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SERVICE DELIVERY AT ITSOSENG PSYCHOLOGY CLINIC: A PROGRAMME EVALUATION

by

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DECLARATION

I, Arnold Victor Phala, declare that this research report is my own work and that all sources quoted and used have been indicated and acknowledged by means of complete references. This dissertation has not been submitted before for any degree at any other University.

ABSTRACT

The aim of this study is to evaluate the service delivery function of the Itsoseng psychology clinic through investigating the demographic profile of the client population that Itsoseng clinic served in terms of age, gender and presenting problems during the period January 2005 to November 2006. This study took the form of a limited programme evaluation using descriptive statistics as primary method, based on an analysis of archival records from the period January 2005 to November 2006. Community psychology was used as primary theoretical framework to situate this study within the larger local and international debate on client profiles and service delivery of university psychology clinics. The results indicate that most of the clients who attended the Itsoseng psychology clinic during 2005 and 2006 fell between the ages of seven and 30, and presented with the following problems in order of prevalence: learning difficulties, relationship problems, depression, career concerns and HIV-related issues. More women (53.1%) than men (46.9%) attended the clinic over the two years combined. The results of this evaluation could prove to be useful in informing strategic decisions regarding marketing the clinic, offering relevant training content to the students as well as recruiting other professionals for whom a need is indicated.

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CHAPTER 1

OVERVIEW

Introduction

This research project aims to evaluate the functioning of the Itsoseng Psychology Clinic by describing the demographic profile of the clients who attended the clinic, which is situated on the Mamelodi Campus of the University of Pretoria. Specifically, the research question states: "What did the client population of Itsoseng Clinic look like in terms of age, gender and presenting problem during the period January 2005 to November 2006?" Of particular interest are the implications that the client demographic profile holds for strategic decisions regarding the future functioning of the clinic, as well as for developing adequate measures to evaluate the current and future functioning of the clinic.

This research project takes the form of a programme evaluation using descriptive statistics to provide an in-depth view of the client population and service delivery activity at Itsoseng clinic in terms of age, gender and presenting problems. The method of investigation entails an examination of the monthly records of service delivery at Itsoseng clinic between January 2005 and November 2006.

This study evaluates Itsoseng Psychology Clinic as a community engagement project. Consequently, the theoretical model or framework on which this study is based derives from the principles of community psychology. These principles are defined and explained in chapter 3, and provide a theoretical context for this research project. The applicability of these principles to the Itsoseng psychology clinic is also examined as part of the limited programme evaluation.

This study furthermore aims to highlight the type of services rendered at Itsoseng psychology clinic, the different professionals involved, and other people who are responsible for the day-to-day functioning of the clinic. It also comments on the type of people in a township setting who are more likely to utilise a psychological service.

Data were collected using the archived service delivery records of Itsoseng psychology clinic from the period January 2005 to November 2006. Three variables (age, gender and presenting problem) were chosen to provide an overview of the client demographic profile.

A descriptive statistical analysis was conducted on the three selected variables mentioned earlier to perform a limited programme evaluation. Descriptive statistics is concerned with describing and summarising the data obtained for a group or individuals (Huysamen, 1990). The results were organised using tables to indicate the demographics profile of the client population in terms of age, gender and presenting problems. A second order analysis was attempted by inferring possible reasons for the findings.

Permission to use the clinic records was obtained from the Itsoseng clinic director, Dr. Linda Eskell-Blokland (see Appendix 1). These records reflect only certain service delivery details (e.g., gender and age of clients and presenting problem). An example of such a service delivery monthly record sheet appears in Appendix 2. No identifying information relating to individual clients or therapists is given. The data used and presented in this dissertation included the total number of clients and the percentages relating to these; and therefore there was no risk of revealing any personal information regarding clients or therapists.

The results of the study will be disseminated and made available to Itsoseng clinic stakeholders, the Department of Psychology, and the examiners of the dissertation.

Chapter Layout

Chapter 1 provides an overview of the aims and justification of this project, as well as a broad description of the research design.

In chapter 2, prominent local and international research related to the topic of this research project provides the reader with both a contextualisation for this research project, as well as a brief overview of the concept of programme evaluation, specifically as it related to Itsoseng Clinic, the site of the research.

