin and Lincoln (1994) unpack the meaning of 'qualitative' as follows;

“The word qualitative implies an emphasis on process and meaning that are not rigorously examined or measured (if measured at all), in terms of quantity, amount, intensity or frequency”( p.4).

In contrast, quantitative research emphasises the measurement and analysis of casual relationship between the variables and not processes (Denzin & Lincoln, 1994).

Qualitative studies, through emphasising process and meaning, reflect a fundamental departure from the tradition of science which quantify objects and purports to study them objectively without the researcher influencing them, by, remaining neutral and independent. The main objective in the tradition of science is to arrive at universal, quantifiable and verifiable truth or reality (Bless & Higson-Smith, 1997; Neuman, 1997).

When the objective is realised then the results are generalised to all situations and contexts without regard to unique factors on the ground. Carey (1989) argues that qualitative research is seen as an assault on this tradition, whose adherents often retreat into “value-free objective science” to defend their position.

## Research Rationale

The philosophical approach that informs this study is located within the constructionist paradigm. This paradigm is based on the assumption that reality is constructed and does not have an objective and independent existence (Gergen, 1985). This means that there is no objective reality that we can discover but the different realities created or constructed. in different contexts.

The creation of reality is a phenomenon that takes place in a social environment through interaction among people. The approach within the constructionistic paradigm which emphasises the social processes between people as the basic creating force of realities is known as social constructionism (Ibid).

The research design of this study is embedded within the social constructionism approach. The basic assumption of this approach to research is that all knowledge (scientific and non-scientific knowledge) is understood and interpreted by understanding the social context in which it is created (Gergen, 1985).

According to Denzin and Lincoln (1994) research based on this philosophical foundation stresses the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry. Researchers using qualitative research argue that different contexts create different outcomes and therefore they do not subscribe to a 'universal truth' that is generalised over different contexts.

The focus of the study is to investigate the differences and the contrasts between the two

community mental health facilities in terms of how they conceptualise 'community' psychotherapy clinic. It also investigates the difference in their physical settings and how their different conceptualisation of community and physical settings influence their activities, processes and procedures of providing mental health services differently. The thesis is that mental health services are not provided and practised universally in the same way. Due regard needs to be given to the different contexts in which these services are.

The researcher does not want to pre-empt the results, but according to the assumptions referred to in the foregoing paragraphs, different contexts yield different outcomes. The research question asked in this study hopes to solicit the constructed meaning and understandings of the participants in the different contexts through their human interaction or experiences, and this question does not hope to yield an objective analysis, quantification and verification about objects or things. Hence the study is not so much about observable and quantifiable regularities in physical phenomenon which requires proof, but rather about meaning and understanding of human issues (Reason and Rowan,1981).

The meanings that people create in interaction and that are reported in the study cannot be subjected to positivistic proof and verification as these meanings are context-specific and create understandings that are also context-specific. This understanding of qualitative research is aptly expressed by Halcolm in Denzin and Lincoln (1994):

“There is no burden of proof. There is only the world to experience and understand . Shed the burden of proof to lighten the load for the journey of experience. When in doubt, observe and ask questions. When certain,

observe at length and ask many more questions. Thus qualitative inquiry cultivates the most useful of all human capacities, the capacity to learn from others". (p.263)

The above quote confirms an assumption of social constructionism that states that reality is created through the domain of consensus between the researcher-participant and the subject-participant. According to Denzin and Lincoln (1994) in qualitative research the researcher and the subject co-create an understanding of reality.

This assertion is consistent with Lincoln and Guba's (1985) conception of 'doing research with people' rather than 'doing research on people'. This assertion is also consistent with the philosophy of working that punctuates the Agape approach, that at Agape research and therapy are done with people.

The study seeks to bring forth the world of lived 'reality' and 'situation-specific' meanings of both contexts and how these 'realities' are constructed by the subjects.

### The Research Strategy and Methodology

According to Neuman (1997) research strategy is determined by the nature of the research question. The research question has been stated above. And to repeat: the question seeks to investigate the differences and contrasting points between two contexts of community facility in terms of both their conceptualising of 'community' and physical settings, and how these influence their activities and processes of providing mental health services.

Neuman (1997) explains that research strategies are only tools, and that each strategy offers a particular and unique perspective that illuminates certain aspects of reality more easily than others, and produces a type of results more suited for some applications than others. The research strategy that is consistent and congruent with this study is ethnography or field research. According to Denzin and Lincoln (1994, p. 248) ethnography refers to forms of social research having a substantial number of the following features:

- a strong emphasis on exploring the nature of particular social phenomenon, rather than setting out to test hypothesis about them
- a tendency to work primarily with 'unstructured' data, that is, data that has not been coded at the point of data collection in terms of a closed set of analytical categories
- investigation of a small number of cases
- analysis of data that involves explicit interpretation of the meaning and functions of human actions, the product of which mainly takes the form of verbal descriptions and explanations, with quantification and statistical analysis playing a subordinate role at most

According to Neuman (1997) ethnography entails direct, face-to-face social interaction between the researcher and the subjects in a natural setting. In this research approach the researcher talks with and observes the people being studied. Ethnography involves the researcher participating in people's lives for an extended period of time, watching what happens, listening to what is said,

asking questions and collecting whatever data is available to throw light on the issues that are the focus of the research (Hammersley & Atkinson,1995).

The researcher chose this approach because, according to Neuman (1997), it is appropriate when the research question involves learning about, understanding, or describing how a group of people are interacting and also understanding the phenomenon that makes them interact. In the light of the research question mentioned above the notion of subjectivity is paramount as the scientific observer deals with how social processes are made meaningful. The emphasis is on how those concerned with objects of experience apprehend and act upon the objects as ‘things’ set apart from observers.

### Methods of Data Collection

It has been stated above that qualitative research is multi-method in focus. These multiple methods create multiple perspectives that enable the researcher to get inside the meaning system of the social context and participants, and then he goes back to an outside or research viewpoint (Neuman,1997). According to Denzin and Lincoln (1994) the multiple methodologies of qualitative research may be viewed as a bricolage and the researcher as bricoleur. Weinstein and Weinstein (1991, p.34) defines a bricoleur as a “ jack of all trades or a kind of professional do-it-yourself person.

The bricoleur (researcher) produces a bricolage, that is, a pieced-together, close-knit set of practices that provide solutions to a problem in a concrete situation.

“The solution (bricolage) which is the result of the bricoleur’s method is an emergent construction that changes and takes new forms as different tools, methods and techniques are added together” (Weinstein & Weinstein, 1991,p.161).

The reason for using multiple methods by the researcher is an attempt to secure an in-depth understanding of the phenomenon in question since no single universal ‘truth’ can be discovered. In the present study the bricoleur (researcher) has used various methods of data gathering such as interviews, observations, self-reflections and personal experiences.

Also, the researcher’s beliefs, values and experiences are important co-creating factors in the research process. Neuman (1997) argues that the researcher brings his history and social narrative into the research process and that the social context of the researcher cannot be separated from the research process.

Neuman (1997) argues that in line with qualitative research the researcher has to be an instrument that absorbs all sources of information. This view about the researcher’s role is consistent with the philosophical viewpoint known as naturalism. Neuman (1997, p.348) defines naturalism as a viewpoint that involves observing ordinary events in natural settings, not contrived, invented, or researcher-created settings. This means that research occurs in the field and outside the safe setting of a laboratory, and that the researcher’s observation of events as they unfold in a natural setting is central and paramount.

The observation method as well as personal experience have been used to describe the physical setting of the two contexts that are the subject of this study. The details about the physical setting provide a rich data base about the contrasting points between the two contexts under study.

According to Neuman (1997) details obtained from observation reveal the atmosphere of 'what's going on here' through careful listening and watching and this may not be easily accessible using other methods. Thus, qualitative researchers believe that the core of social life is communicated through mundane, trivial, everyday minutia (Neuman, 1997).

Interviews have been used in the study to obtain direct responses from participants through questions asked by the researcher. According to Neuman (1997) interviews involve asking questions, listening, expressing interest, and recording what is being said. Ethnographic interviews are a joint production of a researcher and a member since members are active participants whose insights, feelings and cooperation are essential parts of a discussion process that reveals subjective meanings. In this study there was a need for more specific and detailed information which could facilitate comparison of the reactions of different participants. Thus, a non-scheduled structured interview was conducted.

According to Bless and Higson-Smith (1997) a non-scheduled structured interview has a much more precise goal and the types of questions to be answered by all participants are fixed. They argue that this interview is structured in the sense that a list of issues which have to be investigated is made prior to the interview. But it is a non-scheduled interview in the sense that the interviewer is free to formulate other questions as judged appropriate for the given situation (Bless & Higson-Smith, 1997). This means that the respondents are not confronted with ready definitions

or possible answers, but are free to choose their own definitions and to express their particular views and answers to problems.

The collection of “raw” data has proceeded on two levels for this study and the researcher has also documented or presented data obtained separately to indicate the different process levels involved. However, the reader should bear in mind that these levels exist only for purposes of academic nature because in the field one cannot isolate and balkanise data collection.

The first level of data collection is the natural setting of both contexts. Information that is obtained from these two contexts pertain to their physical setting as well as the practical activities and processes that unfold in and around them. Information from the first level is captured through personal experience and observation methods as descriptions of contrasting ecologies. These descriptions are based on the past experience of the researcher when he was engaged as a student and an intern-psychologist at Agape and the CMHCs respectively, and also in his present observer-participant role as a researcher.

The second level of data collection are the interviews conducted with the mental health workers from each context about what they do, the meanings and understanding of what they do and how they do it. The interviews are carried out in each context and the same core questions are asked to each worker in the different contexts. The section that follows will flesh out the first level of “raw” data which is based on the descriptions of ecologies.

## Descriptions of the Contrasting Ecologies

The researcher will now present his own 'raw' data which was collected through observation and personal experience methods. This is to set the stage for the reader to gain background understanding of "what happens inside" each context of community mental health service clinic and to fully appreciate how these contexts differ in terms of "what happens inside" and how it happens.

The aim is to provide the descriptions of the physical settings and the activities that evolved as a result of these settings from both community facilities. Thus the purpose of the descriptions is to take the reader into the settings. The first part to be described is the ecological description of the Community Mental Health Clinics, hereafter called only CMHCs.

### Contextual Background: Community Mental Health Clinics

The researcher worked as intern-psychologist at Eaglemont Clinic in Johannesburg, and Zola Clinic in Soweto (jointly referred to here as Community Mental Health Clinics). The reader should remember that these clinics are to be seen as one (p.37). The researcher first wants to describe the professional atmosphere and physical setting of Eaglemont Clinic and then that of Zola Clinic.

### Professional atmosphere and physical setting: Eaglemont Clinic

The descriptions that are captured here reflect the observations and experiences of the

researcher as an intern psychologist at Eaglemont. The researcher defines professional atmosphere as the prevailing and predominant interpersonal and interactional climate that sets the tone of work and relations among the people within each particular setting. The atmosphere around Eaglemont is very business like and formal. Things appeared to be highly orderly and structured in terms of what belongs where and to whom, who does what, where and with whom. There is also a clear structure and hierarchy of authority. The command structure is spelt out unambiguously in terms of who reports to who. As an intern psychologist the researcher reported to the senior psychologist at the clinic.

The staff complement of Eaglemont consists mostly of professional mental health workers. Among them are psychiatrist, registrars, medical officers, psychologists and interns, social workers, occupational therapist and psychiatric nurses. Psychotherapy, counselling and assessment are strictly the domain of professionals. All clinical mental health work done here is done by professionals. To be a member of the various professionals at Eaglemont one needs training, certification and membership of a particular professional council. There are also general workers consisting of clerks and cleaners.

There is a matron who takes charge of administrative affairs and personnel issues pertaining to allocation of duties, rotation of staff around clinics, leave forms, days off and complaints about overtime and salaries as well as leaking taps, shortage of toilet paper, access to computers and so on. Eaglemont Clinic has the services of two clerks; one who serves as the secretary to the matron, and another who does the typing for mental health professionals on request and all administrative work pertaining to patients' files and their appointments. This clerk also serves as the first port of call for patients who need services.

Despite the unfavourable conditions of squalor and decay in Hillbrow that surrounds Eaglemont Clinic, the clinic has facilities and resources befitting a mental health centre. Each professional who work at Eaglemont is allocated an office which provides privacy and space for clinical work. Each office is fully furnished - with a phone, heater, furn, water basin (originally designed for medical officers to wash their hands after a physical examination of the patient), mirror, table with drawers and chair as well as cabinets for filing and storage of information. There are also sofas that characterise a typical psychotherapy atmosphere. In addition to the office space each professional is supplied with full stationery. For instance, the researcher was given a rim of paper for making photocopies as and when he wanted. He had access to a fax and computer for research report writing anytime after doing clinical work.

Normally at Eaglemont patients are seen strictly on appointment basis in the offices of professionals . This was to avoid patients coming at the time when professionals were working at other clinics besides Eaglemont. The benefits that came with an office were that the professionals as well as the researcher could have space and privacy when no patients were booked for appointments and during this time could attend to matters of administration and report writing of current cases.

The privacy of an office space brought an added benefit of safety and storage. The professionals did not have to carry around all their files with them wherever they went. For instance, they did not have to keep the files in the boot of a car where they would stand the risk of being moved around together with other items that inhabit a car's boot . Therefore they safely locked away. They could bring recording equipments to use in therapy sessions without the fear of losing them. They were in constant touch and connection with everybody outside the clinic

surroundings through the telephone and fax.

### Professional atmosphere and physical setting: Zola Clinic

The mental health clinic at Zola is also run in a formal and businesslike manner. There are certain procedures and rules that the professionals have to follow in a routinised fashion with little or no input to make suggestions as to how things could be done differently.

The senior psychiatric nurse is the first person that the patients have contact with. She usually lets other junior nurses administer the psychiatric interview with patients during the first contact session. When she is not busy she may personally assist with these interviews.

The psychiatric interview forms the primary tool of assessment at the clinic and usually no patient is seen until a proper interview has been conducted. This interview is structured in such a way that it should yield a diagnosis. All clinical work at Zola Clinic remains the exclusive domain of professionals as at Eaglemont Clinic.

The staff complement at Zola Clinic consists of psychiatrists, registrars, medical officers, psychologists, intern-psychologists, social workers and occupational therapists. This is the same staff that provide services at Eaglemont. There is shortage of adequate facilities at Zola which results in psychiatrists and other medically trained personnel receiving first priority in the allocation of consultation rooms, with the members of the psychosocial team playing second fiddle. Among the psychosocial team it is the psychologists who want to play the big-brother role, according to other professionals such as social workers and occupational therapists lesser status.

There are also clerks whose scope of work pertains to administrative duties only.

The physical setting at Zola Clinic resembles that of most health institutions. Zola Clinic is a fairly large clinic which serves a very large part of Soweto, South Africa's largest township. When Zola Clinic was built it was built with the view of off-loading the burden carried by Chris Hani Baragwanath Hospital, in Soweto. This is the largest hospital in the Southern Hemisphere with regard to patient intake and structural size. Zola Clinic looks like a day hospital. It has most departments that are usually associated with day hospitals. For instance, it has the primary health section, the maternity section, the dental section, and the mental health section.

The mental health section is an entity on its own. There is the clerks office where the files and administrative equipment are kept. This section serves as the port of call for everyone who needs psychiatric or mental health services. It has its own waiting room with long rows of benches arranged one behind another for patients to sit when waiting for services. At this clinic patients usually come as and when they feel like and are not seen by strict appointments for the first session.

There is the nursing station which serves as the first port of call for patients that need psychiatric help. There are also separate consulting rooms for clinical work done by each member of the psychosocial team, that is, psychologists, social workers, occupational therapists. There are also rooms for psychiatrists. Each consulting room has basic furniture and equipment that enhance delivery of services. Furthermore, there are separate ablution and toilets facilities for staff members and patients.

The following descriptions about activities and procedures from the CMHCs, namely, Zola

and Eaglemont will be discussed together or as one since their dynamics of staffing and interacting, as well as processes and procedure, are the same. These clinics shall hereafter be jointly referred to as the CMHCs.

### Activities at the clinics

#### Professorial ward rounds

There are a number of activities that take place at CMHCs. One of these activities is called the professorial ward round. Despite the claim to be community clinics the language they use as well as the processes they undertake fashion themselves after those of mental institutions. This is personal observation as the researcher also worked at a mental hospital. At these clinics there is still talk about the 'ward rounds'. This is consistent with Bennet and Morris' (1983) argument that community clinics have been shown to develop some of the institutional practices and tendencies previously associated with the psychiatric hospitals. Professionals working at community clinics still see their role and use language in much the same vein as those working in mental hospitals.

Professional ward rounds were held twice every month, or when there was a very important case to be presented. The ward rounds were held in the seminar room at Eaglemont Clinic for cases arising from both Zola or Eaglemont. The seminar room was the only appropriate and available facility for the two clinics. These ward rounds entailed the coming together of different professionals, particularly senior professionals, with the purpose to find solutions to cases that have proven difficult to be dealt with by the local professional team.

Professionals did not come from the two mentioned clinics only but came from all major mental health institutions around the Gauteng province. In some quarters these ward rounds were called 'the meeting of the giants' as academic professors dominated the discussions and processes.

It was standard procedure of training that intern psychologists had to be present during these ward rounds. After every psychotherapy assessment, the researcher, as intern, had to come with a tentative diagnosis so as to facilitate discussion during ward rounds. Also all team members who had consulted with the patient had to be present. Before the presentation day team members had to prepare a detailed report about the nature of the assessment done, tools of assessment used, procedures of intervention followed, and differential diagnosis arrived at as well as the prognosis.

This report was to become the main document for the presentation. At other times it had to be circulated among staff members prior to the presentation day. All team members were given time to present their individual reports. A short discussion would follow immediately after all reports were tabled. Then the patients ( who had been waiting in some room the during presentation of the various reports) would be brought in and interviewed by the psychiatrist in charge of the unit or team.

After the interview between the psychiatrist and the patient, the patient would be returned to the waiting room and fierce debate would ensue. The debate would normally focus around the issue of diagnosis and prognosis. This would call for the review of all the assessment tools employed towards arriving at the stated diagnosis as well as the course of treatment that has been followed to this point.

The validity, reliability and the relevance of these tools would be questioned with regard to the specific context of the presenting patient. The debate would thereafter change direction and look at the theoretical assumptions that corroborate the diagnosis. This then would lead to a discussion that focused on the need to change the treatment plan and how to accomplish this. Ultimately recommendations would be made with regard to what could be the appropriate and relevant treatment plan suitable to the patient under the present circumstances.

The way things were done, in terms of the procedure and process, clearly indicated that these 'ward rounds' were a replica of the processes that occur in a mental institution. The researcher observed this while he worked at a mental hospital.

#### Assessment techniques

The description that follows is based on the personal experiences of the researcher as well as the observations he made while doing internship at the CMHCs. During the ward rounds the researcher had to perform psychometric assessment which would enable him to provide a diagnosis, formulation of the problems and treatment plan.

When the researcher employed the assessment tools towards making a diagnosis it gave him a sense that he knew what he was looking for and because of this knowledge he felt that he knew what could be causing the problem. He believed that this knowledge about the problem provided him with insight into the problem.

The main or primary tool that he employed for assessment was the DSM-IV. The DSM-IV

is the tool of choice for assessment, diagnosis and treatment at CMHCs clinics. This tool is conceived from the medical model and psychodynamic ideology which classifies illness according to some nomenclature. During his internship whenever the researcher tried to include an alternative way of thinking and doing consistent with his training at Unisa he would find himself marginalised.

For purposes of carrying out treatment and psychotherapy modalities he had to be fully entrenched in and conversant with the DSM-IV which he had hardly ever used during his work at Agape. In the context of the CMHCs clinics it was not enough for him to see people who were presenting with social problems without coming up with a clear diagnosis and etiology of those problems. To diagnose was useful in that one could share professional information across disciplines with various colleagues.

It was imperative that he had to begin to see people as suffering from panic disorder, schizotypal personality disorder, compulsive disorder, and other disorders. By incorporating this kind of language it made it easier and appropriate for him to communicate with psychiatrists, psychiatrist nurse and the entire mental health staff at the centre. This way of thinking and doing was underscored by the psychiatric medical model which is the model of choice at these clinics.

### Paper presentations

The community clinics were not only settings of working but they also provided opportunities for the learning of academic theory. The clinics were part of University of the Witwatersrand`s training placement for psychiatric registrars and psychology students. As part of the academic requirements of training the clinics also offered an opportunity for academic

training through integration of theory with practice.

On alternative Fridays each professional member of the clinic had to present an academic paper extracted from journals or manuscripts that would have a link or relevance with some of the cases that the professional has worked with. At other times the professionals would present papers for their pure academic input without any specific relevance to the cases they were currently seeing.

The paper presentations took place in small tutorial rooms at Eaglemont Clinic. Usually only the members of the psychosocial team attended this presentation. These consisted of psychologists, intern-psychologists, social workers and occupational therapists. At most the psychosocial team would have about ten members and most of them attended. At least one senior psychologist acting as the supervisor and facilitator for the team would attend. The medical team consisting of psychiatric nurses and psychiatrists were never part of the paper presentation for reasons not known to the researcher.

The strange thing about working relations at the clinics was that psychologists always acted as big brothers or sisters to other professionals and this annoyed these team members. All team members together with the supervisor would sit around table for the presentation. The person presenting was supposed to provide copies of his or her paper to other team members.

The paper presentation was for two principal purposes. The first purpose was purely academic where the person presenting would either present in a didactic or workshop format. Usually any of these forms of presentation would be followed by questions and responses, and then the general discussion which integrated all the issues that emanated during interaction.

The second purpose of this presentation was social in nature. It was expected from the person who was presenting to bring along something to be eaten. This could be cake and tea, snacks and fruit or whatever. Normally the eating part came after the presentation was finished. Most people were comfortable with having refreshments after the presentation.

After the presentations the supervisor would leave the team members to be on their own. This would give them much needed space and the opportunity to share their struggles and frustrations about the workload and also about the difficulties they encountered with their supervisors in general. During this time, when the team members opened up they reported feeling calmer and more relaxed. The team spirit was reinforced during this informal 'opening up sessions' as the team would refer to these moments.

The team reported that the informal 'opening up sessions' provided them with support and gave them sustenance to face each more day in their chosen professions. The intern-psychologists would often report that this part of the 'opening up sessions' provided them with the opportunities for renewal and edifying, particularly as their survival was much dependent on the evaluations of their supervisors.

On certain occasions, after the presentation, professionals would go out to restaurants for eating out and even light drinks. This would provide the much needed soothing and relaxed atmosphere as well as support from each other after a hectic week of hard work and fast pace, providing mental health care to many afflicted people at the CMHCs.

## Supervision

Once a week the intern- psychologists had to be in supervision. Supervision was to assess the clinical and professional progress made or not made by the interns, and to provide professional as well as personal guidance towards the growth and development of the interns. Every intern psychologist was allocated to a specific supervisor. Supervision would last for a period between an hour and two hours and was normally held on Fridays. It was during this exercise that the intern had to bring all work done to the supervisor. This could be case reports, including psychological assessment. The reports had to be very detailed and professional. The work could include the therapy process notes. Once per quarter the intern psychologist had to provide an audio cassette on a therapy session held with a client.

Depending on the supervisor, it sometimes became a torture to attend supervision. Although supervision provided for learning opportunities not all the supervision sessions did. It was the impression of most interns that they had to do things to satisfy their supervisors who were in many instances found to be biased towards a particular therapeutical approach. The most threatening thing about supervision was that students progress as interns depended very much on the evaluation of the supervisor. It happened that some students did not have a good working relationship with their supervisor and still the fate of the student would be in the hands of the supervisor.

Coming from the ecosystemic training at Agape the researcher had to maintain a healthy balance between the ecosystemic approach and the psychodynamic frame, which was dominant at the CMHCs. During supervision the researcher would present his work from both the ecosystemic and psychodynamic framework, and sometimes it worked with the supervisor but at other times

it did not. Sometimes the supervisor would only accept an explanation and analysis of a phenomenon if it strictly came from the psychodynamic thinking.

### A typical day at the CMHCs

Patients arrive early in the morning to ensure that they will be among the first in the queue. Their names are written down by a clerk as they come, and in this order they are seen by service providers. Professionals report at 08h00 at Eaglemont in Johannesburg, and drive to Soweto, to arrive around 09h00 finding patients already waiting for them in long queues. Patients usually arrive before the professionals come. While patients are waiting they seldom talk to one another, indicating their strangeness to each other.

The atmosphere that prevails among patients is that of strangers in a strange place, each stranger (patients) awaiting his or her turn to be seen by some other stranger (professional). There is something impersonal about the waiting room as well as the entire clinic situation. People (patients) just sit and wait on long wooden benches like statues. They wait for their names to be called out so that they may be attended to.

There is no opportunity for the patient to engage with other patients on a social and interpersonal level because after he or she has been given medication and a date to come back again, he/she vanishes back into her or his own world. Again, although the CMHCs operate in the community, these clinics foster nothing 'community-like' since not even bare interaction and activities are initiated by the clinics. The clinics do not have programmes and projects to promote community. A general complaint from interns and other new initiates in the system is that all these

clinics are run as extensions of how institutions are run in some secluded areas.

Intern-psychologists tend to challenge things, presumably partly because of their temporary, transient and student status, together with being new-comers to the system and not yet fully loyal. They often complain about the fact that CMHCs are not truly 'community' clinics because of how they conduct their business. A newly appointed occupational therapist had this to say: "Most community mental health centres are community clinics because of their locality and not in terms of any programmes or initiatives that they offer."

When the patients are waiting in long queues professionals just pass by without greeting them, hoping to do so when they consult them individually. It is claimed in the corridors that this behaviour is in line with a professionalism that requires distance between patient and service provider, albeit inhuman. Patients as well as service providers carry around a face which seems to say that they are here for business, nothing more, nothing less.

When patients come to the clinic for the first time, they are first seen by the psychiatric nurse, who will conduct a psychiatric interview with each patient. He or she will write down every detail of the interview in the file to be used by other professionals. This interview can easily make up the first appointment, after which the patient will be given a second appointment, to be consulted by the psychiatrist who will make a diagnosis and either prescribe medication only, or refer the patient to another professional. When time is available and the professional to whom the patient has been referred does not have a full schedule, he may slot the patient in on the same day or give him another appointment.

When patients are finally seen by the psychotherapist for the initial assessment for therapy it could be on the third appointment. At these clinics time is of the essence due to the big numbers of patients that come and the psychodynamic frame of therapy. Therapy sessions are limited to a time period of about 50 to 60 minutes, and not more. This pushes the therapist to be time conscious and technical in approach. Strict adherence to the psychodynamic frame of therapy is kept at all costs.

Only some days may be extremely busy. On busy days the researcher would see up to six (6) patients and on quiet days one or two patients and, very rarely, no patients at all. Time boundaries would be violated on those days when dealing with psychometric assessment. The researcher could easily work with one patient for three hours with short breaks in between.

The foregoing section has described the first part of the different ecologies, namely that of Community Mental Health Clinics. In the following part the Agape Healing Community will be described.

#### Contextual Background : Agape Healing Community

Agape is a psychotherapy clinic situated in Mamelodi, a black township some 30km east of the central business district of Pretoria. Mamelodi is a township not different from any other South African township with different socio-economic classes amongst residents, characterised by high unemployment and high crime rate, dusty streets, squatter or shanty towns and conditions of squalor and poverty.

Mamelodi lacks big industries to give employment to its residents. Most residents are employed in the informal sector that has mushroomed and they may commute to and from Pretoria where they are employed (Blokland, 1993).

It is in and against this setting that Agape has evolved and continues to evolve. According to Blokland (1993) Agape was founded on 29 March 1989 in the community section of the SOS Village. It is now 12 years since Agape opened and has since undergone a lot of metamorphosis and transformation. This includes the changing of its name from Mamelodi Counselling Clinic to the present Agape Healing Community.

The founding members were Prof. Stan Lifschitz, Ms Suzette van Niekerk, both from UNISA, and Ms Betty Kgaodi from Mamelodi. The therapeutic team initially consisted of both Stan and Suzette and Betty a community worker. When Ms van Niekerk left after a short while another new clinical psychologist, Corine Oosthuizen joined. Also, the clinic included masters level students in training from the University of South Africa who spent one or two years of practical learning at this placement, as well as masters level students from the Rand Afrikaans University, who only spent a year of their practical training here.

According to Blokland (1993) after a process of development and evolution the SOS Children Village, could no longer accommodate the clinic. Then it moved onto an adjacent property of the YMCA. The clinic operated from a set of three prefabricated huts. One day the largest of the prefabricated huts was removed from the grounds by its owner, leaving the clinic stranded for adequate accommodation. The two other huts were given to a self-help group that make bricks.

Even before the largest hut was taken away the people who came to Agape would normally sit under the huge bluegum tree since the hut was either too hot in summer or too cold in winter. Gradually people became accustomed to sit and talk under the tree. Therapy sessions would be held under this big tree or under other trees with patients sprawling on the YMCA grounds.

Moving away from the huts brought the work of Agape more and more into the open and this served to raise questions by members of Mamelodi community who began to come to find out more about Agape and its activities. At the same time the tree was used for other therapy rituals such as dancing, drawing and doing other art work. In this way, the tree became the site or central feature of healing and psychotherapy at Agape.

#### Professional atmosphere and physical setting: Agape

As a point of departure a description of the professional environment at Agape is essential. “Agape” is a Greek word that means “brotherly” and “sisterly” love. This meaning of Agape is saliently reflected in the manner its members interact with each other. The environment and the vibe that predominates in this context of healing is one of love and warmth, openness to each other and acceptance of one another as well as sharing and togetherness.

There are procedures and guidelines of doing things, and yet the emphasis is not on absolute adherence to the rules but on how people co-create their existence and meaning about being at Agape. Agape is not about who reports to who, or about the hierarchical organisation of its members but rather about respect for people and co-creation of community.

Currently membership of the Agape therapeutic team is not limited to professional members only. There are now volunteer members without any formal training in psychology but who are gifted and have skills in various forms of art such as painting, sculpture and music. They form part of the therapeutic team. Membership is also extended to committed members of the community who come regularly to take part in the activities of Agape. All activities at Agape provide an opportunity for belonging and create space for individuals to find their voice towards the co-creation of a community of healing. At Agape ordinary residents of Mamelodi are offered the opportunity to belong to Agape, to be part of a healing community that is co-created and co-evolved by patterns of interaction by those involved.

As indicated above, Agape was left stranded after the prefabricated huts were taken away by the owners. When the researcher became a member of Agape as a UNISA student the clinic was operating from under the shade of the big gum tree which seemed to stand at the centre of all other trees on the grounds of the YMCA. With nowhere else to go members of Agape Healing Community gathered every Wednesday under the tree to conduct their business.

The tree literally provided the 'safe' space or 'office' for therapy work to take place. The huge gum tree from which the clinic operated was later referred to as the Healing Tree and Agape became popularly known in the fraternity of healing through this tree. Local residents felt that this tree carried with it the myth and mysteries of healing. The tree concept became so huge that healing, to the locals, was associated with this tree. Some locals would refer to this tree as "sefate sa badimo" which means the "tree of the gods". And indeed, it became an icon as well as an epitome of healing in this community.



Practising psychotherapy under a tree posed many challenges, particularly with the lack of office space, furniture and adequate equipment. It meant that all the client files had to be taken home by certain members of the clinic on a rotational basis. The researcher remembers that his group, two other students and himself, would each take turns in keeping files for a period of three (3) months. They had to exercise extra caution towards the safety of these files in terms of protecting and storing them in line with ethical consideration of confidentiality and accessibility.

Indeed, Agape operated from under a tree without any roof above and walls to the sides. The reader can figure out the challenges faced due to lack of the physical facilities. It was convenient to operate in summer because the tree would provide the shade, but at the same time it would be a disaster in an event of a rainfall. In winter it would be so cold that we would make an open veld fire with dead wood from the same ecology to keep ourselves warm.

When it was very cold and there was not enough wood we would find refuge in the YMCA hall adjacent to the Agape centre. During the month of August it gets very windy, and in the township it becomes quite dusty because of poor road conditions. Agape is no exception to the dusty weather during the month of August. We would again find refuge in the hall on dusty days.

Agape is not funded by anyone. Lifschitz and Oosthuizen (2001) argue that Agape does not want to be sponsored as “we do not want to be tied to the dictates of the givers, nor do we want to become a welfare organisation with a formal constitution and an executive body removed from the grassroots functioning of the community itself” (p. 113).

It runs through the generosity of its members. There are no waiting rooms for clients, no

cabinets for storage, no filed information of the clients and hardly tables on which to write information or notes about clients. When we write notes about anything we do so on our laps. It seems as though the philosophy that gives impetus to working at Agape is: “Do what you can do with what you have.”

Obviously, without offices it follows that there are no telephones and faxes and let alone computers. No stationery is provided. Everyone involved brings his or her own stationery, except for those who may not be able to afford it. In this case again the generous members will organise the stationery and, surprisingly, it never occurs that there is no stationery for those who need it. There is a lot of sharing and co-operating at Agape.

In 1996 a decision was taken at Agape to expand from under the tree and build some shelter which would accommodate various activities of the centre and combat some harsh weather conditions. The main consideration towards the expansion of Agape was that its identity and proximity to the tree should at all costs be maintained.

All members of Agape were tasked with a fund raising project to ask donations from whatever source in the local community of Mamelodi and beyond. When the financial resources were deemed sufficient the building projects started and everybody contributed to the project by, for instance, providing their skills or transport.

When the shelter was finished, at the entrance a rock tower was built with stones that each member brought from home. This was a ritual to foster and inculcate inclusiveness, a sense of belonging and identity with Agape. This was a ritual of co-creating a community in a literal sense.

Out of this ritual a community of healing was once more co-created.

The researcher also brought a stone from Vereeniging, his home town, which is some 150km from Agape. It is now four (4) years since he finished his practical training at Agape, but he still feels very much part of it, and it seems he will not leave it as part of him belongs with Agape. However, Agape is not bound to space and time, it transcends all known physical boundaries. It is like a spirit that is all over at one time.

The shelter is a round hut with thatched roof without any door or windows. It is not closed on the sides and has sitting space which extends beyond the shelter in a spiral- like manner. It is not limited to openness or closedness, inside or outside. There seems to be a connection between the hut and the tree as their shades tend to overlap to cast a big shade for those who are under the hut or under the tree. This blanket-like overlapping shade obliterates the sense of being inside or outside of the healing 'space' or community.

The descriptions that follows here are about the activities and procedures that take place at Agape on each day that the clinic operates.

### Activities at Agape

#### Healing for the healers ritual

The healing for the healers ritual is the hallmark and a symbol of the commencement of the business day at Agape, where the therapists, community workers and clients all gather together

under the hut as well as the tree and begin by first collecting chairs from the adjacent YMCA hall. The chairs are then put in a circular seating arrangement for all to be seated. The circular seating arrangement enhances and educes a healing power. The ritual of healing for the healers begins when everybody is seated. Everyone present becomes part of the group and shares his/her own story or issues that pertains to therapy or their own life experiences. During this ritual Agape becomes a safe place to be at for those involved. A safe place to share their pain, anger, sadness and all types of normally unacknowledged emotions. People reflect on their own involvement inside or outside therapy and the roles they play at Agape.

They reflect on what emerged to them in the process of activities during the past day. They reflect about how they feel about being at Agape, what their purpose is, what they are bringing to Agape in terms of personal issues, what their struggles are and what they hope to learn from them. They reflect about their feelings provoked by this place, the clients and their own role. They reflect about their fears of what will or may happen and what will not or may not happen to them and their clients. During this ritual of healing- talk connections are formed with what people feel, think and believe.

Usually one of the supervisor acts as the facilitator of the process that unfolds. This ritual is highly unstructured and people are encouraged to be in touch with how they feel, think and also with their belief system and how their way of being may or may not affect other people or their clients. As people volunteer or share their issues and stories, the healing process begins for these individuals and tends to have a ripple effect through the entire group members who participate in the co-creating of these stories and in co-evolving community.

According to Lifschitz and Oosthuizen (2001) this ritual is informed by the metaphor of the wounded healer who has lately become the credo of Agape and it means that therapy is not for the client only, but it is also for the therapist. This metaphor provokes the therapist to deal with his or her own issues as they may be reflected through and mirrored by the circumstance of his living or through a client.

This ritual is not about diagnosis and classification according to some nosological nomenclature with the purpose to unravel etiology in the hope to treat and cure people. The ritual is about providing space for each therapist and each community worker to deal with their crisis situation within the safe environment of Agape and to find the different ways with which to co-exists with others.

The ritual is about providing a voice for everyone to share and speak about the hidden and the unspoken and in the process co-created a belonging, a togetherness and a community with fellow members. It is a ritual to connect with one's struggles and issues. It is a healing ritual co-created through language in a particular context by participants.

When the group of healers is too big, it can be divided into two groups with at least one supervisor belonging to each group. Membership to the ritual is open and permeable. Participants who feel that they have taken something from this ritual leave the groups and get into the many other activities that are occurring at the centre.

### Providing space for difference through activities

No typical psychometric assessment takes place at Agape as this would reify an objective and internal existence of some pathology embedded within the clients. The focus at Agape is on the functionality of individuals rather than on some assumed illness lying deep within the client. For this reason as well as the philosophical stand at Agape, Agape then becomes a place that offers opportunity for people to find their own voice and space and to gain an experience as well as a sense of being different.

Thus, there are many activities that occur concurrently at Agape Healing Community, with individuals deciding for themselves on how to be involved. Agape offers the opportunity for clients to be involved in these many activities and to gain a sense of belonging without necessarily having to be sick, afflicted or labelled as “schizophrenic” or patients of whatever sort.

Many people who come to Agape do not do so because they are physically or psychologically ill but because they are experiencing some loneliness in their lives and wish to become part of a particular community for the sake of forming connections. As a result of these people wanting to belong, Agape offers them the opportunity to be engaged differently from their accustomed way of being.

Agape has a wealth of members who are gifted in different types of art. There is an opportunity to belong and engage as a painter or learner painter at Agape. Members who may have interest in doing painting are inducted and led through a learning process. This offers an opportunity to those who are not at Agape to talk about their problem to find a place and space to

be engaged differently. Difference provides for a shift in redundant patterns of life, some of which could be connected to complaints that clients bring to the healing community.

Another new way of being at Agape could be through sculpting. This is another way to discover the otherness of people which could be brought forth outside the usual patterns of being and living. There is also a very popular activity of beating drums. Different members of Agape bring along the *Tragelaphus eurycerus* drums to the community. These drums are placed under the hut for any one to use them. A group is usually formed around the beating of drums and this group will sing and dance to their own music.

#### A sense of community within and beyond Agape

In line with ecological thinking, there are sangomas who occasionally visit the Agape community and who through drumming find a way to belong to this community of healers. This visitation by sangomas shows the holistic approach at Agape which permits for the spiritual dimension to also find expression. Apart from the sangomas that visit Agape there are the rituals of drumming.

Through drumming people find their spiritual connectedness and expression. This drum beating enables people to be physically engaged and also has the potential to transport or transform them from the physical domain to the spiritual domain of therapy, giving them the opportunity to explore and express their different ways of being.

Agape members are involved in performing drama or street theatre as other means of

educating people about mental health issues in general and child abuse in particular. To enlighten and make people aware about the gross child and woman abuse the themes of the dramas are written to amplify and highlight the struggle of the victims.

To be in touch with the community Agape does not remain the “mountain which Mohammed must visit” rather Agape goes beyond the confines of its geographical setting into the community. This is accomplished through therapists visiting their clients at home to gain first hand knowledge of their clients’ social, economic, religious and political contexts of living. This knowledge helps therapists to have a broader or an ecological view of the lives of their clients.

Another broadening of information is brought by volunteer community workers, police, teachers and social workers who come from the local community and bring into Agape their intimate knowledge of neighbourhoods, structures, politics and resources within communities co-created. They also contributed a freshness and innovativeness that are often lost when work is done by professionals who may be hemmed in or trapped by theoretical models.