Chapter 3 discusses the research design and explains limited programme evaluation. Community psychology is explained as the theoretical point of departure. Data type and collection are reported, with reference to archival records. The data analysis, namely descriptive statistical , are discussed in terms of the analysis of the three variables (age, gender and presenting problem).

Chapter 4 presents and discusses the results. Visual presentations of the results are provided in the form of frequency tables. The functioning of Itsoseng Psychology clinic is

evaluated on the basis of these findings, and a demographic profile of the clients seen at the clinic during the data collection period is presented.

Chapter 5 discusses the implications of the findings and compares the results with findings in the literature. This chapter also makes recommendations and draws conclusions based on the discussion of the results.

Chapter 6 constitutes a personal reflection on the research process.

Conclusion

This chapter provided an overview of the background to the study, stated the research question and the research aims. It provided a justification for the research, and briefly outlined the research design and the layout of the dissertation.

CHAPTER 2

BACKGROUND AND CONTEXTUALISATION

Introduction

This chapter provides background information about Itsoseng Psychology Clinic on the Mamelodi campus of the University of Pretoria. The purpose of this chapter is to provide the reader with a holistic view of Itsoseng clinic's inception and functioning, and the role it plays in the community. The services rendered by the clinic are mentioned and the people who deliver those services are introduced. Itsoseng clinic as a community project is discussed. Lastly, the goal of the research is reiterated in light of the history and functioning of the clinic.

Background to Itsoseng Psychology Clinic

The Itsoseng Clinic on the Mamelodi Campus was established in 1997 as part of Vista University's Department of Psychology. Initially it started as a screening clinic run by the Psychology Honours students. At that time, this was the highest qualification in psychology offered by the university. The students screened clients and administered psychometric assessments with a view to referring the clients to appropriate professionals. In 2001 the Department of Psychology identified a growing need for an academic programme that could address the psychological needs of the community of Mamelodi. As a result, the Masters Programme in Counselling Psychology was introduced at the campus, and to date the department has trained approximately 60 students as counselling psychologists.

The Itsoseng Psychology Clinic operates according to the principles of community psychology. Community psychology seeks to empower people at grass roots level who cannot afford expensive health services. Community psychology also intends to mitigate the impact of disorders on people by addressing the core needs of the community. This includes providing people with the necessary information on how to cope and effectively deal with their problems.

Itsoseng Clinic remained the only fully functioning and full-time psychological service on Mamelodi campus and to the people of Mamelodi until 2006. Services are offered free of charge to students and to members of the Mamelodi community and its surrounding areas in Pretoria. Services offered include individual and couple therapy, psychometric assessment, HIV/AIDS counselling, child assessment, and so on. Itsoseng clinic operates Monday to Thursday from 8h00 to 16h00; and Friday from 8h00 to 13h00. The clinic obtains referrals from schools, churches, hospitals, clinics and civil organisations in Mamelodi. The clinic also has partnerships with local clinics, hospitals, nongovernmental organisations, churches and schools, who also refer people to the clinic. In addition, workshops are offered to schools to assist educators to in gaining a better understanding of learners' problem behaviours. Other stakeholders in Itsoseng Clinic who play a significant role in the day-to-day operations of the clinic include the Departments of Psychology from Unisa, the University of Pretoria and the Mamelodi community as a whole.

In 2002 a BPsych degree was introduced on the campus to students who had completed their undergraduate degree with psychology as a major. The BPsych was offered in two areas of specialisation, namely HIV and AIDS counselling, and psychometric assessment. Students who successfully completed this degree were able to register with the Health Professions Council of South Africa as registered counsellors.

Itsoseng Psychology Clinic was conceptualised with the primary objective of offering psychological services to members of the Mamelodi student community. This objective emanated from the Vista University Psychology Department's identification of the need for free psychological services to people who were less privileged and who had no access to these services. Many people benefit from the services of the clinic. This is especially true of the schools in Mamelodi, which fast became one of its main referral sources.

Psychological services were offered by BPsych and Masters students and intern psychologists under the supervision of the Department of Psychology, and after the BPsych was discontinued, by the masters students and intern psychologists. Students are supervised on a weekly basis and each student reports directly to assigned supervisors. In March of 2004, appointments were made for 93 new clients. This reflects the rapid growth in clients and the utilisation of the clinic at the time. In 2004 the clinic was upgraded by the inclusion of a nursing sister, a medical doctor and final-year occupational therapy students.