Agape co-creates support with its members and the entire Mamelodi community. This support can be targeted at mothers with learning disabled children, a group of abused women or any other groups targeted as at risk. Over and above being involved with specific groups Agape is connected to a number of NGOs such as PAHA (People Against Human Abuse). There is a constant interchange of information and skills between Agape and PAHA. Agape is connected to the Mamelodi Aids Centre where it offers exposure and opportunity to its members to counsel and co-create support and community with the sufferers.

The co-creation of belonging and support with the broader Mamelodi community is illustrated by one case in point of an Agape client who died in a car accident. When the Agape community learnt of his death, the members organised and arranged for his funeral, and also even participated in the programme of his burial. The deceased client was also a psychiatric patient at Weskoppies (a psychiatric institution in Pretoria).

Agape did not save his life, but it was however there to comfort, to struggle together with the family, to hope and cry with them and also to face its own pain over the loss of its client. Agape was there to help co-create a sense of belonging for the family, togetherness and community with everyone experiencing loss.

Agape is a place where people come to form connections and a community for themselves. People do not come only to deal with dysfunctional behaviour. There are clients who come to Agape without seeking to be in a therapeutic dyad but only seeking to become part of something - belonging to Agape. There are clients to whom Agape offers the opportunity to deal with and face the discomfort of their loneliness, isolation and emptiness.

Agape organises workshops with professionals from different backgrounds to learn from each other about each one's way of intervening in dealing with the plight of people and the multiple strategies that can be deployed to help make people's lives effective. Agape members consult with sangomas and inyangas to learn about their frustrations and pains as well as achievements as members of the healing fraternity.

The bond between Agape and the residents of Mamelodi that has co-evolved is so strong

that they sometimes see it as everything to them. They come to inquire about where to take their family members when they do this and that; they come for advice, for instance, about disputes over housing; they come with financial problems. Agape does not try to play jack-of-all-trades nor does it offer a “one stop shop”. It however, look at the human element of things and attempts to understand the processes, dynamics and patterns of life that lead people to ask for help about almost everything. When and where it is necessary and relevant Agape refers people to the appropriate resource for help.

### Paper presentation

Basically Agape is a community of healing but its activities expanded beyond the domain of healing in that it (Agape) also provides space for academic growth and development. For this reason and also as part of the academic requirement for the MA in clinical psychology training the students or trainee therapists are expected to write academic papers and to present them to a panel of their trainers and lecturers.

The paper presentation is normally carried out and conducted in lecture halls at Unisa and RAU which served as the academic wing of Agape Healing Community. The papers could either have a purely academic and theoretical focus and content, or they could blend theory and practice as it unfolds at Agape. Paper presentation represented one of the tense moments for students since they are evaluated on their performance.

## Supervision

Agape is not only a community of healing but is at the same time a context of academic growth and learning for the therapists in the making who come to this place as students from both Unisa and RAU. Agape is a context where theory and practice interface. As a requirement for training and development the masters students have to receive continuous supervision to ensure that their professional growth and development meet the required standards for the clinical psychology profession. The supervision is handled by the trainers as well as therapists who have already finished the clinical or counselling course.

On each Wednesday supervision takes place all over the grounds of Agape. The trainee therapists are mostly given leeway to work independently with clients without someone watching over their shoulders. Since their involvement with clients is initially a novelty, they often run into difficulties with their clients and this necessitates the utilisation of supervision services.

The trainee therapists normally take clients on the recommendation of supervisors. They tackle all cases with vigour to solve problems, only to find themselves confused. To be untangled from this situation they have to break from the current therapy session and consult with their supervisors.

Supervision often takes place on a low wall where the supervisor would sit with the students. But this is not the only place where supervision takes place. Depending on a number of variables supervision could take place virtually anywhere on the grounds of the YMCA. For instance, on very hot summer days some supervisors prefer to do it under the trees.

On cold days it could be held inside the hall or even inside a parked car, if it works for both the supervisor and the student. There is virtually no restrictions imposed with regard to the actual physical place where it could take place except to create a safe space for reflection.

The supervision that takes place every Wednesday at Agape pertains to case supervision during which the trainee therapists bring the difficulties and challenges for supervision. It is quite often the case that the trainee therapists find themselves overwhelmed by certain issues and this necessitates their seeking supervision. The researcher wants to point out that supervision is however not an exclusive domain of therapists only. Even the community or lay counsellors have an opportunity to be in supervision and to benefit from it.

For Unisa students supervision never ends with the sessions at Agape on Wednesday, which mainly focuses on the clients. On other mornings there are supervision sessions held at Unisa where groups of students meet with supervisors. These supervisions are not only limited to the data that comes from the cases that the trainee therapists are dealing with but also include the self of the therapist.

The focus of these supervisions has to do with personal knowledge and awareness. It is also to do with the personal growth and development of trainee therapists. Supervision provides space for an inward looking search and to honestly reflect on how one's own issues are influencing one's working. Supervision also touches on professional and ethical issues.

### A typical day at Agape

Agape Healing Community begins its business at 09h00 in the morning. The therapists and community workers arrive much earlier, around 08h00 in the morning. Occasionally there are working clients who, per arrangement, come earlier than 09h00 so that they can get back at work during the morning part of the day. There is flexibility with regard to times for sessions. The Agape community does not have an official time for closing business. It depends on when the last client of the day will be seen and usually nobody leaves before 16h30 in the afternoon.

Agape's clientele come from the township of the greater Pretoria Metropolitan Area. They come from Atteredville, Ga-Rankuwa, Soshanguve, and mostly from Mamelodi. A great number come from as far afield as Nkangala in Mpumalanga Province. The clients come to Agape through a number of ways.

Some clients are referred by their medical doctors, schools, social workers, the police, churches, family and word of mouth. Others come on their own initiative. Agape has established a network of relationship with local social agencies, organisations, and government departments across the health, education and police sectors. Agape has a healthy working connection with doctors, dentists, sangomas, physiotherapists, teachers, spiritual healers, police and social workers.

The work that is done at Agape proceeds on two levels. On the first level what is done at Agape is conventional counselling and psychotherapy. There are individual and group therapy sessions that take place almost anywhere on the grounds surrounding Agape. These sessions as hinted at in the preceding sections take place under the trees, inside the hall, under the hut or just

about all over the place.

During individual sessions the identified client could be one individual, a couple or even the entire family, but whatever this identified client may be, the philosophical stance that underpins the working at Agape is that of ecosystemic thinking. According to Reiff (1968) ecosystemic thinking uses various levels of analysis to understand a phenomenon and it focuses on the contextual aspects of phenomenon. The frame of working at Agape does not impose a lot of limits on the therapy process with regard to structure and time that has to be adhered to.

The second level of what is done at Agape is the co-creation of a community for belonging and healing. This level of working is informed by Agape's philosophy of not "serving" or providing a service to the community. The working and thinking at this place is rather punctuated by a philosophical stance that seek to co-create or co-evolve a community with every member who comes to Agape.

There are usually visitors who come from abroad in the form of therapists, educationists and sometimes ordinary people who have heard and read about Agape and who make an effort to visit South Africa the for purpose of finding an opportunity to co-evolve as members of the Agape community. The 'visitors' do not remain visitors in the sense of just being observers as nothing is to be observed from the outside at Agape.

Every person who comes to Agape participates in its activities by finding whatever role he can play towards the creation of a healing community. Also, there are numerous groups of students from various institutions, such as schools, colleges, universities as well as from different historical

and cultural backgrounds who periodically visit Agape to be engaged as participants and members in the co-creation of this healing community.

On every Wednesday Agape members who can afford it bring along various types of food or contribute money in order to buy food. There are community members who volunteer to prepare the food for the rest of Agape members. The volunteers are members who have defined their role and involvement at Agape as such. Through becoming involved in that way they create their space and find their own voice and way of being at Agape helping to co-create a healing community.

At lunch time everybody at Agape gathers and takes his or her seat around a prepared table. Before food is served members observe a ritual. Members are welcomed, new people who are visiting for the first time are recognised and any special events are spoken about. Sometimes one person may talk out, making a confession or voicing a difficulty he or she may be having. Then one member leads the others in prayer or in spiritual talk, thanking either God or the gods of Africa for the food. Then people will share whatever is put on the table with one another. Typically people share from the same plate or bowl.

After lunch people go back to their various activities. Some go back to therapy while others go back to support groups, supervision, drumming and other activities. Time after lunch could also be used to make contacts and network with the broader Mamelodi community by way of visiting clients who for various reasons have not been able to keep their appointment. Contact is also maintained with the social welfare officials, schools, sangomas and all stakeholders of Agape Healing Community. Simultaneously those members who are not going out and who are in therapy and supervision will go on with their work until the last client is served.

The reader should now be able to see the contrasting picture between the two contexts of psychotherapy, that is the CPCs or CMHCs and Agape, in terms of their physical space, practices and processes. Table 3.1 below summarises the contrasts between these two contexts of community mental health provision. The contrasting picture will then serve as the foundation on which the ensuing research is based and from which the results shall be obtained.

Table 3.1

A summary of the differences between two community mental health facilities

<b>Community Mental Health Clinics</b>	<b>Agape Healing Community</b>
<p>1. <b>Contextual background:</b> CMHCs- state funded. Serve catchment area.</p>	<p>1. <b>Contextual Background:</b> Agape no state funds. Co-creates a community/ belonging</p>
<p>2. <b>Professional atmosphere:</b> Formal, business-like; highly structured ; clear hierarchy ; staff compliment professionals ; admin staff filling clerk, cleaners</p>	<p>2. <b>Professional atmosphere:</b> Openness, love; sharing; togetherness ; no hierarchy &amp; line of authority but respect of another ; Agape members therapists, community people &amp; all who take part in rituals and activities.</p>
<p>3. <b>Physical Settings:</b> Buildings, facilities &amp; equipment; office furniture, phones, faxes ; waiting rooms; port of call nursing station;</p>	<p>3. <b>Physical Settings:</b> No buildings, offices, waiting rooms ; big bluegum tree &amp; shelter ; files rotate between therapists ; no inside or outside-transcends physical space.</p>
<p>4. <b>Activities</b>            4.1 <b>Professional Ward Rounds:</b> Panel of medical specialists ; medical language- ward rounds ; processes similar to psychiatric hospitals ; medical ideology- treatment, diagnosis &amp; prognosis.</p>	<p>4. <b>Activities</b>            4.1 <b>Healing for Healers Ritual:</b>            Reciprocal healing ; central theme- healing- safe space for sharing stories and pain ; metaphor wounded healer ; co-create belonging, connectedness &amp; community</p>

<p><b>4.2 Assessment techniques:</b> Valid, Objective Psychometric tools ; provide diagnosis, problem formulation &amp; treatment plan ; individual sit of pathology ; cause &amp; effect principle ; DSM-IV popular</p>	<p><b>4.2 Providing space for difference:</b> No standard assessment tools ; no sick role - Agape give space &amp; voice for difference thru activities ; sculpting, dancing, drumming, drawing ; holistic approach spiritual, physical &amp; psychological ; a sense of community .</p>
<p><b>4.3 Supervision:</b> Held in offices only; strictly fitted within one hour period ; deals with professional issues.</p>	<p><b>4.3 Supervision:</b> No fixed place- under trees, low wall behind YMCA, inside hall, anywhere ; on the spot when stuck in therapy ; deals both with professional issues and personal issues.</p>
<p><b>4.4 A Typical day at CMHCs:</b> Patients queue in waiting room ; no interaction between patients- stranger atmosphere ; no activities -no sense of community ; provision of service ;mind your business attitude ; clinics replicas of hospitals ; professional distance kept between patients and service providers ; strictly 50-60 minutes session ; work done-assessment, therapy, counselling &amp; treatment.</p>	<p><b>4.4 A Typical day at Agape:</b> Agape members arrive early collect &amp; arrange chairs ; therapists do not provide service but co-create a community ; high interaction between Agape community thru activities ; sense of community ; visitors come to Agape not to be onlookers but co-create a community ; people come to Agape to belong ; lunch time all people share meals together from same bowl ; introduction of new members &amp; confessions.</p>

## CHAPTER 4

### INTERVIEWS

#### Introduction

The two levels of data collection used in this study were alluded to in Chapter 3. These have been presented in two different chapters purely due to the length of their content. The one level of descriptions of ecologies has been dealt with in the previous chapter, and the second level comprising interviews is presented in this chapter. The interviews represent the 'raw' data obtained from service providers in the two different contexts of psychotherapy. The chapter has been arranged in such a way that the background to the interview procedures and the interview process for each context are presented separately.

#### Background Procedure: Community Mental Health Clinics

Although the researcher began the field interviews at Agape and then continued at the CMHCs, however, for the purpose of the dissertation and in line with maintaining consistency he will present data on the CMHCs first to be followed by information from the CMHCs.

On the last Wednesday of the interviews at Agape, when the researcher had finished, he drove to Johannesburg in search for the Central Wits Health Region offices. It was the first time that the researcher went to these offices. These offices serve as the regional head office of the community mental health clinics in the southern region of Gauteng province.

On arrival the researcher landed in the office of the director in charge of community mental health clinics in southern Gauteng. The researcher explained the purpose of his visit and was requested to write an official letter detailing the technical aspect of his study and what the study hoped to achieve. He complied with the request and delivered it by hand to the director's office. It took longer than one month for the request to be processed but nonetheless the researcher was happy that ultimately permission was granted.

The first Friday following the granting of the permission the researcher went to the offices to make personal contacts, briefing and arrangements with the participants. Friday was the only day on which the participants could be involved in the study since it was a day set aside for the administrative work and report writing at the CMHCs. On that Friday he made contact with all the senior health officers to inform them about who he was, his purpose for being there and soliciting their support. At the end of the business day he had made agreements about the day and time of meeting with all participants.

There were nine members of the mental health complement at the regional offices who worked at Zola Clinic. After liaising with the head of the unit only seven (7) were selected for the interviews. The two staffers omitted were psychiatrists. The criterion for omitting them was that in the context of Zola and Eaglemont their scope of work was limited to pure medical practices which entailed physical examinations and the prescription of medicines only due to the high patients load.

In this context the psychiatrists were never involved in any psychotherapeutic or psychosocial work of any kind as this work was the sole domain of other professionals such as

psychologists, intern-psychologists, social workers, psychiatric nurses and occupational therapists. Therefore the selection of participants was based on their involvement in either psychotherapeutic, psychosocial or biosocial therapeutic work. The criterion included the professionals whose actual practice at the clinics went beyond just prescribing and dispensing of medicines to the patients but to those who also deal with the psychological or social issues around patients' illness.

Finally the seven (7) participants were interviewed. This number correlated with the number at Agape. The people who were included in the interviews at the CMHCs were two therapists, three intern psychologist who were in their second year of studies for a masters degree, a social worker and occupational therapists. These people were collectively referred to as the psycho-social team. The criterion for selection was that people should be oriented towards psychotherapeutic interventions of a psychosocial nature rather than medical intervention.

No psychiatric nurse was included for the simple reasons that, firstly, other professions were preferred since they are not heavily rooted in the medical and biological sciences and secondly the scope of operation of psychiatric nurses at the CMHCs was to administer medication only; they were never involved in psychotherapeutic interventions. Senior psychologists who are supervisors were not included in the study since their high position in the hierarchy renders them occasionally unavailable as they normally act as consultants somewhere outside the clinics.

#### Interview Process: Community Mental Health Clinics

On the first Friday that the interviews were scheduled to commence the researcher arrived at the regional offices at about eight-thirty (8h30) to find that some professionals had already

arrived and were busy with the report writing and yet at the same time ready to be interviewed. Within less than a quarter of an hour after arrival the researcher had already begun the process of interviewing the first professional.

Firstly the researcher had to conform to ethical principles of informed consent, privacy and anonymity implied and defined in the section on Agape which follows below. Interviews were held in offices of professionals. The offices were suitable and provided well for privacy and blocking out possible distractions. Since the offices were located in the city centre the researcher's level of anxiety during the interview was minimal as there was little chance of possible destructive variables such as noise from hooting cars, passing buses and taxis. Everything ran smoothly at the CMHC.

The researcher interviewed one professional after the other with a pause of about five (5) to ten (10) minutes in between. By two o'clock (14h00), he had already interviewed seven (7) professionals with the longest interview lasting thirty minutes and the shortest lasting eighteen (18) minutes, an average of about twenty five minutes.

Although the researcher does not want to preempt things it is important to indicate here that overall, the time it took to interview people at the CMHCs was much shorter than anticipated. This was despite the fact that the same set of questions was also asked at Agape. The responses that the participants provided at the CMHCs were rather short and focused on the technical aspects of therapy than on personal issues. Participants responses were guided by the medical psychiatric ideology which was the dominant thinking in that context.

## Background Procedure: Agape Healing Community

The first leg of the interviews at Agape Healing Community started with a telephone conversation with Stan and Corinne, the conveners of Agape Healing Community, to request permission to interview members of Agape community. Subsequently I drove to Mamelodi, a township east of Pretoria, where Agape is located to formalise the permission in terms of the days and times of interviewing participants. Since Stan was my supervisor we had to negotiate issues such as how many members to interview, who was suitable to be interviewed as well as the structure and format of the interviews. After considerable discussions and negotiations, I finally could interview seven members of Agape excluding Stan.

In line with the philosophy of qualitative research, the researcher did not set out to obtain a representative sample but interviewed seven people selected in consultation with the supervisor. The participants were chosen on the basis of the members who formed the core of the work done at Agape. Members from both the therapist group and the community workers were involved. The participants who were involved were therapists, therapists-in-training (MA clinical psychology students from Unisa and RAU as well as the MA community psychology students from RAU) and Agape community workers.

## Interview Process: Agape Healing Community

The researcher first had to obtain informed consent from the participants. The participants were assured of privacy and anonymity in the research report. According to Neuman (1997) privacy means that information obtained about the research subject should be used only for the

purposes of that research and not for any other purpose unless with the consent of the subject. Anonymity refers to the researcher's obligation to protect the identity of the subject after research data is gathered (Neuman, 1997). When all ethical issues were dealt with, an agreement about days and times of the interviews was entered into.

As per agreement with everyone the researcher had to interview seven (7) people but to start at times and days agreed upon proved a futile endeavour. The reader should be aware that interviews could only take place on Wednesdays after therapy sessions were finished. It took three Wednesdays before the first interview could commence. On these three Wednesday participants just seemed busy with therapy sessions and supervision as this seemed to matter most to them.

After having driven for almost two(2) hours from his home the researcher would on each Wednesday arrive at Agape at about eight-thirty (8h30) in the morning with the hope that he could begin the interviews at nine (9h00). Although the researcher embraced the philosophic assumptions of qualitative research on one level, on another level that of the pragmatic stance, he was pressed for time to deliver the research report within a reasonable period . Therefore this pragmatic stance sometimes made him act like a technician who was only concerned with work no matter at what cost.

He became vulnerable to transgressing the very principles of qualitative research he holds so dearly. The researcher would come to Agape with the attitude of conducting interviews within a certain time frame, following a particular format and schedule and being as technical and professional as possible. The researcher did not want to go to Agape to be sucked into the dynamics and processes that take place there. His business was to get in there as a technician with

no human-affective strings attached, and do the interviews following a particular sequence as quickly as possible.

However on each Wednesday morning when Agape members arrived there is a particular process that unfolds together with concomitant rituals. The first ritual that marks the beginning of the day is gathering into groups of healing . This is where Agape members get into groups to reflect on their own issues and processes that unfold at this place. The researcher was very reluctant to become part of these groups as, his sole purpose was to conduct interviews, nothing more and nothing less. Ultimately the researcher joined in these groups initially out of boredom and being frustrated by waiting for participants to finish what mattered most to them.

Being part of these groups perturbed the researcher to a point that he began to reflect about his own issues and the struggle that he was experiencing around research. This confirmed Agape being a healing community where people come in different ways to seek their own healing. The researcher came as an interviewer and at all cost wanted to maintain that stance, but would be perturbed into opening up about his struggles in the human enterprise called research.