It was also boosted by a partnership with the Centre for the Study of AIDS, which also serves as source of referrals to the clinic for clients with HIV-related problems.

Students who are registered for the Masters programme in Counselling Psychology are responsible for marketing the clinic services. Every year the students compile flyers, pamphlets, posters and notices to disseminate information about Itsoseng Clinic to individuals and institutions in Mamelodi. Some of the posters are taken to schools, clinics and hospitals with the aim was making the services known and accessible.

In collaboration with the Centre for the Study of AIDS, the clinic implemented a Voluntary Counselling and Testing service to students and the surrounding community. A medical officer or nursing sister administers the technical aspects of the testing while the trainee counsellors and psychologists provide clients with pre- and post- test counselling. In most cases pre- and post-test counselling was done by the BPsych students who were enrolled for the Registered Counsellors BPsych HIV/AIDS stream. The students enrolled for the Mamelodi Campus Masters in Counselling Psychology programme were encouraged to conduct their research in the field of HIV and AIDS, in line with the main focus of research in the department. The main objective was to contribute to the scientific knowledge on issues around HIV and AIDS, and also to develop researchers who could apply their skills in mitigating the impact of HIV and AIDS.

The statistical records of service delivery to clients are kept and stored in the departmental files for confidential reasons and in line with the requirements of the Professional Board of Psychology. These records were collated monthly by BPsych and Masters students and two intern psychologists under supervision. Each therapist compiled a monthly statistics form detailing the number of clients seen for that month. The statistics form includes the gender, age and presenting problem of each client seen. At the end of the month the therapists submitted these statistics to the department for administrative and control purposes.

Since its inception, Itsoseng clinic has offered services to a great number of people from Mamelodi and the areas surrounding Pretoria. Taking into consideration the nature of the services rendered by this clinic, I decided to conduct a study to investigate service delivery trends at Itsoseng clinic for the period 2005-2006. The research question (what did the

client population of Itsoseng Clinic look like?) was applied to three categories or variables, namely age, gender and presenting problem.

A Limited Programme Evaluation of the Itsoseng Psychology Clinic

The Itsoseng Psychology Clinic can also be conceived of as a community psychological programme established to provide free psychological services to people who have no alternative access to such services. This programme has been in existence for almost a decade and has been positively received by many people, including local schools. In this study I employed programme evaluation as part of the research methodology; therefore is necessary to briefly discuss programme evaluation and its basic principles.

Rossi and Freeman (1989, p.18) define programme evaluation as the "systematic application of social research procedures for assessing the conceptualization, design implementation and utility of a social intervention programme". Potter and Kruger (2001) mention that the central goal of evaluation is to analyse how people involved in a programme go about their work. In other words this study seeks to understand how therapists involved in the clinic run their day-to-day activities. This includes how many clients are seen in the space of a month, a quarter, a semester, and a year.

According to Kumar (2005), evaluating the delivery manner of a programme is a very important aspect of process of the evaluation. This study investigates what services were delivered at the clinic, and to whom they were delivered in terms of gender, age and presenting problem. Baker (1989) argues that programme evaluation is not really a different method of doing research, but is a type of research which is carried out with a specific purpose. Itsoseng clinic as a programme was established with a specific purpose, and this research investigates how the programme has been managed.

A similar study was done in 1991 by the Witwatersrand University Health Policy Centre on the Kangwane clinics in Mpumalanga (University of Witwatersrand Centre For Health Policy, 1991). The aim of the study was to investigate and review service delivery at community level; and to ascertain whether the clinics were effective and efficient to the people they served. The second aim of the study was to investigate who attended and received services most frequently, and what services were available to people. The findings of this study are discussed in chapter 4.

Similarly, this study seeks to investigate services delivery trends at Itsoseng psychology clinic during 2005 and 2006. Since the clinic was temporarily closed in 2007, the records for 2007 were not included. It was felt that a two-year span would provide sufficient records to produce a fair indication of trends in service needs and delivery.

Conclusion

This chapter provided the background and history of Itsoseng Clinic, together with a brief outline of its functioning and main stakeholders. The goals of the study were reiterated, and the concept of programme evaluation was introduced. The following chapter outlines the research design, including the theoretical framework of community psychology principles, as well as the methodology research and process.