The researcher's frustrations were not only limited to the rituals performed but were exacerbated by many of the reasons that the participants would provide as an excuse not to be interviewed on the day and time schedule agreed upon. Their reasons ranged from having to be in therapy with clients or doing house visits to clients who may not have shown up for countless sessions.

The researcher would indeed be frustrated and became very angry to experience plans

which were agreed on earlier being broken. The researcher would sit around seeing people moving from therapy sessions to supervision the whole day. During this process the researcher was reminded of a fundamental principle in research that is consistent with qualitative research that:

**“he does not do research on people as though they were objects and things that he only could manipulate, measure and classify but rather he was doing research with people who had to be understood and respected for who they are and their own issues” (Maruyama, 1981).**

Remembering this principle brought about an important turning point in the researcher's attitude and approach. The researcher began to do introspection into his approach to people and realised that he was pressurising them to fit his own agenda, without negotiating with them on day to day basis what is to be done and when to do it.

The researcher then arranged with participants that they could begin with what they had to do for the day, and only when they have finished their business would they then arrange with him for interviewing. This new arrangement seemed to empower participants and they began to have a sense of owning the process and being in control of when they wanted to take part or not. It was amazing how participants became cooperative and showed willingness to participate once they became part of the decision of when to talk or not.

Once participants believed that they had a say regarding the timing of the interviews they became more readily available. This further confirms the qualitative research principle that the researcher has to do research with the people, that is, in collaboration and consultation with them,

and without imposing certain aspects of the research procedure on them (Denzin & Lincoln, 1994). With their cooperation guaranteed, at times it turned out that two participants were willing to be interviewed at the same time.

When the interviews were finally held they were initially held inside a community hall. Fortunately for the researcher, after doing the first interview he immediately listened to the quality of the recording and established that the recorded material was of a poor quality. A decision was taken to change the interviewing venue but because of a lack of proper and facilities there was no other place where the interviews could be held. Ultimately a decision was taken that the interviews would be held inside parked cars so as to minimise the level and extent of the noise since all the interview material had to be audiotaped.

In the light of these circumstances the researcher had to endure a lot of anxiety and frustrations about the ultimate quality of the recorded material. The researcher developed anchor questions which constituted the core of the interview. However, he had a space to make probes and follow up on some unclear responses. In almost all interviews the researcher endeavoured to follow the same sequence in asking questions.

The same set of questions were asked at the CMHCs and it turned out that the responses of participants from Agape were longer and more elaborate. Their responses went beyond the technical aspects about therapy to include reflections on personal issues and meanings. The longest interview lasted for forty (40) minutes while the shortest took twenty two (22) minutes. The average time it took for most interviews was thirty minutes (30).

## Analysis of Interviews

All the interviews were analysed using the same headings as those emanating from the interview questions. The interview questions were grouped into headings which were used as the anchor points of analysis. That is for each interview the analysis proceeded from one heading to the other. The contents within each heading were analysed to see what pattern of information emerged and what differences and contrasting points evolved.

Table 4.1 below has grouped the main questions under headings. The use of similar headings is to enable consistency and comparability between these interviews. However, due to the voluminous data gathered by qualitative methods the researcher has adopted the cross-case analysis as the strategy for analysing interviews with the dominant ideas forming the core of the analysis.

Patton (1990) defines cross-case analysis as “grouping together answers from different people to common questions or analysing different perspectives on central issues” (p.376). He states that this analysis is fairly easy if the standard open-ended interviews are used. The interviews questions used in the study met this criterion. He further argues that with an interview guide approach, answers from different people can be grouped by topic.

All the research participants were asked the following interview questions:

- What does the concept ‘community’ mean to you ?
- Where is the ‘community’ that you are serving ?
- What kind of work is done here (at the clinic) ?

- Who come here (to the clinic ) and what do they come here for ?
- What do people do (activities) when you are seeing other clients ?
- What else do you do (activities) beyond engaging people in therapy ?
- What effect or impact does the frame of therapy or physical setting has on therapy ?
- What is the role and scope of the DSM-IV here ?
- What personal meaning does the clinic have for you ?
- What lessons have you learnt from the clinic ?
- Is there anything else you want to comment on ?

Table 4.1 : A summary of headings used in the analysis of interviews.

1.Perception and Meaning of the concept 'community'
2.The type of people seen and the nature of work done at each context
3. What people do when mental health workers are seeing other clients (Activities)
4. Activities that mental health workers engage in beyond therapy
5. The impact of the frame of therapy and the physical setting during therapy
6. The relevance and usage of the DSM-IV and other assessment tools at each context
7. The meaning that each context has for mental health workers
8. The lessons that the mental health workers have learned from each context

#### Analysis of Interviews: Community Mental Health Clinics

The interviews of participants from the CMHCs have been given names of minerals so as to protect their identity. The analysis is based on the topics derived from the standard questions,

and the dominant ideas are extracted from the interviews.

### Perception and meaning of the concept “Community”

Most respondents in this group conceptualise community as a geographical entity. This is evidenced by most of them referring to the name of geographical places they work in for instance, Zola in Soweto and Hillbrow in Johannesburg. Their understanding of community is that of a physical space or place with boundaries through which people can enter and leave as and when they want.

Furthermore they see community in terms of the different racial backgrounds of people who stay in those communities. To most of them community is made of people who share the same cultural background. For instance Ferrum talks of a ‘black area’, Carbon talks about the ‘background that people come from’ and Manganese talks about ‘black , coloured and Indian communities’. This is an indication of how entrenched the racial division was in health issues.

Respondents see themselves as a separate entity from the geographical community that they serve. They perceive their role as that of service providers . Community for most of them means a group of people who are one way or the other disadvantaged economically. This is evidenced by the following words from the extracts: poor, needy, and disadvantaged . They perceive themselves as outsiders and experts who render valuable services to the communities that are in need of their services. Some of them see community as consisting of people either as a group with common interests or doing something together. Extracts from the interviews:

Ferrum: "I serve the poor who go to Zola clinic which is a black area. I also serve Hillbrow area. As experts we are involved with people in a particular area who need treatment."

Platinum: "community to me is made out of various stakeholders, people that stay in that geographical area. I serve mostly the needy community of Soweto and Johannesburg."

Carbon: "I work in Soweto and Hillbrow. For me community means entering at the level that you understand a group of people from a given area and the background they come from. Most members we see from these communities are disadvantaged."

Manganese: "I understand it as speaking about a group of people having various links with each other. Another link would be through common area in which they live. This area can be a black community, Coloured community or even Indian community."

#### The type of people seen and the nature of work done in each context

All members interviewed were part of the psychosocial team while medically trained personnel were not part of this study. The participants were selected to be part of the study primarily because they are members of the psychosocial team at the clinics. However an analysis of their responses indicate the predominance of the medical ideology in their conversations, which show their role and functioning in these ecologies. They see the clinic as having a single function: to provide treatment to mental illness with biological and medical causes.

Therefore the language of these professionals is riddled with psychiatric medical terms, despite the fact that most clients who come here are suffering from social, marital, family and financial problems. The medical terms that often and popularly used are "diagnosis", "patients", "mental examination" and "treatment". Extracts from the interviews:

Platinum: "Patients come regularly for treatment, they come here for medication as well as psychotherapy."

Ferrum: "Its whole range of patients those that have psychiatric diagnosis and those who are referred for assessment. I am the first line of contact that the patients come across and I do a proper psychiatric assessment and mental examination right through to the diagnoses and many a times I recommend treatment."

Carbon: "We treat patients who mostly come from poor backgrounds who cannot afford medical aids. It is a variety of people who bring different ailments who come from low socio-economic status."

Steel: "I do work with high functioning psychiatric patients who have insight and can benefit from therapy. I do assessment on children who present emotional problems such as ADDH, anxiety disorders and depression usually associated with learning problems."

#### What people do when mental health workers or therapists are seeing other clients

The Community Mental Health Clinics (CMHCs) only cater for psychotherapy and counselling from a clinical perspective that is based on the one-to-one approach. The respondents share a common sense of understanding that people have to wait in idleness when the service providers are busy. The waiting is the result of the fact that the clinics do not operate on an appointment basis. Patients are seen on the first-come, first serve basis.

The long wait the patients endure render service providers helpless since they cannot find alternative ways of engaging them otherwise besides only in their sick role as patients. Therefore because of lack of alternative activities to engage patients when they are busy, unfortunately the

patients will just have to wait without doing anything.

There is a general belief that the situation can be alleviated if the staff complement is boosted through hiring of additional staff. The current reported shortage of staff leads to frustration and helplessness among staffers. Respondents seem to be saying that if we had more staff then the patients would not have to wait and therefore they would be better treated. This assertion is congruent with the medical ideology of treating people. The responses do not include references to specific activities that could create a sense of 'community'. Extracts from the interviews:

Iron: "It is always difficult at the community clinics to have people keeping to their appointments...it is difficult to schedule appointments here. People come anytime when they want to come and unfortunately they will have to wait while I see others. We are short staffed."

Thorium: "Unfortunately the clinics are not run on an appointment basis .. So ...ya they have to wait. When they wait it can be for two or three hours depending on the turnout that day. If maybe we had projects to keep them busy."

Manganese: "The wait can be as long as three hours. That is a bad issue here... they don't do anything while waiting and I know that the system has to change. Maybe we need to set in motion the process of training nursing sisters, nursing assistants and health promoters in counselling and I think this will expand the numbers of trained counsellors and will have effects to lessen the amount of time required to queue."

Carbon: " I see people on a first-come-first basis. Unfortunately in the process of doing things some will have to wait. We run on a skeleton staff here. My observation is that people are

willing to wait.”

Platinum: “Well there is not much I personally can do when people have to wait as a result of the shortage of personnel at the clinics. People have to be prepared to wait here. While waiting they do nothing, besides there is nothing to be done here.”

#### Activities that mental health workers or therapists engage in beyond therapy

Mental health workers perceive themselves as service providers whose scope of practice is determined by their professional training and ethics of their profession. For this reason they do not engage in any other activities that are not aligned with professional practice. There is a clear indication of the separateness between the service providers and the community that they are serving. There is a theme that the CMHCs are there to offer professional and clinical services such as psychotherapy and psychometric assessment only. Other activities or projects of whatever nature fall outside of the ambit of these clinics.

Another emerging theme is that of service providers who are more willing to do community work outside of the clinic and not with the people who come to the clinic. This is consistent with their view of community as something ‘out there’ and external to themselves and having physical boundaries. Therefore it is inconsistent that the participants find a way to do projects with the people ‘out there’ rather than to engage those who come to the clinics. The respondents’ main task at the clinics is to do therapy or clinical work. Extracts from the interviews:

Platinum: “I do a bit of community work liaising with various outside community organisations.”

Thorium: “We generally come to the clinics for therapy and basically that is about the only thing we do and know better.”

Iron: “From my social work background .. I would love to engage with people not from a therapy side only..ah getting to know them better .. To discuss other things not related to therapy but doing therapy from the psychodynamic view is very difficult. If you have already established rapport there is no way that you can extend it outside of the therapy situation and formulate some bond with people..this is impossible. I cannot engage with people outside therapy therefore I don’t do much beyond therapy.”

Ferrum: “...eehm..I contact various organisations and structures from outside the clinics. I try to involve the community that is the outside stakeholders. I involve the people out there in general.”

#### Impact of the frame of therapy and the physical settings during therapy

The researcher describes the frame of therapy as the structure and organisation that govern or direct the process of therapy from a specific theoretical and practical perspective. The frame of doing therapy at the clinics imposes restrictions, rules and guidelines with regard to the length of the session, the nature of the physical setting and also what to do or not to do. At the clinics the sessions last for a period between fifty minutes to an hour, but usually a period not exceeding an hour. Time is of the essence in this setting.

The sitting positions between the mental health worker and the patient as well as the physical arrangement of furniture is organised in a particular manner in advance. This means that the service provider has a predetermined sitting position which cannot be negotiated with the

clients. Usually inside the consulting room there are two chairs and a coffee table between the therapist and the patient.

The physical arrangement of providing sitting space for one 'client' presupposes that the client is one individual who fits with the view that the site of the problem is within the person. This conforms to the psychodynamic approach and the medical model that locates the seat of pathology within the individual. The therapist has his/her own chair where he/she sits daily.

The consultation rooms impose restrictions and do not allow mental health workers flexibility in terms of where they could choose to do therapy. Therapy is usually done indoors. The setting at the clinics and the frame of therapy create the idea of 'rooms' as the ideal contexts for therapy. For some respondents there is a theme that sees the rooms as imposing limits on how service providers have to carry out their duties. The arrangement in the rooms are seen as not friendly and welcoming to clients and also do not provide an opportunity for relaxing. Extracts from the interviews:

Ferrum: "I see them strictly for a period of about fifty minutes and I have an office where I normally see them."

Steel: "I have an office where I usually work...I have to work within a period of an hour but not exceeding it. There will be no justification psychodynamically to do therapy beyond an hour."

Manganese: "I could see a person for an hour or for less time it all depends but it is unacceptable according the frame of therapy here to exceed the hour limit. ...Ah the rooms I find them very dull and limiting. I would like rooms that are more comfortable and relaxing ...eehm

to have pictures, to be welcoming and inviting to the clients. I also would like to invite clients to, say, have coffee with me but I know that psychodynamically it is totally not acceptable.”

Iron: “It is in a small room with two chairs and a table. It is kind of limiting, just having two chairs across each other with a table in between. We don’t normally go out ..eehm just to go out to sit in the shade somewhere or other space, except to be in this confined four walled room. I wonder how it would be like to have an informal kind of a situation or even walking for that matter. I know that other people are not into discussing issues in a confined kind of space ...it is like they are closed or blocked and they want to talk outside where they can have fresh air and maybe even bask in the sun. Eeehm.. personally I would like to work that way with people but because of the frame of therapy here I dare not even think about it.”

It is usually the case at CMHCs that the frame of therapy is imposed. According to data from the interviews it appears that the frame of therapy imposed at the clinics determines the consulting rooms as the absolute space for doing therapy. Therapy is seen as suitably done only in a ‘room’ and not in any other context.

#### Relevance and usage of the DSM-IV and other assessment tools in each context

Within the contexts of the CMHCs, the DSM-IV together with psychological assessment play a central role towards diagnosis and treatment. All respondents attaches great significance to the usage of these two activities as tools. This is consistent with the psychiatric medical model adopted at the clinics.

Therapists at these clinics believe that for them to be able to treat their clients properly they need to understand the root cause of behaviour. Their underlying assumption is that treatment is contingent upon correct assessment and diagnosis. However, all of them call for the need to be cautious about fixing permanent labels on patients and rigidly lumping them into fixed categories of pathology.

It should be noted that the respondents use DSM-IV language not only to treat patients but as a way of defining themselves or oneself as being on the treatment team, that is, a professional and not a patient. Another implication of using the DSM-IV is that when the service providers do not find anything in the DSM-IV the patient gets sent to another professional. This is indicative of how the professional defines the extent of his or her role. Extracts from the interviews:

Manganese: "Psychological assessment is some kind of a diagnostic tool that helps to arrive at some answers. The DSM-IV is useful in giving the profile of a person's symptoms and perhaps what the person could be suffering from. I use it with mood disorders and temporal lobe epilepsy, these conditions often get misdiagnosed if you do not follow the DSM-IV."

Iron: "We do a lot of assessment especially with children. Schools refer a lot. Assessment is used to establish if there is any learning disabilities and where we have managed to find the problem to know how best to manage it and if nothing is found to refer the client to the other professional. However we use the DSM-IV as a guideline. It is difficult that you can always adjust your criteria to the group of people we are seeing in community."

Thorium: "Yes ofcourse as a psychologist I do assessment. It is very much important. I think

the DSM-IV is an important indicator of people's functioning and it is an important guideline into understanding people and also understanding different methods of treatment. But the DSM-IV can be restrictive at times where you look at the symptoms and you need to follow each symptom and think you need to keep an open mind to remember that each client is different."

Ferrum: "As psychologists we don't just treat the symptoms but always go deeper to treat the underlying cause..eehm. I get to the roots of the problem through assessment tools. I believe in the DSM-IV. If you do not have an accurate diagnosis you cannot treat your patients. If you are unable to diagnose your patients and you don't know what symptoms you are looking for and you don't know the differential diagnosis of each patient, you could be making major mistakes and totally overlooking cases like, say, bipolar mood disorder."

Carbon: "Without the DSM-IV and assessment you basically do not have any basis for treatment. You have to possess sufficient knowledge about all tools of assessment and diagnosis, otherwise I may find myself out of touch with the rest of the group without this important knowledge. Therefore the DSM-IV is very much important for survival as a member of the treatment team."

### Meaning of the clinics for mental health workers or therapists

The meaning that the clinics have for therapists is for most of them very impersonal and appears to be technical. The clinics are the treatment centres for the community. When people in the community have mental health problems they make use of the clinics. The clinics mean to most of them places where they provide clinical services only to the community. The clinics are

seen as centres where the experts provide a professional service to the community.

They see the clinics as places that cater for the needs of the poor and the disadvantaged. Their work there is seen as some kind of charity project done for those who are unable to do things for themselves. There is a theme of respondents seeing themselves engaged in a benevolent act towards the clients from the clinics. There is a sense of respondents having a grandiose feeling about what they are doing.

On another level the clinic has a personal meaning to the respondents. There is clear evidence of themselves feeling proud about what they do 'doing something for them'- and what the clinics mean to themselves. To the respondents the clinics are not about the people who come there with issues. Little is said or noted in the responses about the plight and sufferings of people and how the clinics have strived to help them or bring a difference to their lives. To the respondents it is about the mileage that they gain from their involvement in these clinics. Extracts from the interviews:

Ferrum: "For me they mean providing services to people who do not have medical aids, who cannot afford private practice and who desperately need our services. I have turned down offers to work in the private sector specifically for this reason to serve the poor ...the community."

Manganese: "I see myself as the caretaker of the needs of community. I provide a service from an expert position that is valuable to the community. To me the clinics mean giving something to the country and making some form of contribution."

Steel: "The fact that I am making a difference to the people who come here is meaningful to

me...by providing different services to different people that come to the clinics ..ya..that I feel proud that I am doing something for the community.”

Platinum: “I just see poverty and suffering when I get to the clinics. I see high rates of HIV. I see squalor. I see desperation in the faces of the clients. These clinics mean working with people that are badly affected by poverty. Its poverty, poverty and poverty all the way. It is sad for me to work here but it brings the joy that at least I am doing something for them..eehm the poor.”

Iron: “My sense of working here and what it means to me has diminished with time. I saw myself as somebody who is providing services to the community but now it has changed. Because of shortage of staff and rigid management style I no longer see myself as such. I am no longer productive.

Iron’s response in particular reveals the problems and the hardships facing therapists who are working in the CMHCs. His response reflects the low morale and struggle that it entails to be functional at the clinics.

#### Lessons mental health workers or therapists have learned from the clinics

There are varied and various lessons that each therapist has learned. Each individual has learned a unique and personal lesson that cannot be generalised for the whole team. Despite the diverse answers that they gave there is a common opinion expressed by most of them: That regardless of the different communities that they serve the human problems are the same and that all people from different corners of the world suffer pain about hurt. The responses of participants lack depth in terms of the personal lessons that have brought personal growth and transformation to each one of them. Extracts from the interviews:

Manganese regards himself as a white liberal who deals with issues of black people in the community and this is what he learned:

“I have learned that there are no white or black issues. All humans are fundamentally the same and suffer pain in the same way. Therefore issues are issues and occur to people in general regardless of race or whatever.”

Ferrum: “For me ..the greatest lesson is that the community needs psychologists. I find that many people have never had this benefit and were treated for years and years on medication are now getting the benefit through the psychologists.”

Steel: “I have learned about networking. Networking is very important. If you don’t network you don’t become effective. I need to liaise with the police, child protection unit, social workers, schools and every important group in the community.”

Carbon: “If you want to take anything to the community you need community support and the various ways of doing that is through getting to know different structures and leaders. I have also learned that when you take a project to the community you need to take responsibility.”

Thorium: “I have learned that there is such a great need for people to be heard and allowed to express their fears, anxiety and problems. The greatest lesson I have learned is that you can impart so much to the people and that you can also learn from them.”

Platinum: “I have learned that people are different and have different coping mechanisms. Clients may come across the same problem but they present differently.”

Iron resisted talking about what he learned. He complained about the poor management style at the clinics:

“I am not happy with how these services are managed. They are run like hospitals or even

mental institutions. We care very much for our profession than the plight of clients. Things are not well here. There is low morale and high stress levels due to poor management.”

### Analysis of Interviews: Agape

The interviewees at Agape have been given fruit names to conceal their identities. In line with analyses from the CMHCs or CPC, the analyses at Agape shall proceed from the same headings emanating from the interview questions, with the dominant ideas forming part of this analysis, so as to provide a contrasting picture between the two community clinics in terms of their epistemology, ontology, processes and procedures.

### Perception and meaning of the concept ‘community’

Therapists at Agape do not understand “community” in terms of a geographical setting or a catchment area. All respondents have indicated this viewpoint about ‘community’. The central word about community to Agape members is ‘people’. They see community as the involvement of people with one another. They see it as an interaction among people who want to achieve a common aim. They see it as a bond that ties people together and that enables them to share between themselves with each other.

They see it as created by people who have certain issues to deal with. Community to them is about belonging to and connecting with others. To them community is not a physical entity or a location with physical boundaries but it is socially constructed by the members who participate

in it.

It is interesting to note that the participants do not see themselves as serving a particular geographical setting or catchment area, instead they see themselves as co-creating a community with the members of Agape. Data extracted from the interviews in support of the analysis:

Apple: “ehm..community for me its people. First of all its people and meeting together and using what is around you. Community is about belonging..about people..being connected to others. Its not about locality because I am carrying a lot of people with when I am going to Johannesburg and I know that I am staying behind as well. So its not about the physical space Mamelodi I am not serving a community ‘out there’ I am co-creating a community with the people who come to Agape. The people I am working with is my community as well.”

Lemon: “It’s a very broad concept..eehm..it involves interaction with people..relating with them. Agape creates a community with people who come to us with problems. Agape also caters for a community of people who want to belong and do not have anywhere to go.”

Apricot: “Community is about people..eehm..you can have a community of healers, you can have a community of drug addicts, you can have a community about healing itself but mainly community is about people. My understanding of it is probably a bond, something similar that the people share in some way that they bond and there is connection between them. Agape does not serve a particular place, it works with its people who have come and continue to come here in different ways. Some come as therapists, some as clients and some as neither therapists or clients but as people who come to find their own belonging.”

Banana: “The way I see..a community is not something that is bound by geographical setting of the place that we live when I think about a community I think about something that you

feel, so it's a feeling between people, the bond between them, the sharing between..ya its about people I think.”

Peach: “It specifies a certain group of people who are living in the same culture having the goals and dreams and same feelings about something and they share and work towards helping each other.”

Orange: “Its people who share common goals..I don't understand it as a geographical area..its people with common interests, they share similar things and issues together. We do not serve here..serving implies that people cant do for themselves. We only create a community here with the therapists, clients, students, workers and just with everybody here.”

#### The type of people seen and the nature of work done in each context

Agape members do not see what is done at this place in terms of the first order level only. That is they do not see what is done in a linear sense wherein someone does something to somebody. Furthermore they do not see what is done in terms of counselling or psychotherapy only. The buzz word about what is done at Agape is “healing”. They see healing as mostly to create a community wherein people will feel safe to explore their own issues. They see healing as creating a safe environment for people to find their voice and experience their different state of being.

They see themselves as working with people who are experiencing a crisis of living and who are at certain points in the journey of their lives. They do not see pathology in people by referring to them as patients. People who come to Agape change their roles as required by the

context. That is: Sometimes clients become community members who participate in certain activities such as preparing meals, doing art work, interpreting for therapists who cannot speak the language of the clients, and sometimes therapists also become clients.

Banana: "Agape is a place where community is formed, where people come looking for community to belong to. On a first order level counselling is done here. Also people get healing and we try and make a space of healing between people."

Apricot: "It is difficult to say on a tangible level because my experience here is more emotional and I have nothing practical to show. What is being done here is about bonding and forming connection with people and feeling like having a place that is safe to say whatever you want to say. Its more about bonding and joining with people in terms of where they are and you are. Eh.. .. on one level you could say psychotherapy but not traditional one with boundaries and rules about what to do and not to do. Traditional psychotherapy is more rule based there is a lot of should, should....whereas what is done here is much healing which involves a lot of could, could.... We see clients initially and with time they become friends and members of Agape. This may not fit in terms of conventional psychotherapy but in terms of what I call healing it does. To see people as patients would break down the community as well as the respect that is fostered through creating a community together with people."

Mango: "We make connections with people at different levels whether as clients or as even just as people. Some people could be coming because they are feeling lonely at home so Agape is the place they come to in order to form connections. Others come because they have problems with life situations-be they marital, school, drugs, financial or whatever. .. Some people come here initially as clients but with time I cannot refer to them as clients anymore

because they become part of Agape. They become regulars even beyond what they had initially come for. People don't just occupy one role here and even me as the therapist sometimes I play with the children and become a peer to them, sometimes I become a sister or a mother..ag its different all the time..its creating a community."

Orange: "Agape provides a space for people to bring their problems and to feel safe to bring those problems here. But Agape at the same time does not provide solutions to people. It is not a solution station. It's a meeting station ..a meeting place, a connection station and a place to be safe to talk about your staff and to belong. ... Its not only those who bring problems who are helped but even those who help also receive their own help here hence we don't talk about patients here otherwise it would create lots of confusion."

Apple: "What we do here is to meet with people and healing. I think first of all we do healing. Healing is about meeting people where they are at in their suffering and your own suffering. I don't try to make things better or change them because that will assume that I know better and can change them and I can't. All I do is to allow people to find their own voice, to hear their own voice and to open themselves for healing....I must say anybody can come here even the therapist. Let me tell you that I also come here for myself. I find my own healing through the staff I am doing. People come here for themselves to create their own space and to find their own voice...ya for healing."

#### What people do when the mental health workers or therapists are seeing other clients

Usually on the days that Agape is open there are groups which are run and there are also many activities that complement therapy. In fact these activities are themselves therapeutic as they offer people the opportunity to experience being different and to engage differently. Agape has no

waiting rooms for people to wait in idleness. When people arrive at Agape and the therapists are busy there are activities that they can engage in to explore different roles.

People who come to Agape come in different ways. Some come looking for help in terms of their personal problems, others come to seek company and to belong to Agape. So the activities that Agape members co-create with the community are intended not to perpetuate the sick role that many people may find convenient to act out in order to gain entry to this community. Activities that are co-created are there to offer the people the opportunity to become different and experience themselves as such at Agape. There is a theme that says that Agape is a community that allows people to experience difference in the lives through many activities.

Mango: "We do not have waiting rooms here for we do not make people wait. People come here to belong and not to wait. There are a variety of activities going on at the same time. People are normally encouraged to participate in any of those activities. When a person has come to see me in particular, and I am busy, he can always take part in many rituals and activities of healing that Agape members co-creates"

Apricot: "Unfortunately we do not have waiting rooms here, instead we have many activities that offer an opportunity for healing even before there is a direct therapeutic conversation between the therapist and the client."

Orange: "In a sense people don't have to wait in idleness here when I am busy. Agape provides alternative activities in which they can participate until I finish off and I am ready to talk to them."

Apple: "We do not have waiting rooms literally and otherwise. We co-create opportunities of being different at Agape through different therapeutic activities. This could be drama,

painting, music or anything. This affirms our belief that people are just not patients who are sick and cannot do anything for themselves. Here they are not only clients or therapists but their roles constantly change.”

Banana: “There are no waiting rooms here. They will have to find an activity to fit in with other people.”

### Activities mental health workers or therapists engage in beyond therapy

Members see Agape as a context wherein community is created. The members do not have hopes of serving people ‘out there’ but rather they co-create a context of healing for those who come to it. Agape is a context that offers lots of space and an opportunity for people to engage and interact in different ways than the accustomed ones. For instance, Agape members engage in ordinary tasks such as bringing chairs from the hall before the day’s work begins. Sometimes members make fire when it is cold or for cooking purposes.

There are different ways of being at Agape both for the clients and the therapists. When they are not in therapy they find another way of being at Agape through activities that are co-created by all the members. Thus at Agape people engage in multiple roles. Both therapists and clients can put on different caps as offered by the situation. All respondents indicate that they are not at Agape only to do therapy or counselling but are also at the same time involved in many other activities that they co-create with the community.

The respondents’ conception of therapy is not limited to the formal sessions that they have with clients but they also see the activities as being equally therapeutic on their own sake.

Respondents do not view the activities as being primarily organised for the clients but they see themselves as party to these activities for their own personal involvement and healing. Through these activities they find their own voice and space to be different, and without defining their roles as only therapists. Data extracted from interviews in support of the analysis:

Lemon: "I personally get engaged in all kinds of art work - painting, sculpting, drumming, etc.

Through these activities we co-create a space for belonging without necessarily being in conventional therapy. Remember that therapy is not a static venture, it changes, so this activities are very much therapeutic. On other occasions I go out to liaise with other agencies of healing such as PAHA and the Aids Centre. Sometimes I stroll through the streets checking on my clients and their well-being. "

Apricot: "I do a lot of stuff with kids..ehm painting, singing, and just anything. I play with the children but not your kind of classical play therapy. I mean I just play with them for the sake of forming connections and bonding with them. Sometimes I would walk with them to the shop holding their hands and that would provide connection to them. For me this is relationship building and therapy is about relating and connecting."

Mango: "I spend lot of time with my peers. I play a lot with the children...I enjoy playing soccer with them. There is a lot I do here besides therapy. For me therapy is broad..ehm what is therapeutic for me often happens outside of the traditional therapy setting in the sense that I get different perspective of my clients when they get involved in the cooking, drumming, singing or when I see them informally interacting with other clients. This gives a more global view of the clients and you get an idea of their strengths and you also get an idea of the client as a normal human being. I think this is more therapeutic than what happens inside of the therapy settings. I also do home visits to my clients to gain sense of their

broader social and economic contexts.”

Apple: “There is a lot of drama, dance, paintings that goes on..ehm.. I do art with the children and this is also healing so it is difficult to say that these activities are not therapy. These activities provide a different way of being in therapy through different modalities of art, singing, dance, painting and drama.”

Banana: “There are a lot of activities. We have a lot of people who come and often involved in activities around dance, sculpting, cooking and even support talks. I also find my own sense of belonging and being different through taking part in these activities. There are also projects that run from here - school projects, visiting others in the fraternity of healing like sangomas and dingaka”

#### Impact of the frame of therapy and the physical settings during therapy

The frame of therapy has been described in the previous section that deals with this topic. It should be remembered that Agape does not have buildings which could provide rooms for the therapists and its members. It is amazing to note that no respondent has raised concerns or even complained about the lack of offices and facilities at Agape. The theme that emerges is one that indicates people who have not only accepted their material conditions, but have also transformed these conditions to suit and work for them.

There is a theme that suggests that at Agape people can do anything with what they have for the betterment of the entire healing community. The lack of proper physical structures does not make it impossible for therapy to be done whatever the conditions. The lack of rooms for therapists is not an obstacle for doing therapy. This lack of facilities instead allows for greater

space, flexibility and movement towards doing therapy and the many other activities undertaken in this context. In fact how people work under the prevailing circumstances at Agape yields a theme that says that therapy is not bound by any material or other boundaries and that it transcends all physical facilities that demarcate a given space as proper for therapy.

Therapy at Agape transcends all the physical limitations that conventional therapy may be faced with. Members function according to principles of therapy as informed by the dominant philosophy of doing things. Thus Agape does not impose restrictions on the process and structure of therapy in terms of the time allowed for therapy, the sitting arrangement and the place where it can take place. The lack of facilities is not an impediment to respondents but allows for difference from the conventional way of doing therapy . Instead, Agape allows for openness and creativity. Extracts from the interviews:

Mango: “I am controlled by the process of therapy..ehm....I usually do not work rigidly according to a time limit. It depends on so many things. Where therapy is done is more dictated to by the situation..ehm..if it is hot normally clients want to sit under the shade. Because of the physical setting this place creates an openness that is welcoming and a less threatening environment. When people come they don't think of the 'hospital' vibe like I am sick...so the context is very good and it does not define illness and it does not reinforce the difference between people.”

Lemon: “Agape is a nice open and big place you choose all the time where you want to conduct therapy. You are not confined to some place. You do therapy anywhere you find it suitable, under a tree, in a hall, beside the hall, just anywhere. I know the conventional way of doing therapy but if I were to compare the two I would much prefer this place. It promotes

creativity and flexibility and independency. The lack of structure permits one to work unhindered with regard to these issues.”

Apricot: “It is not easy to be here. We work with what we can and do what we can do. Its quite liberating also. Here you are not in an office and you are free to do things that are little bit different. I don’t advocate being wild and irresponsible but it opens up the space and lots of opportunities for flexibility and creativity.”

Apple: “The physical setting enhances my way of working, you sit outside you grab a chair or you sit on the ground. I often sit on the ground with children. You sit under the tree..you hear and feel the wind..you hear the drumming..you hear cars, the bicycles and the people.”

Orange: “Sometimes I have ambivalent feelings about this place. I am used to working in hospital wards and this place throws you out a bit. But when I compare here and there this place offers liberation and freedom in terms of what you can do.”

#### Relevance and usage of the DSM-IV and other assessment tools in each context

The thinking that predominates at Agape is one that does not see people as the site of pathology and as going around carrying disorders. At Agape people are respected for who they are and not given labels that indicate illnesses. People are not seen as sick but as struggling to deal with the issues of their lives. Hence people are not called patients for even the therapists at Agape come for their own healing as well.

Members of Agape evoke the ecosystemic perspective in attempting to understand the nature of people`s problems. The ecosystemic perspective is one of multiple intervention focused

on the context of interaction among individuals and their environment.

Agape members see the problems that people bring to them in terms of relationships that people have with others and their environment but not in terms of symptoms which need to be correctly diagnosed and treated. There is a theme that says that relationships cannot be found or seen through using the DSM-IV. The DSM-IV as an objective tool diagnoses symptoms and relational problems are very subjective and contextual.

There is no diagnosis that is done that seeks to categorise people according to their ailments. Therefore the DSM-IV does not have any relevance in this context. However Agape members do concede that the DSM-IV may have some relevance in the medical psychiatric setting where diagnosis plays an important role. Extracts from the interviews:

Apple: "DSM-IV gets deconstructed here. Its used by people trying to get answers for something that they don't understand and that might scare them and maybe... I just don't have to criticise it.. Maybe there must be use in it.. ..but here we don't talk about medication. Medication here is community - sharing and opening up and allowing yourself to be healed. Here its about connectedness, its not about take this drug and you'll feel better, its not about chemicals in the brain. We work from the stand point here that its about relatedness and that is the fundamental healing power of people not drugs."

Lemon: "I don't see any use of it here because the way I see it the role of the DSM-IV is to diagnose and look at the symptoms and classify according to a certain criterion. You diagnose a person then what? Here we are dealing with the issues and not the symptoms. We are dealing with the relationship and not something out there - an entity. We are

dealing with interrelatedness and I don't see it....interrelatedness in the DSM-IV. The DSM-IV also sees itself as an objective tool which might limit me as a person who is used to creativeness. You see if you don't cough or don't sleep well at night or do one, two and three then you are depressed - this is what the DSM-IV says. I don't agree much with that staff."

Orange: "We don't normally label people here. At the hospital where I work- (here I am a student, an M.A. clinical psychology student)- they use a lot of that staff but here there is no room for such labelling. We do not put people into some categories of classification. Personally when I am here I never think of diagnosis. I just work with people's issues and where they may be at with their lives."

Mango: "I can say that reference to classification of mental disorder is almost bizarre in this kind of context because we don't operate in this kind of way. We don't label people like that...like the DSM-IV does. You get somebody labelled as schizophrenia it presupposes that there is a certain treatment regime to follow for schizophrenia and we simply don't follow such regime. The 'treatment' here is rather unconventional it doesn't fit with the DSM-IV at all. We don't have intentions overtly or covertly to find out what is wrong with people in that sense of the word."

Banana: "The DSM-IV is a very useful tool in the medical setting. In this kind context here, I am afraid, I don't use it at all. I don't think it would be appropriate to use it in this setting because it labels people. At Agape the people who come here are busy with the staff of life as much as the therapists are and I think that the DSM-IV would create an unnecessary distance between people in terms of its labels but I also think that it is pathologising and it can be quite disrespectful of people's journey."

Apricot: "I don't think that it has any role here. I know that in other settings it is used but here the

problem would be with labelling of people. Although it is just a tool it can be dangerous to classify people according to it as it tend to diminish the individuality and uniqueness of people. Probably here the DSM-IV could be used as firewood for lunch.”

### Meaning of Agape for mental health workers or therapists

Agape has a special personal meaning to its members. Each participant feels a deep connection with and personal meaning about this place. Agape means a place to belong to. It’s a place for sharing between its members. It provides a safe environment for even therapists to deal with the difficult stuff of their lives. It is a place where members - therapists and clients alike - receive their own healing. To participants it is like home to them - it provides support, love, care and warmth.

It is amazing that no single respondent sees Agape as a place where people are treated. Agape is not seen as a clinic by those who work in it. All respondents have expressed a deep sense of connection to this place. Agape brings personal transformation to the people who work in it. To them it is not only a place of work but it is also a place of healing, not for their clients only but even for themselves. People come to Agape to confirm themselves. This is both for the therapists and the clients.

Mango: “Here I can be comfortable, easy, relaxed, I don’t need to be ‘this’ therapist. It releases me from the rigid role as the therapist. I easily get support. Agape is an open community so people hug and touch and I get supported through that also . It is quite humane here and I like the hugs and touches that I receive here.”

Orange: "It's a place for searching who I am really. I come here to create my own space for healing and dealing with my own stuff. It's a healing place for me."

Peach: "This place is home to me...it's a place where I belong, where I could go when in difficult situations."

Apple: "It is a home for me. I have been here for my own process of searching for a home...ah I've lost my mother when I was really very young and father kind of rejected me when I was eighteen and I have never had a home since,.....since then and this is the place where I came first and people accepted me. This is a place where I could find myself even if it was towards my anger. Now it's a place of coming back to, when I lose faith in myself and people, I can come back here and it pulls me out.. ..pulls me out. It gives me hope..it's a place of hope to me. Its home, home, home..."

Lemon: "It has created a sense of belonging for me. I really belong here. It has created some upliftment to the community that we have so far co-created. This is also therapeutic to me. It means a place that I can bring my own issues and dealing with them here. It provides space for my own healing. Ya...it may be tough sometimes coming here but it certainly provides for one's own healing."

Banana: "This place means so much to me personally. I have to answer it on a personal level. For me this is the place where my soul gets food every week. To me Agape is a place of healing for myself. I come here looking for situations and places in myself that need healing and exploring. It means a lot because of my connection with the community of Agape, the people who come here, the students, clients, therapists and just everybody coming here. In some way it is also like my home."

Lessons mental health workers or therapists have learned from Agape

Most responses of participants show lessons learned on a personal level. Their responses are an indication of a learning process that does not focus on the technical and skill based aspects but rather it is a self-reflexive exercise. They have learned that community work is not about serving people 'out there' but that they are also part of the community that they are co-creating. They learned that Agape is not a healing place for clients only but for the therapists as well.

People also learned that therapy has nothing to do with the physical structure of a context but is rather about the relationship between the therapists and the client. People here have gained deep personal values and virtues such as sharing, openness, giving without expecting to receive back, helping, love that is unconditional, acceptance and warmth. Working at Agape brought transformation to almost everybody who participated in its rituals and activities. Extracts from the interviews:

Apple: "I have learned respecting...ehm..respecting others..respect for oneself and movement...ehm ..moving that it is not comfortable but one can move and one should move and one must do it respectfully to yourself and others."

Orange: "Initially I did not understand how could people do therapy here without any structure..ehm ..offices or equipments, but I have since realised that therapy is not about a setting..ehm..that its about a relationship, how you relate to people, you have to develop that trust, and create that environment of mutual trust and respect between you and the client. Its more about treating people with respect and dignity than about facilities or structure."