CHAPTER 3

RESEARCH DESIGN

Epistemological and Theoretical Framework

Visser (2007) defines epistemology as a theory of knowledge and a way of thinking about the world. It is an understanding of how knowledge can be constructed and what methods can be used to understand the world. There are two methodological perspectives in social science research, namely a positivistic framework and a contextual framework. In light of the research question that this study seeks to answer, a contextual framework was considered suitable.

Tolan (1990) defines contextualisation as the epistemological theory that knowledge is relative to a given empirical and theoretical frame of reference; and that we are implicitly embedded in the world we observe. This model opposes the idea that research can be objective and value free, and states instead that it is embedded in a certain context. To understand community research, the researcher has to be a part of the process. This immersion may facilitate the research process.

Dalton, Elias and Wandersman (2001) argue that contextualisation occurs in relationship and is a product of social connection between researcher and research participant. It is therefore important for the researcher to understand the context of the research. In this study I describe the client population of Itsoseng Clinic during 2005 and 2006 in terms of age, gender and presenting problems. Since the context of the research is Itsoseng Clinic, I need to fully understand the nature of this context.

Visser (2007) mentions that the introduction of an ecological perspective provided a new dimension to community issues. This new perspective challenges psychologists to take the context in which therapy or any intervention takes place into consideration. It facilitates the process, and allows interventions in the community to become relevant and appropriate. The community context also plays a pivotal role in meeting the needs of people because the psychologist may be more aware of the strengths and weaknesses of that particular

community. From here, the psychologist may develop more appropriate and effective intervention strategies.

A programme similar to Itsoseng clinic was introduced in Jamestown in Potchefstroom by counselling psychology Masters Students from the University of Potchefstroom. The primary aim of this project was to provide psychological services to the community of Jamestown, and entailed providing life skills programmes to different schools in the area. This project is still operating under the auspices of the University of Potchefstroom. Many people from this community have reported positive outcomes from this project although evaluation is still underway (Naidoo, Tshabalala & Baca, 2003).

Most community models function according to the person-fit-environment and person-in-context notion, which assist psychologists to conduct research that is culturally responsive and relevant to that community. The same processes were encouraged in work conducted at Itsoseng clinic: the philosophy was to promote research that will bring betterment and advancement in dealing with local people. As result, the Psychology Department employed translators to help therapists provide effective and culturally-orientated services to clients.

Community psychologists also take into consideration the relationship between person and environment. They acknowledge that psychology cannot be value free, but is influenced by the values of the community in which it operates. This means that clients are part of the community, and whatever is happening in that community impacts on them. For any community intervention to be successful, psychologists need to fully comprehend the values of that community. This facilitates the process of intervention because the latter is more likely to be relevant to community needs.

The theoretical orientation of the study has its roots in community psychology. The definition and principles of community psychology follow.

Community Psychology

The central premise of community psychology is to develop theory, research and intervention that locate individuals, social settings and communities in a sociocultural context. Duffy and Wong (2000) argue that the goal of community psychology is to

optimise the well-being of communities and individuals, and to apply innovative and alternative interventions to uplift them. Seedat, Duncan and Lazarus (2001) state that although there is no single definition of community psychology, all the approaches in community psychology have the common goal of improving the human condition and promoting psychological well-being. This being said, Seedat and Lazarus (in Nicholas, 2003) define community psychology as a branch of psychology which concerns itself with broadening the focus of psychological services delivery. They add that community psychology emphasises prevention and development initiatives. From this it is clear that community psychology encompasses the principle of mental health for all people, especially those who cannot afford private psychologists. The definitions above suggest that the primary goal of community psychology is to alleviate and prevent problems from both an individual and a community point of view. Individuals are regarded as part of a community, with the implication that interventions must be relevant both to their needs and to the community in which they live.

Principles of Community Psychology

According to Seedat et al. (2001), the mental health perspective aims to treat and prevent mental disorders within a geographical catchment area. The role of the psychologist is to provide expert, professional interventions to individuals and organisations in the community. These principles of community psychology formed the cornerstone of the approach at Itsoseng Clinic. The main reason for the existence of the clinic was to render services to individuals and community members in Mamelodi, Pretoria.

The fundamental principle of community psychology is prevention, which is divided into three categories, namely primary, secondary and tertiary intervention. Primary intervention is aimed at reducing the number of new cases. This may be achieved through psychoeducational programmes. Itsoseng Clinic previously conducted these types of programmes with school learners and the community at large, including effective coping skills and study methods, as well as HIV/AIDS workshops.