Lemon: "I have learned to be in community for others and myself as well. I have learned to belong

to others and with others. Here its quite pragmatic than academic.”

Peach: “I have learned to share here..to share myself and to share everything with everyone. I have learned also to respect people for who they are and for where they are at. I have learned to receive my healing from this place as well and that this place is not for clients only. I have learned to deal with situations that do not have any structure and to feel comfortable about this.”

Apricot: “I have learned about the essence of personhood. That clients are persons before they are clients. That I have to love and respect them. How can I ever hope to be in a community with them if firstly I don’t love them and secondly don’t respect them. For me being in community with them means being able to love and respect them.”

Mango: “I have learned about being comfortable and not being upset about what the therapist can do or not do regardless of the material conditions of the context in which therapy is taking place.”

Banana: “This place is about humanity...love, sharing, caring, appreciating, respect, and all of that. It is difficult to put it in words what I have learned. But yes I have learned to be more human and I have seen the power of human connections and how they affect a person.”

## CHAPTER 5

### RESEARCH OUTCOMES

#### Introduction

This chapter has the title Research Outcomes since, according to Maykut and Morehouse (1994, p.156), it combines what traditionally has been called the results and discussion sections or chapters. Maykut and Morehouse (1994) argue that so naming a section of a research report is appropriate to alert the reader that he is to engage in a different type of discussion, one that involves themes and patterns rather than statistical results. Such naming becomes even more relevant and appropriate in this qualitative research report.

The aim of this chapter is to identify and discuss the themes and patterns that emerged from the collection of data. The later parts of the chapter contains reflections on the link between the research outcomes and the literature, the recommendations, the limitations of the study as well as the role of the researcher in the study.

As pointed out in the preceding chapters , data was collected on two levels. Firstly, data gathering was aligned to the research objectives and was based on the descriptions of the physical settings, processes and activities that take place in each community centre context. This method yielded the descriptions of contrasting ecologies (Chapter 3) from which themes have been derived.

Secondly, data was gathered through the interviews. The interviews provided data from the participants about each community centre context in terms of their physical settings, processes and activities. The themes that evolved from the interviews were informed by the anchor questions which were the basis of the interviews. The responses to the anchor questions have been analysed through the cross-case analysis of data. This method of data analysis was defined above.

The collective levels of data gathering has resulted in patterns and themes together with their sub-themes becoming the focus of this present discussion. The identification of the themes and patterns is intertwined with their discussion. In the research outcome the researcher has juxtaposed the presentation of the themes to enable a clear cut contrasting picture to emerge.

Below the researcher presents a table that summarises the juxtaposed themes. Table 5.1 is presented at the beginning of this chapter with the intended purpose to aid the reader (co-author) right at the beginning of the chapter to almost immediately access at glance a summarised overall view or sense of the contrasting and different themes emerging from the different community contexts that are the subject of the study.

Table 5.1 Summary: Comparing the themes of the two contexts

<b>THEMES</b>	<b>CMHCs</b>	<b>AGAPE</b>
conception of community	<ul style="list-style-type: none"> <li>- physical space/ geographical</li> <li>- disadvantaged environment</li> <li>- charity and service</li> </ul>	<ul style="list-style-type: none"> <li>- co-creating</li> <li>- connectedness/ belonging</li> <li>- sharing</li> </ul>
therapists identity and relationship with community	<ul style="list-style-type: none"> <li>- separate entity from community</li> <li>- outsiders/ service providers</li> <li>- experts</li> </ul>	<ul style="list-style-type: none"> <li>- members of community</li> <li>- self reflexivity/ insiders</li> <li>- non-expert co-creating</li> </ul>
conception of Problem	<ul style="list-style-type: none"> <li>- pathology</li> <li>- people seat of pathology/ labelling</li> </ul>	<ul style="list-style-type: none"> <li>- non pathologising</li> <li>- interconnected patterns</li> <li>- respect for people/ no label</li> </ul>
role of Therapists	<ul style="list-style-type: none"> <li>- single role: expert therapists</li> </ul>	<ul style="list-style-type: none"> <li>- multiple roles / realities: therapists; sister/brother; peer; painter; cook; dancer</li> </ul>
physical setting and frame of therapy	<ul style="list-style-type: none"> <li>- closed space / rooms</li> <li>- highly structured, restrictive, imposing, limiting</li> </ul>	<ul style="list-style-type: none"> <li>- openness</li> <li>- unstructured, liberating</li> <li>- flexibility and creativity allowed</li> </ul>
conception of intervention	<ul style="list-style-type: none"> <li>- treatment</li> <li>- diagnosis using objective tools</li> <li>- therapists treat clients: 1- way treatment. Linear approach</li> </ul>	<ul style="list-style-type: none"> <li>- healing</li> <li>- connecting &amp; dealing with people`s issues</li> <li>- reciprocal healing</li> </ul>

## Juxtaposed Research Themes

There are many ways in which these themes could have been presented in this chapter but the researcher has decided to juxtapose them so that a clear pattern of contrasting and different points from the two contexts can be discernible. It is therefore hoped that the reader (co-author) will also find for himself a way to see the contrasting points represented in an interrelated and coherent way.

### Theme A : Conceptualisation of Community

#### Geographical space

Community Mental Health Clinics: The concept or theme “community” is seen and understood differently by many people and groups even those who work in community settings. For the people at CMHCs the concept of community is seen in terms of a catchment or geographical area. The geographical view of community has a territorial base that serves to distinguish clearly the outsiders from the insiders (Dunham, 1977; Levine & Perkins, 1987; Mann, 1978). People can move into and out of this community. Community is described as having physical boundaries.

It would appear that such a community has a point of entry. People coming in must go through some check-in point in order to meet with the community gate-keepers. This approach involves reaching out to people in their areas of dwelling, so that they would not have to go out to the limited medical facilities to seek help ( Hunter & Ringer, 1986; Mann, 1987; Rappaport, 1977; Zax & Specter , 1974 ).

This view of community separates the service providers from the consumers of such services, the community . The service providers usually come from outside to provide services . Usually the service provider is an expert who has the skills to help the community. The consumers of services are from inside and usually cannot do much to change their lot (Dunham, 1977). There is a sense of ‘them-and-us’ that prevails between service providers and the community members who are the consumers.

The professionals at CMHCs understand the community in terms of the locality in which the clinics are found. For instance, when they are asked about the communities they serve it is interesting to note that all participants indicated the geographical areas in which they work. They identified Zola, a township in Soweto, and Hillbrow, a suburb in Johannesburg. For them the community is thus a group of people living in close proximity and occupying a given geographical area ( Mogadielo, 1994). This is a perception of community consisting of geographical boundaries and through which they can go to visit and render a service .

**Agape Healing Community:** At Agape community is not defined in terms of the physical or geographical area. Most Agape Healing Community members agree that the concept community transcends all known physical space and time limits. Oosthuizen (1995) argues that defining a specific community merely according to its geographical location invariably runs into trouble. This point is echoed by Apple (a participant) in the analysis section:

“Community for me is the involvement with certain issues and groups of people. Its not about locality because I am carrying a lot of people with when I am going to Johannesburg and I know that I am staying behind

as well. So its not about the physical space Mamelodi.”

Community is understood to mean working together by people or doing something together by people for themselves and not necessarily for others (Hunter and Ringer, 1986). The central words in the conceptualisation of community at Agape are co-creating , connecting to people, belonging and sharing. This means that for the Agape members “community” is not an objective physical thing but it is co-created around the issues and activities that bring them together. The relational community refers to qualities of human interaction and social ties that draw people together (Hunter & Ringer, 1986; McMillan & Chavis, 1986).

Community is about people, people coming together in search of belonging, wanting to connect to those who will be open to their issues and will share the experiences of their struggles and daily challenges. Community is a collective and a joint effort that is manifested in and through co-creating networks through which people`s resourcefulness can be optimised (Hunter and Ringer, 1986; Kelly, 1986; Oosthuizen, 1997).

According to the interviewees community is co-created or co-constructed by its own members. Consistent with the views of interviewees, Lifschiz (in Magodiello,1994) state:

“At Agape .. we do not serve a community but we co-create a community, the network of relationships creates the context in which therapy is done. Agape Healing Community is a shifting community in size and in intensity and many other aspects. Its character is derived from the composition people around activities at any one point and it is not a fixed entity but a shifting pattern of connectedness between people

This means that community is not seen as something 'out there' or having an independent existence as a separate entity from the people who are involved in it. Hunter and Ringer (1986) confirm this conceptualisation by stating :

“Community is not a received truth, something out there to which individuals simply relate, rather, a community is what people define it to be.” (p.64).

### Disadvantaged

Community Mental Health Clinics: To the people working at CMHCs community is understood to mean a disadvantaged environment. When staff members at the clinics refer to community they are referring to those places where the people are poor, homeless, lack resources and recreational facilities. Community is characterised as a place of poverty, and squalor where people are very desperate and have lost hope and faith about their lives.

This view of community, which is associated with poor and mostly disadvantaged black townships, is consistent with Bozzoli's (1987) argument that the process of community formation could have further perpetuated the general perception that communities exist only in the townships.

It is worth noting that staff members interviewed, when asked about who are the people that they are serving, all spoke with one voice, albeit at different times and offices, that community is about serving poor people who do not have medical aids and who cannot access psychotherapy

privately. It is perceived as a counterpoint to the private practice in the Northern Suburban areas of Johannesburg. For instance as an extract from the interviews with Platinum shows clearly:

“People who come here are people who do not have medical aids, who come from low socio-economic status. When I drive to the clinics I just see poverty and suffering and I see it also when I get to the clinics.”

**Agape Healing Community:** The characterisation of community as underprivileged and disenfranchised is one that was held and shared by Lifschitz (in Blokland, 1993), the first trainer and supervisor at Agape. When he initiated the Mamelodi Clinic which later became Agape, had the idea that he was going to serve an underprivileged and disenfranchised community. However he has since shifted from this conceptualisation.

None of the respondents from Agape Healing Community stated that the work they do is targeted at disadvantaged people or the poor. The Agape community respects people for who they are and does not categorise them in any manner that detracts from co-creating a community with them. At Agape members create a community with people in need of belonging and connecting to others (Lifschitz and Oosthuizen, 2001). Through the process of connecting there is no room for viewing people's conditions as 'poor' or disadvantaged.

According to Oosthuizen and van der Worm (1991) communities are things that people create. They say that communities are not solid, timeless givens, but are realities that people create for themselves. This means that the characterisation of community as “disadvantaged” renders that

community as a fixed , time-bound and static entity and would contradict the fact that communities are created.

### Charity

Community Mental Health Clinics: Linked to the issue of community being seen as a disadvantaged environment is the notion of charity. Service providers are people who normally do not come from the communities that they are serving. According to Dunham (1977) service providers usually come from either middle class or elite communities see themselves coming to the disadvantaged communities to help the poor. This view of helping poor people in the townships is clearly evidenced at the CMHCs.

The community clinics and their staff members end up doing charity work for the community, since the skilful and well-resourced experts and professionals from outside do something for the poor, disadvantaged and from a low socio-economics status people who hope to get something. Perhaps this citation by Ferrum will highlight this issue:

“I have turned down offers to work in the private sector specifically for this reason to serve the poor community.... .”

The notion of charity is captured quite clearly in the words of Steel:

“I feel proud that I am doing something for the community. I am making a difference to the lives of children and adults in these communities....”

Entailed implicit in Steel's words are ideas of grandiosity about being the saviour of the community and this can boomerang with negative consequences in that it fosters a sense of dependence and helplessness in the community. Sarason (1974) states that the community start to hope and believe in some people, other than themselves. They also believe that people from outside can give something to them to help them.

**Agape Healing Community:** The notion that what is done in community can be perceived as charity was shared by Stan Lifschitz. Lifschitz (1999) asserted that there is a danger with some white students coming to Agape and beginning to think that here is an opportunity to help and give something to the black people in this poor area.

As it emerged from the interviews, the Agape community is a place where people share ideas, experiences and themselves. As Agape's working is informed by an ecological approach to therapy. O'Connor and Lubin (1984) define an ecological approach as a multilevel intervention perspective focused on the context of interaction among individuals and their environment. Hoffman (1990) argues that ecological approach does not leave room for a one-up or one-down relationship between those who help and those who receive help.

In fact, at Agape there is no group that helps the other group with the presumption that the helped group is invalid, this also because the healing community is a co-creation consisting of all the members of Agape Healing Community. Agape has a credo that says that 'healing is also for the healer' (Oosthuizen and Lifschitz, 2001). This credo dispels the notion of Agape becoming a place for charity as the healer also needs to be helped and is not always in the position to dispense some help.

Theme B : Therapists relationship with community: experts and  
outsider versus non-expert and self-reference

Community Mental Health Clinics: The professionals working at the CMHCs see themselves as separate “entities” from the community that they are serving. There is no single activity that takes place in the clinics where the staff members do something with clients except for treatment. At all times when they interact with clients they do something for or about clients. They provide services, assess and diagnose clients.

Professional workers do not identify with community members and nothing bonds them to the community. Sarason (1974) states that this evidences a lack of ‘sense of community’. They perceive themselves as “outsiders” who deliver a service to the “insiders” who are helpless, in line with mental health model (Mann, 1978).

This perception perpetuates the chasm that exists between the two parties and upholds the dividing line which results in the them-us relationship (Heller, 1989). There is an extreme polarity and differences between service providers and the community in that the service providers have an impersonal sense about what community means to them (Sarason, 1974).

It is as though when service providers interact with the community, they are interacting with inanimate, non-living objects. Consistent with Sarason’s (1974) lack of ‘sense of community’ their answers to what the community means to them is shockingly impersonal; they show no connection, identity and belonging to and with the community.

Heller (1989) argues that where there is a notion of 'us and them' existing between the community workers and the community there is usually a sense of grandiosity that accompanies the delivery of services in the community context. Service providers see themselves as experts, who possess the skills and the techniques to handle the issues of the helpless community. These experts exalt themselves to a one-up position and put their clients in a one-down position (Anderson and Goolishian, 1990).

Service providers, particularly psychologists, see themselves as specialists who do not have to be lumped with others in the primary mental health field since they have, as it were, a monopoly of the access to the field. They act as if they can understand and master the mental health issues of society by virtue of their training. This sentiment is aptly echoed by Ferrum's responses during the interview:

"We psychologists are a specialist services and we cannot be considered as part of primary health care as everyone else is, because there is a tendency amongst nurses and doctors to shun or push psychiatric patient away. There is a movement towards training people as some kind of one-stop facility professionals, but this cannot be done with mental health, it needs specialists who have the inclination to talk to people about their problems not all professionals train people to talk deeper with other people. I have seen how doctors and nurses run away from patients who have the slightest mental illness or any kind of emotional problem. So we are a speciality and need to be treated as such."

This sentiment is embraced and shared by all participants interviewed. The relationship

between therapist and clients is neither reciprocal nor equal and this seems to be influenced by the psychodynamic frame of doing things. Bannister ( in Pilgrim , 1983) argues that during the interaction between the therapist and the client, the client sits on either side of your (therapist) desk or table, in your (therapist) office, or your (therapist) patch.

According to Bannister (in Pilgrim, 1983) the therapist's presence signifies qualification, expertise and prestige, the clients' presence signifies that he or she has "given in", "confessed failure". Bannister (in Pilgrim , 1983) further stresses that as a therapist one prescribes the pattern of relationship; one decides time and frequency of meeting, termination of meetings, form and duration of conversation. This pattern of relating is shown in Ferrum's assertion: " ...I see them strictly for a period of about fifty minutes which is consistent with my frame of doing therapy."

This clearly shows the power structure that the institution imposes on the therapist and the therapist ultimately finds this congruent with himself or herself. Therapists are empowered by access to the knowledge and skills which are exclusive to their training such as the assessment tools, psychological tests and the DSM-IV .

There are clients in the community clinics who refer to psychotherapists as "doctor" and many therapists have come to accept this without any protestation. There are also psychotherapists who refer to people coming to the clinic as patients. Bannister (in Pilgrim , 1983) asserts that this is the most traditional style of relationship and it accords best with the medical model implicit in psychiatry.

He further argues that it is a style of relationship familiar to most clients, who have been

meeting doctors since they were children, and it fits most easily into the organisational system adopted in psychiatric institutions. He concludes that conventionally, it is seen as a relationship of honour and authority with a historical halo compounded of science and saintliness (p.140) .

**Agape Healing Community:** It has emerged from all the interviewees that their view or understanding of the concept “community” is self-reflexive. They see themselves as part of the community and do not regard the community as something independent of themselves or as a separate entity. This is echoed by Banana’s response during the interview:

“This place means so much to me personally. ...for me this is the place where my soul gets food every week. ...in some way it is like my home.”

Their reference to the community entails their own reflections about the community as well. They share a common identity with the community that they are co-creating. This is in line with the philosophical assumption of second order cybernetics that states that one cannot make claim to any “objective” observation since it is the observer who chooses what and how to observe (Keeney,1983). According to Colapinto (1985) the observed is in the observer.

Anderson (1983) states that community exists when people language about it, and that it develops through a process where a shared ecology of ideas is evolved. The notion of self-reflexiveness is further echoed by Anderson (1983) when he says:

“This conceptualisation of community demystifies the idea of finding communities

and also emphasises that when people think they have found a community, they have actually created one.”

When the therapists engage people who come to Agape they do so without wanting to take a one-up position. Often they relinquish their status as experts to becoming co-creators with the people.

According to Anderson and Goolishian (1990) when the therapists have a conversational dialogue with the client they should adopt a not-knowing position. The not-knowing position communicates the therapist’s genuine curiosity to know more rather than convey preconceived opinions and expectations about the client.

At Agape there is a co-creation of community wherein in this healing community the healer also receives his own healing. This has implications for the non-expertness of the therapist. According to Kvale (1992) people talk ‘with’ one another and not ‘to’ one another. This has implications for how the therapist relates with members of a community. The therapist and the community participate in the co-development of new meanings and new realities.

Theme C: Conception of problem: pathology or labelling  
versus non-pathological or respect for people

Community Mental Health Clinics: The manner of working at the CMHCs is fashioned on the medical model of the psychiatric approach which views the problems that people present with as pathology and places pathology within the person or individual. Psychotherapists at the CMHCs deploy tools such as psychological tests for assessment, to help them to arrive at some

diagnosis. All participants interviewed hinted the importance of the psychological assessment as well as the DSM-IV. They have with much emphasis indicated that one cannot come up with a correct and appropriate course of treatment, if one is unable to diagnose correctly.

According to Goudsmit (1989) when the therapists intervenes through employing his many diagnostic tools it implies that he knows generally how people function and can specifically diagnose and treat what is wrong with a particular client. Since the therapists come up with a diagnostic classification system and label the clients problem as some illness, there is an implied assumption that he can as well treat the illness (Goudsmit, 1989). This sentiment and view about assessment and diagnoses is echoed by Manganese:

“I am the first line of contact that these patients come across and I do a proper psychiatric assessment, psychiatric mental state examination right through to the diagnosis and many a time I also recommend treatment. If you do not have a diagnostic criteria by which you can diagnose your patients I think you will be making a mistake in the long run...if you do not have an accurate diagnosis you cannot treat your patients. I strongly believe in the DSM-IV and that it has a role to play because if you are unable to diagnose your patients and you don't know what symptoms you are looking for and you don't know the differential diagnosis of each patient you could be making major mistakes.”

Goudsmit (1989) states that it is very common for the therapist to regard their tools of assessment and diagnosis as yielding absolute truth that is underscored by scientific rigour. This implies that once a diagnosis has been made, it remains the only valid way of understanding the

problems of people. A social and ecological perspective to the problems then becomes irrelevant

Bannister (in Pilgrim, 1983 ) argues that any insistence by the client ( who is now known to be suffering from depression, 'personality disorder', 'schizophrenia' and whose thoughts are therefore suspect) that his or her problem is to do with spouse, job loss or whatever, can only be seen as symptomatic evidence for the diagnosis itself. So this is a no-win situation for the client.