Secondary intervention attempts to treat a problem at the earliest possible moment before it becomes severe or persistent (Duffy & Wong, 2000). Itsoseng Clinic provided therapeutic services to clients to help them to deal with the problem before it escalates or deteriorates to an undesirable level.

Tertiary intervention deals and focuses on minimising the impact of those disorders and problems. Most of the work done at Itsoseng occurred on the secondary and tertiary levels of intervention. It is hoped that by identifying certain trends through this study more preventative work can be done (primary intervention).

Principles of Community Psychology at Itsoseng Psychology Clinic

Mental Health

According to Seedat et al. (2001), the mental health perspective aims to treat and prevent mental disorders within a certain geographical catchment area. The role of psychologist is to provide expert, professional advice and assistance to individuals and organizations in the community. The concept of mental health has changed because it no longer only refers to medical practitioners but to anyone who works with patients in either the public or private sector. Community psychologists also have a professional obligation to step out of the office and get their hands dirty.

The goal of initiating a clinic in Mamelodi was to provide needed mental health services to the local people. Mental health in South Africa has undergone several changes at community level. The first and most common challenge is insufficient numbers of trained professionals who can provide professional services to people. The Department of Psychology therefore decided to take psychology to people of Mamelodi.

According to van Niekerk and Prins (2001), mental health refers to a state of physical, mental and social well-being; and forms part of primary, secondary and tertiary health services. Mental health is further defined as the level of the mental well-being of the individual and the community at large. This concept encompasses the holistic well-being of the people in three major areas, namely physical, psychological and social. The practitioners who operate from this model strive towards optimisation and actualisation of clients in these three areas.

Community psychologists aim to offer mental health services primarily within geographical area located as near as possible to where members of the community live. Lazarus (1987) states that mental health in psychological services include crisis intervention, trauma

centres and community level clinics that provide services to people. Unlike mainstream psychology which tends to pathologise and diagnose clients, psychologists who operate from this perspective strive to understand internal and external forces that could have contributed to creating problems for the clients. Community psychology tends to make resources available to people and to optimise their wellness. At Itsoseng, therapists are taught not to pathologies, but to seek out the forces and factors behind the client's problems.

Unisa operates a psychology clinic on university premises for the use of students and residents of Pretoria. It aims at offering psychological services to community members who cannot afford private psychologists. Clinic services include individual and group therapy, couples therapy and child therapy. This indicates the critical role that community psychologists strive to play within the realm of community, and also represents an attempt to take psychological services to the people.

In addition to this clinic, Unisa's Department of Psychology also initiated a community project aimed at providing psychological services to the people of Mamelodi that was a first of its kind in the area (Lifschitz & Oosthuizen, 2001). The name of the project was Agape, meaning unconditional love. Since this project was the first of its kind in the Mamelodi community, it may initially have been experienced as a peculiar and foreign concept to the people; however, its continued functioning suggests that it has made an impact. It was established during the time when the political system in South Africa was unstable and chaotic; nonetheless, a few white people who were registered as psychologists decided to defy this political instability and come to work in Mamelodi.

This project has also been used as a vehicle in training masters students enrolled for clinical psychology at Unisa (Lifschitz & Van Niekerk, 1990). These students come every Wednesday to consult with people who seek psychological interventions. These students are supervised by lecturers from Unisa. Lifschitz and Van Niekerk (1990) state that though psychotherapy in the West is usually been conducted behind closed doors, at Agape therapy is conducted in the open, under the trees, which send a strong message that psychological therapy may be accessible and available for everyone.

Agape in Mamelodi was established primarily to take psychology to Mamelodi, though at beginning the founders encountered several challenges. However, the success of this clinic suggests that such an approach is gradually finding a position. Psychologists operating from a community psychology model believe in reaching out to individuals and to the community at large. Community psychology challenges psychologists operating from this perspective to go to the local people; to learn and use their languages, and to see the world through their eyes.

Prevention

Rapp-Paglicci, Dulmus and Wodarski (2004) define those interventions that occur before the initial onset of the disorder as preventative interventions. From this definition it is apparent that prevention is concerned with the identification and elimination of a disorder from the beginning. This concept of prevention also entails comprehensive and holistic intervention plans that seek to address problems from even before the onset. Mental health prevention includes primary, secondary and tertiary intervention. The following discussion explains these three concepts in detail and the applicability of each to Itsoseng clinic.

The fundamental principle of community psychology is prevention, which is divided into three categories, namely primary, secondary and tertiary prevention. Most of research conducted on community level is done to address existing problems and initiate policy to deal with those problems. Bloom (1996) defines prevention as action taken by mental health practitioners to eliminate those social, psychological and other conditions that cause or contribute to physical and psychological problems. Community psychologists also provide services to people with the objective of eliminating psychological problems.

Promotion of health and well-being are central tenets of community psychology. These involve the prevention of mental health problems and promotion of health at all levels of community (Visser, 2007). Itsoseng clinic provides psychological services to both individuals and the community at large. Clients are equipped with knowledge and skills to cope with their problems. Cowen and Gesten (cited in Visser, 2007) mention that such services are aimed at equipping people with the resources to cope effectively with dysfunction.

Primary health aims at reducing the number of new cases in the community. One way of achieving this goal is through psychoeducational programmes. Psychoeducational programmes are aimed at equipping people with necessary skills and developing insight before problems occur. Bloom and Hodges (in Bloom, 1996) argue that primary intervention in community psychology deals with preventing problems from occurring. It includes all measures and activities that can be taken with a population to maintain its health, both physically and emotionally.

The mandate of Itsoseng Psychology Clinic is to promote healthy living and provide psychological and counselling services to people. The clinic collaborates with schools in ensuring that students receive adequate information on a healthy lifestyle and well-being; school workshops are conducted and teachers are taught how to identify any learners with psychological problems. People are encouraged to seek psychological services as early as possible to minimise the severity of the problem.

Another example of primary intervention that Itsoseng clinic practises is to develop problem-solving skills. This is attained through and during counselling. Clients are taught basic problem-solving skills that they can apply in their lives. Many psychological problems arise as a result of poor problem-solving skills; and so this kind of intervention encourages clients to use these learned skills in coping with intra- or interpersonal problems. This plays an important role in preventing psychological problems that may arise as a result of a lack of such skills. Itsoseng clinic also collaborates with the Centre for the Study of AIDS in educating both university students and the local community about HIV. Students are encouraged to test for HIV as early as possible so that they can know their status. During counselling, people are advised to take precautionary measures with regard to HIV. As part of primary intervention, people are encouraged to remain healthy not only psychologically but also physically.

Secondary intervention attempts to treat a problem at the earliest possible moment before it becomes severe or persistent. At Itsoseng Clinic therapeutic services are provided by masters students and intern psychologists under the supervision of the Department of Psychology. Most of the clients who present for therapy already have symptoms. They come to have those problems eased and eliminated, and the goal of therapy is to intervene to minimise the impact of the problem. The main objective of secondary intervention is to

minimise the impact of the symptoms before they escalate or deteriorate to an undesirable level (Duffy & Wong, 2000).

Tertiary intervention refers to attempts to reduce the severity of a problem once it occurs persistently. This type of intervention also deals with the rehabilitation of patients to a functional level. Some of the clients that come to Itsoseng clinic present with problems that are severe and that interfere with their normal functioning. Therapists therefore strive to provide relevant interventions that will assist clients to return to a previous level of functioning. The aim of this intervention is to decrease the rate of relapse and to rehabilitate clients back to society (Ahmed & Pretorius-Heuchert, 2001).

Empowerment

Another central value of community psychology is empowerment. Nicholas (2003) defines empowerment as an intentional, ongoing process, located in the local community, and involving mutual respect, critical reflection, caring and group participation. Community psychology seeks to empower people on grassroots level who has less access to psychological services. Itsoseng Clinic endeavours to provide mental health services to such people, and to ensure continuous participation of the community in this endeavour.

Visser (2007) defines empowerment as the process of having people gaining control over their own lives. This entails interpersonal, emotional, political and spiritual control. It also involves making resources available to individuals and to the community at large. The process of empowerment is embedded in the principle of capacity building, where resources are channelled towards equipping people with necessary skills to cope with future ordeals. The primary aim of empowerment is to help people to live effective lives, and to sustain themselves with little supervision from practitioners.

Rappaport (1981) argues that malfunctioning in a community may be attributed to insufficient resources; and this makes it difficult for people to cope with their problems. Itsoseng Psychology Clinic was initiated as an effort to remedy the existing imbalances and unstructured mental health programmes. There are few people in Mamelodi who can afford to see a private psychologist. As a result, the majority of people are left unattended. The inception of Itsoseng was a response by the Department of Psychology to this need and the shortage of psychological services.