In line and consistent with the particular ideology of these community clinics, clients normally find themselves labelled with illnesses that they never bargained for. Bannister (1983) argues that whereas initially clients only had social, mental and financial problems they come back from clinics carrying with them the baggage of illness. They then begin to play the role of a sick person according to the roles of the game of that sickness.

The therapists at the CMHCs are passionate about the psychodynamic frame of therapy as imposed by the institution. The danger of this is that they regard the concepts of theory and practice as having an independent reality, as if people do walk around as the containers of a weaker superego, or split ego .

Basaglia (1990) states that to see clients or people as carriers of illnesses or containers of pathology is to be devoid of respect to such people, to say the least. To see people not as presenting with relationship problems but wanting to diagnose and fit them into some label is dehumanising and mockery of the very notion of the help that therapists purport to be practising.

To focus on the 'sickness' found and to come with treatment plans without meeting the

person where he or she is at in terms of his or her own personal problems is like putting plaster on a wall that has defective cracks. This manner of diagnosing takes away the voice of the client and replaces it with the techniques that brings about confusion about what is the nature or causes of this person's problems (Basaglia, 1990).

**Agape Healing Community:** At Agape the conception of the problem is not in terms of pathology. According to Anderson and Goolishian (1988) through the use of language people's problems are not made to appear as an absolute 'truth' or reified and then seen to objectively exist as pathology. Rather, people presenting with problems are seen as being on the journey of their lives and not given pathological labels (Gergen, 1985). Agape is a healing community that accords respect to its members.

Through languaging people who come to Agape are not called patients and therefore they come without fearing to be called names which associate them with illness. This confirms social constructionism's assertion that people construct ideas about their world in conversation with other people (Anderson & Goolishian, 1988, 1990; Gergen, 1985; Hoffman, 1992).

Therefore it is not amazing to see that Agape members disconfirm the universal and objective assessment tools which normally impose certain classification categories on people without due regard to the social and otherwise conditions that inform their presenting problems. The role and relevance of diagnostic assessment tools is reflected by Orange's statement:

"We don't normally label people here. At the hospital where I work they use a lot of that stuff (diagnostic tools) but here there is no room for such labelling. We do

not put people into some categories of classification. Personally when I am here I never think of diagnosis. I just work with people's issues and where they may be at with their lives."

At Agape people are first seen as people who together with others co-create a healing community for themselves and these are not labelled according to some diagnostic manual. Through their interaction with other people, individuals may have problems, but problems do not just have an existence independent from the context of the sufferer (O'Connor, 1984). This conforms to the ecosystemic thinking which shifts from a single to a multi-interactional conceptualisation (Bateson, 1972).

Ecosystemic thinking brings a fundamental change in terms of interpreting behaviour from a linear cause-and-effect sequences to conceptualising the same behaviour as resulting from a reciprocally causal system of interaction (O'Connor, 1984). Thus with this perspective people are treated for who they are with the full knowledge that they are having issues that they are currently dealing with in their lives. Humanity and respect are the cornerstone for working at Agape. Banana echoes this sentiment by saying:

"Agape has taught me respect and respecting people's power and inner strength and the ability to heal and the capacity for sharing in times of greater stress. It has given me new understanding of community in terms of the feeling between people."

Usually when people seek health services at institutions they are accustomed to queueing

and waiting for a long time before it is their turn to be helped. The treatment they receive sometimes dehumanises them. Bannister (1983) argues that often the inhuman treatment that people receive at health care clinics make them lose their identity and dignity through being called patients and this may necessitate that they play a sick role. For instance, when they are seated waiting for a service it is quite usual for the service providers or attending officer to call them out as 'next'(Bannister, 1983).

Theme D: Role of therapists: single-expert role  
versus multiple roles

Community Mental Health Clinics: During the discussion of the theme on therapist` relationship with the community the role of therapist was touched on. It was mentioned that the therapist`s role at the CMHCs is that of an expert service provider who applies his skill in a manner framed by the context. It has further been stated that the prevalent context at the CMHCs is informed by the medical-psychiatric ideology. For instance, in a context such as the medical context psychologist are often perceived as and often even called "doctor" by their clients. Due to the framing of such a context psychologists often find themselves agreeable to being seduced to embrace the notion of being called "doctor" (Bannister, 1983).

In the context defined by the medical-psychiatric ideology, the therapists or any service provider would usually function only within the parameters set by his or her profession. Each profession`s practice in terms of rights and obligations of its members is regulated by a council. It is not customary to find a professional who will do more than his or her professional training requires.

In fact, all professions define clearly the roles, scope of practice and responsibility of their members so that these members should not be seen to overstep their scope of practice and duties. Therefore these councils act as watch dogs over standards, practices, duties and responsibility of their members and the profession.

**Agape Healing Community:** It has emerged from research that members of Agape do not have only one role to play or occupy but rather have multiple roles. The multiple roles are pertinent to the epistemological frame of a multiverse reality that is underpinned by social construction theory. This theory asserts that our beliefs about the world do not reflect observable, objective truths (Hoffman, 1990).

Therefore the rejection of objective and universal 'truth' by Agape yield a multiverse reality in terms of how members can become involved in different roles. The thinking at Agape does not reify the objective existence of 'one' reality. Instead the thinking at Agape is informed by the social construction of multiple realities arrived at through a consensus. As consequence of this thinking all members of Agape see themselves beyond the position of fulfilling just one role - that of 'the therapist'.

There are no people whose role is limited to therapy only at Agape, unlike at the CMHCs. Equally there are no people who are clients only at Agape. This is syntonic with Anderson and Goolishian's (1990) assertion that the roles that people play out or occupy are constantly changing due to new meaning that is created or negotiated. They argue that meaning about phenomena or roles is not arrived at but created (Anderson and Goolishian, 1990).

The notion of multiple realities is reflected in the sense that people do not come to Agape for one thing only therapy. People do not find therapy to be the only thing through which they can find their voices and space at Agape. So at Agape people co-create their reality through numerous activities that are equally therapeutic without being involved in a specific therapeutic conversation as such.

In line with Anderson and Goolishian's (1990) argument of constructed meanings, the meaning of therapy at Agape is co-created and therefore the meaning of therapy is not limited only to healing talk, but it also means 'healing doing', 'healing sharing', belonging and connecting. For Anderson and Goolishian (1990) the source of change is to be found in the multiverse of possible meanings that inhere in every communicative act.

The role that therapists and clients occupy extends even beyond the confines of a conventional therapy session. Both 'client' and 'therapist' participate in a shared developmental process and they are free to become involved also as peers, cooks, artists, fire-makers, poets and so on. At Agape people have the opportunity to explore the different roles that they occupy. Mangos echoes this:

"Some people are clients as well as being part of Agape fulfilling another role. People don't just occupy one role here and even me as the therapist sometimes I play with the children and I become a peer to them, sometimes I become a sister or a mother sometimes I cook, .. its different all the time .. its co-creating a community."

Theme E: Conception of intervention: treatment or service provision  
versus reciprocal healing or belonging and connecting

Community Mental Health Clinic: The language used at the CMHCs for intervention in people's problems refers to treatment. The treatment can assume many forms, from prescribing medicines to psychotherapy. Usually treatment is preceded by assessment which employs objective tools that seek to uncover the underlying reasons for the problem. The process of assessment results in a diagnosis which is a process that purports to have arrived at the 'truth' about what is the problem and what causes it (Golann, 1988).

In terms of first-order psychotherapy, the therapists at the CMHCs exist outside of the client system and can do the job of observing without being involved in what is observed. Hoffman (1990) describes first-order psychotherapy as therapy in which the therapists unilaterally influence or intervene through observing the client system. According to Golann (1988) the therapists can intervene in the client system, in accordance with the 'objective' formulation arrived at, in a linear way so as to achieve a predictable outcome.

Intervention at the CMHCs is seen according to a linear perspective wherein the therapists do something for the client and this cannot be vice versa because the therapist is an expert whose professional proficiency must be utilised to help the person needing help. The linear approach to assessment, diagnosis, and treatment is informed by the assumption that there is one objective reality about mental illness (Hoffman, 1990).

Therapists at the CMHCs perceive themselves as service providers. The assumption of

being a service provider is that one is an expert who can dispense his professional knowledge to people who are not capable of doing things for themselves. Service providers are usually endowed with skills which the recipient of their services do not have.

**Agape Healing Community:** At Agape intervention is conceptualised as healing. Healing is perceived as a mutual process that unfolds between the therapists and the clients. Thus according to Lifschitz and Oosthuizen (2001) healing is not for the clients only but often for therapists, as captured in the credo. When Agape members were asked who come to the healing community and what issues do they bring, they all indicated that it is not only the clients who come to Agape but that they also bring their own issues to Agape.

Agape Healing Community members indicated that Agape is a safe place for them as well to which their own issues are brought. They indicated that the healing that takes place at Agape is not for the clients only but that they also receive their own healing. They also indicated that they do not do therapy to help others only without themselves benefiting from or also receiving healing in return.

Since, according to Gergen (1985), our beliefs about the world are social inventions, therapy at Agape takes various forms which are unconventional and co-created by the members. These forms may vary from therapy being a dance, painting, sculpting, sharing a meal together, playing, visiting people at home, or any activity through which members co-create their belonging to the community and find a way to connect with others.

There is a popular metaphor that is commonly held as a credo at Agape and that is practised

as the one fundamental principle at Agape, the metaphor of a wounded healer (Lifschitz and Oosthuizen, 2001). The reciprocal healing that takes place at Agape is echoed by Lifschitz (in Blokland 1993):

“I`ve allowed myself to appreciate .. .. .that I am being healed as well. The clinic is not a place for altruism where I am here to serve the underprivileged .. .. in many ways, being a healer, is also to be healed .. .”

Again Agape`s members make use of an ecosystemic perspective to conceptualise people`s problems and do not see the problems of people in terms of pathology or illness. The context of an individual`s problem is considered as more meaningful or relevant than the intrapsychic issues. Agape healing community is a place for belonging. There is a consensus among all the interviewees with regard to their understanding of Agape to mean ‘a place to belong’. They also indicated that for them as well Agape is a place to belong - to which they can also bring their own personal stuff.

Agape Healing Community does not provide services but instead co-create a healing community with people presenting with problems. Whatever issues people bring, be they social, marital, financial, these issues usually are related to the loneliness and isolation that the people could be experiencing. Agape is one place where people can come and not talk about ‘anxieties’ or ‘disorders’ but just come to form connections and relationships with people and in the process create their own communities.

Some people come weekly without talking about any issues or being involved directly in

therapy session. They may come to be involved in the many activities serving as interventions that are co-created at Agape. This point is illustrated by Mango:

“Some people come here initially as clients but with time I cannot refer to them as clients anymore because they become part of Agape... .. they become regulars even beyond what they had come for.”

Theme F: Physical setting and frame of therapy: psychiatric or psychodynamic versus ecological and open

Community Mental Health Clinics: Data has been collected from the interviews about physical setting and frame of reference of the CMHCs. The discussion of the description of the contrasting ecologies have yielded information about this theme. All data gathered from various sources indicate that the CMHCs operate in highly formal and structured settings.

These settings, as indicated above, are characterised by buildings and equipment befitting their purpose. Information about the physical setting of these clinics has been given in the description of contrasting ecologies. Here it suffices to say that the physical settings of the CMHCs play a pivotal role in organising the processes and activities that flow in the clinics.

The frame of therapy has been described as the structure and organisation that govern or direct the process of therapy from a specific theoretical and practical perspective in a particular setting. It has been pointed out to that the frame of therapy at the CMHCs imposes a certain way of operating. The psychodynamic frame of therapy that is predominant at the CMHCs determines

the nature and extent of the relationship between the therapist and the client.

This frame determines the time limits to be observed during therapy sessions. It also reflects the nature of the space in which therapy can take place. Within that space it shows the sitting arrangement between the therapist and the client. It goes even further to indicate the rules and regulations of what may be done or not. There is a general consensus among the interviewees that the frame of therapy is very limiting and controlling. This sentiment is echoed by Iron when he explains the setting where therapy takes place:

“It is in a small room with two chairs and a table. It is kind of limiting, just having two chairs across each other with a table in between. We don’t normally go out ..ehm..just to go out to sit in the shade somewhere or other space, except to be in this confined four walled room. I wonder how it would be like to have an informal kind of a situation or even walking for that matter. I know that other people are not into discussing issues in a confined kind of space ...it is like they are closed or blocked and they want to talk outside where they can have fresh air and maybe even bask in the sun. ehm.. personally I would like to work that way with people but because of the frame of therapy here I dare not even think about it.”

**Agape Healing Community:** The physical setting at Agape makes it informal, friendly and approachable to the people who need help. The frame of therapy that informs how work is done is the ecological perspective. This frame of doing therapy does not impose limitations by way of rules and boundaries as is the case with the psychodynamic frame at the CMHCs. The psychodynamic frame places much more emphasis on ‘should’, ‘should’, ‘should’ whereas the

ecological frame is not rule based and it encourages a lot of 'could', 'could', 'could'. Agape encourages opportunities for doing things differently while the status quo is maintained at the CMHCs. This is echoed by Iron:

"I would love to engage with people not from therapy side only, ...getting to know them better ... ..but doing therapy from a psychodynamic view is difficult. If you have established therapy rapport there is no way that you can extend it outside of the therapy situation and formulate some bond with them ... this is not possible."

People are not stifled in their interaction by some 'boundaries' that have to be observed between themselves. When people greet they hug and shake hands with each other and this practice is found to be in line with the thinking which people have about themselves and therapy. The frame of therapy does not require some observation of "professional distance" between the "therapists" and the "clients". Mango echoes this:

"Agape is an open community ... ..so people hug and touch and I get supported through all that. It is quite humane here and I like the hugs and touches that I receive here."

On the level of physical setting, Agape indeed provides lots of space and opportunity for movement congruent with the ecological approach. The therapy dyad does not have to be confined in rooms which may be poorly ventilated even during hot summer days. The confining space of the rooms creates a sense of more of the same and this may breed monotony and burnout among

health workers. Apricot, a therapist at Agape, says the following with regard to the openness in that context:

“It’s quite liberating here you are not in an office and you are free to do things that are little bit different. I do a lot of art stuff with kids... .. painting, drawing, drumming.. ..just everything we can do together but not being technical about things. Sometimes I would walk with them to the shop holding their hands and this would provide connecting to them. For me this is relationship building and therapy is about relating and connecting.”

At Agape when therapists are not in a formal therapy or engaging in activities, they usually make visits to their clients` homes to gain first-hand information about their broader ecology.

#### The Link: Research Themes, Literature and Discussion

The differences and the contrasting points resulting from both the themes of the interviews summarised in Table 5.1 as well as the descriptions of the ecologies summarised in Table 3.1 suggest that different viewpoints or perspectives exist which inform the formations, processes and operations of the two contexts of community service.

The Community Mental Health Clinics (CMHCs)`s geographical conception of community is consistent with the Mental Health model (Mann, 1978). It is evident from the themes of the interviews or research findings that professionals who work at the CMHCs view ‘community’ in terms of the physical space or catchment area. This geographical view of community is consistent

with notion of 'treating people within their environment' that is espoused in the definition of the mental health model.

The Community Mental Health Clinics clearly envisage that mentally distressed people should receive care and treatment within community settings. The researcher, however, has concerns with their notion of 'community'. Firstly, the researcher wants to address the notion of 'community' since to him there is a lack of conceptual clarity that seems to be intrinsic to the notion of community mental health care.

The researcher's concern is informed by Sarason's (1974) question of whether community clinics provide a 'sense of community' or not. This poses the question whether the clinics providing are some sense of belonging and creating togetherness among all stakeholders, or are they community clinics because of their locality. Stefansson et al. (1990) argue that the CMHCs are community clinics only as far as their locality is concerned and that by and large their operations are purely psychiatric in nature.

It has been shown above that CMHCs see the notion of 'community' in terms of a catchment area with physical boundaries. It is because of this that the professionals at the CMHCs see themselves as outsiders who are coming into the community to do something for the people of that area. This view links the CMHCs to the Mental Health model. Mann (1978) confirms that the Mental Health model is inherently concretized by an exclusively geographical conception and that professionals attached to the agencies of this model see themselves as outsiders.

Mann (1978) argues that the mental health model is manifest through the creation of

pockets of self-contained and self-sustained community clinics in different geographical settings. Thus it is apparent that the community to which the professionals come has physical boundaries through which they have to go that keep them apart from the serviced community.

Mann (1978) emphasises that the model is committed to the development and implementation of psychotherapeutic strategies and general mental health service delivery in and to a particular catchment area. The community clinics are situated in relevant catchment areas and are seen as having the potential logistical capacity to provide a wide variety of impactful services to a relatively large group of people.

Stefansson et al. (1990) argue against the much hoped for 'community-like' character of these clinics which conceptualise and understand people's problems as a function of their social and cultural environment. Instead, the community clinics have operated their business according to the core tradition of the psychiatric medical system. It is not the intention of researcher to portray psychiatry as an unwanted curse in the community mental health services. Rather, the issue here is about the extent of psychiatric intervention in problems that seem to have family and social connections.

Sarason (1974) argues that it would seem that psychiatry has taken an upper role in community clinics and that it should not be imposed on problems that appear to be social in nature. For instance, if a person is distressed because of a marital relationship that has gone wrong then the person suffering from distress should not be put on medication unless there is sufficient proof that some biological problem has occurred.

According to Sarason (1974) the theoretical cornerstone of the community mental health model relates to the fact that mental illness, like mental health, is a function of the interface between individual and the environment factors, but the model tends to treat mental illness as synonymous with individual psychopathology. In other words, while the model claims to address itself to the social and environmental determinants of mental illness, it still, as Sarason (1974) argues, remains largely committed to primary psychiatric conceptions of symptomatology and diagnosis.

Dunham (1977) argues that initially when the Mental Health model was conceived it had the noble intention of looking at people's problems and afflictions beyond individual illness and to take cognisance of the broader social, cultural, religious and economic environment. Unfortunately the noble intention remained an ideal that did not shake the epistemological roots of an approach that looked at people as the seat of pathology. According to Pilgrim (1993) this was due to the dominant role that psychiatry continued to play, which overshadow the intended objectives.

The objectives of the CMHCs were to address the mental health problems of communities taking into consideration the environmental contexts of people in dealing with their problems. But however grand the intentions were, they were never realised due to close relationship that developed between the Mental Health model and the Medical model. Thus the Mental Health model like its partner (the medical model) has a tendency to look for remedies of social problems by proclaiming biological causes (Pilgrim, 1983).

The dominant theory of psychotherapy used at the CMHCs is the psychodynamic approach. According to McNamee (1992) the approach is entrenched in the assumption that some standard of normality and some method by which abnormality can be assessed exists. And consistent with that rationale, with proper treatment, any abnormal behaviour can be brought closer to if not completely within the expected norm.

There is a link between the psychodynamic approach and the Psychiatric Medical model due to the fact that they both are based on the same scientific tenets. According to Pilgrim (1983) these scientific tenets purport to know the causes of human suffering and how to treat them. Therefore they both employ scientific and objective methods of diagnosing and assessing human problems. Also, the models ultimately make use of an objective system of classifying human illnesses according to some scientific nomenclature (McNamee, 1992).

It has emerged from the interviews that professionals at the CMHCs put more emphasis on the diagnostic tools as well as on the techniques and methods that can be used to treat people. McNamee (1992) argues that this is consistent with the operational philosophies used in most mental or medical institutions. He further argues that this is contrary to the practice of psychotherapy in community settings that upholds the multiple reality viewpoint about people's struggles and sufferings. He aptly expresses this sentiment by stating that:

“When our conversations (therapeutic conversations) begin with the assumption that there are essential features of individuals that can be known or discovered with the proper tools or methods, it is not surprising to find ourselves developing techniques that we believe are better suited in meeting particular goals. Similarly,

the goals we establish are presumed to fall within the reaches of progressive action. Our modernist belief that we can objectively assess a person, a situation, or a relationship is based on the notion that there are (or could be) some clear standards of evaluation. And this reify the objective knowledge about an individual's illness which runs contrary to the notion of acknowledging the social context within which the individual is embedded." (p.145)

The similarity between the approach of the CMHCs and the Psychiatric Medical model is further deepened by the similar language used by both of them. It has emerged from the interviews that at the CMHCs there is talk about patients, ward rounds and disorders according to the DSM-IV.

Bennett and Morris (1983) state that this language is an extension of the Psychiatric Medical model and that it (language) recreates a medical hospital context which have little or no recourse for work involving human social problems that is done within community services. They further argue that community clinics have shown to develop some of the institutional practices and tendencies previously associated with the psychiatric hospitals. Basaglia (1990, p.126) confirms this perception by arguing that:

"There is a danger then that community care is a somewhat empty slogan fuelled by criticism of the mental hospitals yet failing to articulate in a clear way the nature of alternatives provision. Despite much talk and advocacy of community care it seems that the patterns of care remains the same since the era of the mental hospitals".

Therefore there is a clear indication that although there is a shift in locality from the hospitals to the community clinics there is no equal and comparable shift in ideology and practice. Hence merely changing the locus of care from hospitals to the community clinics is not a panacea (Bennet & Morris, 1983).

Hence Bannister (1983) argues that it is common to find these clinics serving mostly people with serious psychotic problems mainly by offering medication. Many people with problems about the issues of life who could benefit from psychotherapy do not turn up at the clinics for fear of being regarded as sick and being treated in the same dehumanising way that the sick are often treated (Bannister, 1983).

The labelling and institutional practices that are prevalent at the community clinics lead Bannister (1983) to argue that “the old hospitals are now decaying and crumbling away” but their pattern of operation is finding its way into the new modern community clinics. During the description of the contexts of community services it emerged that the physical settings at the CMHCs are akin to the settings in medical institutions and therefore the patterns of operations that evolve from these settings are also similar to those in medical institutions.

Thus the clinics just become an extension of hospitals in terms of protocol and procedures and create a sense of more of the same (Bannister, 1983). The mirror image is contrary to the ‘community’ call about unique community needs, and care dictated to by these needs.

The physical settings of the clinics together with the dominance of the medical model at

the clinics confirm Bannister's (1983) argument that the value of psychotherapy when practised according to the medical model is extremely ideological and contradicts its philosophy of caring. Therefore community services should emphasise programmes of care that will bring people within the field of these programmes with the explicit purpose to create a difference in their lives.

In the light of this Basaglia (1990) argues that most community mental health centres are community clinics because of their locality and not in terms of any programmes or initiatives that they offer. But with the highly structured settings of these clinics, although they have ample open spaces on their grounds, there is bound to be very little or no more informal activities at all that can be initiated.

It has emerged from the research results that Agape has a different conception of 'community', 'problem' and 'intervention' from that of the CMHCs. The conception of phenomena in Agape community differs and contrasts with how phenomena are understood in the clinics. The fundamental issue here is about difference and not about which conception is better or best or more favourable. The conception in Agape community is informed by post-modernist thinking.

According to McNamee (1992) post-modern thinking challenges the notion of an objective observer which has been the anchor of scientific knowledge for many years. Avis et al. (1999) state that according to post-modern thinking knowledge about any phenomena is constructed through an interaction between the observer and the observed. This means that the very act of observing a system influences the system. The idea of an observer outside the system thus in question.

Post-modern thinking goes beyond the understanding that knowledge and truth is not an individual creation, but that it is also socially constructed. This understanding of a socially constructed reality emphasises that the interactions of people create knowledge or realities about different phenomena. The construction of knowledge in this manner is called social constructionism (McNamee, 1992).

Consistent with this thinking people at Agape do not talk 'about' community but rather they talk 'in' community. This means that people do not talk about 'community' as something that is external or that is a separate entity from them. Instead, through their collective interaction they build a community together.

Agape community does not conceptualise 'community' as a geographical area or physical space. Community is seen as a co-creation or co-constructed by members who form that community. Community is when people come together and what happens between them. Lifschitz and Oosthuizen (2001, p.119) confirm this conception of community by saying that: "The community of Agape, like any community, is made of people and what happens between them"

This conception of community not only differs from the geographical conception at the CMHCs but also show how people can do something for themselves by themselves through connecting beyond physical boundaries.

The conception of problems is different for the Agape community. The community of Agape does not see people's problems in terms of intrinsic pathology but rather sees their problems as part of the journey or struggle that the people are going through in their lives. According to

Anderson and Goolishian (1990) in dialogue, new meaning is in constant evolution and no 'problem' will exist forever. Agape community acknowledges that people come in search of meaning to their "problems" and to connect to others. O'Connor (1984) states that people's problems are part of the greater ecological context with which they interact.

The struggles that people confront in life become unbearable when they have to tackle them on their own. Thus they become isolated from their families, friends, and other community agencies. For this reason they come to Agape in need of forming connections with others and to create a community with them. This conception of the problem is consistent with social constructionism. This means that the problem is seen within the social and environmental interactional context in which it takes place (O'Connor, 1984).

When people come to Agape with their problems they are assured of being respected for who they are. The language of Agape community does not label them as pathological. According to Slotter (1990) by applying local meanings people become members of this community without having to play a sick role or without needing someone to feel pity for them. Their presence in the Agape community does not limit them to the 'patient' role; Agape offers them the opportunity to experience their 'otherness' or 'difference' without having to adopt a 'patient' status.

This sentiment is echoed clearly by Lifschitz and Oosthuizen (2001):

"Some people who come struggling with meaninglessness and loss, would also be connected to existing projects or groups. In this way they would find healing by discovering alternative definitions of themselves as care givers,

“parents” beyond the definition of patient or victim.”

The conception of intervention at Agape is not seen in terms of treating people with problems through some scientifically based techniques and methods. The role of the therapist as seen by Agape members is not to unilaterally change the client, but rather his or her role is to co-create a safe space for the client to be able to talk about his or her problem.

This assertion is echoed by Anderson and Goolishian’s (1988) argument that therapy consistent with social constructionism entails an ‘in there together’ process wherein therapists cannot unilaterally determine the pace and process of therapy. This implies that there has to be a mutually agreed upon arrangement between the “therapist” and the “client”.

The community of Agape allow its members to engage in different roles other than those that they originally came for to Agape. Agape provides for its members a safe place to explore the various aspects about self and to engage in activities that they would have otherwise never have thought of. Such participation in a community enables members to move beyond the reified categories and patterns that would otherwise organise things along traditional conceptualisations and processes (Shotter, 1990).

Therefore Agape members have multiple roles rather than single roles. In the conventional setting such as the CMHCs the therapists are stuck with their role definitions as therapists and equally so patients are stuck with their roles, so that each time “patients” have to present as patients, otherwise they will lose their status and access to membership of that community. The position of changing roles in Agape is illustrated by Lifschitz and Oosthuizen (2001):

“We noticed how some psychologists appeared and re-appeared in different ways. Sometimes they would be recognised as social workers, then as community psychologists. Then the same people would re-appear at different times as charity givers or researchers, sometimes as individuals in crisis, and then again as psychologists.”

A wide gap and a vast difference exists between the two contexts of community services in terms of their physical setting. In a literal sense Agape is all about openness, an open community. There is the open space, the open sky, open hearts and open minds. The open space relates to the sprawling grounds on which Agape operates without any hindrance whatsoever. Members of Agape community have abundant space for whatever activities they may engage in. The open sky is about lack of physical structure and buildings above the heads. The sky is directly visible which enables openness - no roof, no walls, no windows and no doors.

The open hearts refer to the people who come to Agape to share their struggles and difficulties openly with other members. They bring their sadness and anger as well as their pain and agony to be shared with other members in a safe environment. The open hearts are also about the sharing during lunch time. Members who can afford to bring along food to Agape or contribute money for buying food do so. When the food is prepared all people share from the same bowl. There are no separate bowls for therapists, community workers and even for the clients. The bowls from which people eat are for the entire Agape community.

The open mind is about moving beyond reified positions and conceptualisations about phenomena, categories and issues. The openness in mind is about transcending the notion of

objectivity towards embracing a social constructionist position in understanding issues of life. This openness of mind brings about a point of difference in thinking and doing between Agape and the CMHCs.

Agape because of its physical setting as well as its frame of therapy allows for freedom, flexibility and creativity. The physical setting as well as the frame of therapy do not impose any structure or restriction about where therapy can be done or not done and also about the mode of therapy. Therapy in the Agape community is not only limited to a conversation between the client and the therapist but it can take on various modes in the form of activities that are co-created by members of the community.

The activities that are co-constructed or co-created at Agape foster or create a sense of “belonging together” and a of “connected network”, and a feeling that binds this community together. This sense and feeling that binds Agape members together is a brotherly love or sisterly love. This love is Agape and Agape is the name given to this healing community.

### Recommendations

The call for community mental health clinics has sounded loud and clear that mental disorders are best treated in the local community, preferably on an outpatient or day-care basis, and this has shaken the foundation upon which the mental hospitals are built. To some this call could have been construed to mean the doomsday and abolishment of mental hospitals.

The abolishment of hospitals would indicate a mono-visual and an ‘either or’ position.

This position would be lamentable as it would elevate community clinics to being considered the only suitable places for dealing with all kinds of mental problems. The researcher's position is that despite the benefits of accessibility that communities would derive from the community mental services, hospitals would still form an important component of the overall mental health treatment strategy.

Schulberg and Baker (1975) state that service provision by hospitals and community clinics should be seen as part of the bigger comprehensive mental health program. They advocate for the 'both and' position that is attainable through the complementary provision of hospital and community care services.

However, in the researcher's view the most important implication of this study for all those who work in community mental health clinics is that these clinics or contexts should be regarded as community services through the projects or programmes or activities that they co-create with their members and including those they serve. This has implications regarding the physical settings and buildings which may have to be transformed to accommodate co-created community activities.

This also means that community services in their effort to help their clients, should look at interventions that focus on the interactional context of people as far as possible so that people will not be stigmatised people with labels of pathology. Community service clinics should remain true to their course of "truly" being community by allowing professionals who work at them to identify with and to become part of the community. In pursuit of "truly" becoming community services these clinics should foster the attainment of a 'sense of community' as advocated by Sarason (1974) through engaging in programmes that foster a feeling that people belong to the clinics and can make a positive contribution.

The formal and businesslike atmosphere that prevails at community clinics should be addressed. Professionals should move beyond their professional statuses and become human. An atmosphere should be created where those who require the clinics' services will feel that they are not reduced to 'sick' people who cannot do anything for themselves. This can help to bring a shift in the clients's position of hopelessness and dependency towards wanting to co-create or co-construct a safe place with others for their own betterment and healing.

Community services' understanding of people's problems should be informed by a view that Auerswald (1969) describes as follows:

“A view that believes in a multiverse of realities, that embraces a move towards seeing knowledge as a product of social negotiation, that acknowledges the interrelatedness of everything and the importance of context, a focus on perspective and pattern rather than discrete facts.”

It is evident from the research findings that Agape Healing Community is consistent with Auerswald's (1969) assertion and that this community goes a long way in creating a place of belonging and connecting for its members - through a number of activities that are therapeutic - beyond the problems that they are presenting with.

The study had set out to investigate if there are differences and contrasting points between the two contexts of psychotherapeutic community services in terms of their conception of community as well as their physical settings, and how these inform the processes, procedures and activities that unfold in each context. Indeed, the research results have shown that there are

differences and contrasting points between these two contexts of community services.

From the beginning the researcher has alluded to the fact that this study is informed by a qualitative approach to doing research. This philosophy of research departs from the long held tradition of research which has as its goal objective, quantifiable and universal results that can be generalised to different situations and contexts (Neuman, 1997). The philosophy of qualitative research believes in a multiverse reality which is context specific and context bound.

The contrasting views that emerge from between the two contexts of community services, namely, the CMHCs and Agape, reflect their different philosophies of knowing or their science of knowing called epistemology (Keeney, 1983). From the research outcomes it has emerged that the CMHCs lean strongly on the philosophy of knowing that embraces objective observations which yield objective results that are universal in nature and can be generalised over situations and across time.

This emerging view of a universal reality then becomes a source of concern since the primary objective of the community mental health movement was to bring help to people taking into consideration their social, economic, cultural, political and other factors. An approach that seeks to look at these factors “objectively” with a view of using standard and universal tools of assessment, diagnosis and intervention would be inappropriate in achieving these objectives.

It is therefore recommended that a useful context of doing community services - in a way that supports the idea that people`s problems will be seen contextually - is one that acknowledges that differences and diversity exist for each person that presents with problems.

Agape Healing Community embraces a multiverse of realities in that it moves beyond the generalised, reified and objective ways of dealing with human issues. The usefulness of Agape`s approach is manifest in members co-creating a community for themselves and coming to Agape to belong and connect to others. To them community is formed by people and what they do when they are together. And truly, what else could community be!

The usefulness of a community such as Agape should not mean that the CMHCs do not have a role to play. The researcher believes that such a role exists, although they have defined for themselves a role more oriented to the medical model. This role may also be useful where people`s issues may have an underlying medical or biological problem. Therefore these clinics should exist side by side to Agape type operations with the purpose of providing medical support where needed and necessary. But these clinics should not become the major agencies of providing mental health as long as they operate according to their current approach.

The researcher wants to further recommend the following guidelines that may, when applied with care along with appropriate shifts in ideology, make community clinics more useful and transform their dominant medical psychiatric practices into community services:

- **Conceptualisation of community:** CMHCs should operate in a way that will create a ‘sense of community’. Clinics will first have to face the challenge of re-defining the concept of community not to mean a catchment area characterised by disadvantage. Rather, community should be a place where people come to form connections and are associated with enablement. Community should be created by all its members rather than serve only those defined as “sick”.

- **Adopt a not-knowing position:** According to Anderson & Goolishian (1990) this position entails a general attitude or stance in which the therapist's actions communicate an abundant, genuine curiosity. This means that the therapist's actions and attitude express a need to know more about what has been said, rather than convey preconceived opinions and expectations about the client, the problem, or what must be changed. The therapist does not 'know' *a priori*, but rather relies on the information given made by the client.
- **Members seeing themselves as an integral part of community:** Members who work at these clinics should not feel like outsiders who are only providing professional and expert services to the community. The members need to identify with and co-create a community with those that they help. These members should be helped to deal with their own attitudes about community clinics providing service to the poor and should find ways to belong and identify with those who seek their services.
- **Recruitment of volunteers community workers:** There is acute shortage of qualified professionals to provide adequate service to the community. The CMHCs should recommend the recruitment of committed community workers who demonstrate the passion to deal with the struggles of people in their lives. These community workers should be trained in basic counselling skills and should work under supervision of the therapists.

The quality which these workers need to possess is the capacity to provide space to people needing help. The reader should be reminded that the capacity to heal does not come only from theoretical knowledge but from the real commitment to be with and for

people in their time of need. Furthermore, the community workers` s contribution is unique in the sense that they bring into the co-created community their intimate knowledge of neighbourhood, structure, politics and resources.

- **Alternative ways of engaging:** The CMHCs will have to provide space for alternative ways of engaging within the co-created community. People do not have to first become patients before they can “belong” to the clinics. The clinics can make provision a number of projects that will allow people to experience their ‘otherness’ or alternativeness. For instance, the clinics can provide group work on life skills for adolescence or they can provide training to parents about effective parenting. Participants in these projects do not have to become patients in order to take part. The alternative ways of engaging also holds true for the mental health workers so that they can seek other roles besides being only professionals.

### Limitations of the Study

It has been stated above that the study is based on qualitative research methods and that these methods are informed by the constructionist. The major limitation of this study - if this is a limitation at all - is inherent in the basic assumption of the paradigm. According to Gergen (1985) this assumption states that reality is constructed and does not have an objective and independent existence. This means that working from this perspective advocates a multiplicity of realities.

It may seem to some absurd to think in terms of a perspective in which no objective reality

exists and that people can discover different realities through social interaction. The perspective proposed here advocates this kind of thinking. The position that the study has adopted is one that argues that an objective 'community' does not exist, just as an objective view of the client does not exist.

The study has refuted the geographical conception of community by the CMHCs in favour of 'community' that is a co-creation by its members and those it serves. But the danger may be wanting to reify this co-created community as if it is the 'only' community. This has the implication that meaning can never be imposed and that meanings are generated in conversations and experience.

The other limitations of the study are about the nature of the research tools that have been employed. Research tools such as personal experiences of the researcher carry with them the bias of the researcher. The material gathered from this source relies heavily on the researcher's selective experiences and the meaning he gives to them. Descriptions are highly selective and depend on the researchers' memory of events, issues and contexts. It should be remembered that when these tools are employed they are used with the purpose of re-capturing or re-creating the story that unfolded and not "the" entire story as the only truth or as absolute facts.

### The Role of the Researcher in the Study

The researcher's notion of science is informed by a social constructionist understanding

which asserts that what one perceives is a consequence of how one participates in perceiving within a given social context. Keeney and Ross (1985) argue that what one sees or perceives reveals more about the perceiver and his context, than about the object of study. It is according to this way of thinking that the study has been perceived and conceptualised and thus reflects the researcher very personally. The researcher acknowledges that the flow of the research has been influenced by who he is, his beliefs, values, likes and attitude. This means that the researcher upholds the value of subjectivity in creating knowledge through research.

The process that has unfolded from the conception of this study until the moment of writing the research report has been mutually directed and influenced by the researcher's thinking and the social mind with which he interacted. The researcher's social mind assumed different roles such as researcher, interviewer of participants, describer of physical settings and creator of an understanding of the two settings. Hoffman (1990) argues that people evolve sets of meanings through their network of interactions and these meanings are not skull bound and may not exist inside what we think of as an individual 'mind'.

The researcher recognises that he influenced the research from the moment of choosing this topic. The interview questions were construed by the researcher. The manner in which these questions were asked was influenced by him the selection of the verbatim material to be published was also done by him. Therefore the researcher would have selected some data above others which may have been especially important to the participants, but that did not fit in with the researcher's ideas and ideology. This argument reflects the inherent limitations of the study which therefore should not be taken as definitive.

The limitation of this study is so for all research done within the social constructionism paradigm. Hoffman (1990, p.129) confirms the notion of subjectivity in research which is informed by the social constructionism paradigm by stating that: “man cannot transcend himself or herself ....., so that no matter what modes of perception or what sorts of world interpretation he chooses, they are still his or her own, constructed in interaction, through language, with fellow beings.”

In concluding the researcher briefly wants to recapture his initial responses to both settings how a shift occurred to what ultimately became the thrust of the study - exploring the differences between the two facilities.

When the researcher initially started working at Agape he viewed that context with a measure of contempt due to its lack of “proper” structure, facilities and how it was run. Also, due to the South African political and historical background the researcher thought that this lack of facilities and structure characterised life in the townships and was a legacy of the past Apartheid ideology which believed that black people were not deserving of anything that was decent, well planned and properly run. To the researcher Agape at first symbolised the disregard that Apartheid had for the lives and care of black people.

To him the hospital and “proper” clinic buildings symbolised a preferred reality. The equipment and facilities at these institutions made these institutions acceptable. The involvement of different professionals ranging from medically trained psychiatrists, social workers, occupational therapists to nurses symbolised a ‘true’ community mental health centre. But with more and more involvement, the researcher found himself challenged on a higher level to make an epistemological shift about “reality” and “truth”.

After the shift, as can be seen throughout the study, the researcher had a bias towards Agape. He developed a soft spot for this context of doing therapy. He felt that this was the most useful and appropriate context of reaching people in communities. He felt that this context did not stand out like an ivory tower. But that it was a co-created community that wanted to help others form places of belonging and connecting. He felt that this context was congruent with the life styles, beliefs and values of the people who came to seek a place of safety for themselves and their families.

Undertaking this study was initially for purposes of fulfilling academic requirements. This has since changed as the researcher has immersed himself in the study. The study can no longer be seen as objective or as a separate entity from the researcher himself.

The researcher now realises that what he undertook as a study is actually a story about what he went through and how he felt about it. It is a tale about the two community contexts told from the researcher's point of view and experience. There is no way that the story is perfect or final. This story would take different forms and shapes if told by another narrator. Perhaps the final word about the story is that it is a non-ending story.

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