Cowen (2000) argues that instead of blaming people, the community psychology model deals with environmental factors that contribute to the difficulties people face in trying to cope. He continues by saying that community psychology promotes wellness, and encourages people to find strength for themselves. According to Levine and Perkins (1997), community psychologists try to work through a variety of institutions and use community resources to empower people, instead of being a search for psychopathology. In other words, community psychologists are more concerned about finding resources and strengths within the community, and work to optimise people's potential.

A prime example of empowerment is the Pelophepha Health Train, which was an initiative of Transnet. This train travels throughout the country (except Gauteng province), with the intention of offering health services to people in rural areas who seldom have access to this services. The train offers mainly dental services, although psychological services are also offered under supervision. The latter include psychoeducational programmes such as life skills to schools and community organisations. The core objective of the psychological services is to empower people psychologically and mentally with skills to cope with life demands.

Naidoo (2006) argues that psychologists have moved from treating illness to promoting health. This obliges psychologists to abandon their office work and enter the community. The Itsoseng supervisors have made it their obligation to train students who may provide services to people in the community. In other words, Itsoseng clinic is taking psychology to members of community; it seeks to intervene from individual level to community level.

Primary intervention deals with preventing problems from occurring; secondary intervention aims to minimise the impact of the problem; and tertiary intervention deals with reducing the impact of problems once they have occurred (Duffy & Wong, 2000). Most community intervention models are designed to address needs that a specific community lack or needs. Visser (2007) argues that psychology in South Africa is still in the early stages of changing to a more community-oriented focus; and calls for more research to be done on community level.

Community empowerment also includes community participation in the project or intervention. Lewis, Lewis, Daniels and D'Anrea (2003) indicate that if the intervention focuses on the real needs of the people in a community, then they might consider getting involved in the intervention because of this sense of ownership. They are aware of their resources and what methods work for them. Consequently, community psychologists work as participants in the process.

Research Method

Design: Programme Evaluation

This study took the form of a limited programme evaluation using descriptive statistics as primary method, based on an analysis of archival records (viz. Itsoseng clinic service delivery records) from the period January 2005 to November 2006.

Descriptive research is undertaken to collect facts about a specified population or sample. Itsoseng clinic was established as a programme that seeks to address and improve the limited psychological services to the community of Mamelodi. This study seeks to describe the demographic profile of the client community and subsequently comment on the service delivery of Itsoseng clinic from 2005 to 2006 in terms of age, gender and presenting problem. The aim is to provide a clear and vivid understanding of the client population in order to inform strategic decisions regarding the training content of students, marketing, and the establishment of multidisciplinary networks. This study furthermore seeks to understand how therapists involved in the clinic conducted their day-to-day activities based on the demographic profile and service needs of the client population. It will hopefully also provide material for reflection on marketing and record-keeping for future programme evaluations.

Rossi and Freeman (1989, p. 18) define programme evaluation as a "systematic application of social research procedures for assessing the conceptualisation, design implementation and utility of a social intervention programme". Potter and Kruger (2001) state that the central goal of programme evaluation is to analyse how people involved in a programme go about their work. According to Kumar (2005), evaluating the delivery manner of a programme is a very important aspect of the process of evaluation. Baker (1989) mentions that programme evaluation is not a different method of doing research, but is rather a type of research which is carried out for a specific purpose.

Data Collection: Archival Records

Archival research involves accessing records or documents that describe the characteristics of individuals, groups and organisations (Cozby, 1997). Usually, the data in these records are collected and maintained for purposes other than research. In this study, data were collected by selecting specific units of information from existing records in the Itsoseng clinic archives. Specific permission to use this data was obtained from the Itsoseng clinic coordinator, Dr. Linda Eskell-Blokland.

These data already existed and were stored at Itsoseng clinic. They were collected by masters students and intern psychologists during their daily functioning at the clinic. This method of collecting data has some definite advantages. Other data collection methods use participants' current behaviour or feedback as the main source. Since participants may change their behaviour because they are aware of proceedings, the data may be less accurate. Researchers may also encounter apathy or enthusiasm from participants, which can pose a serious threat to the validity of the results. According to Mouton and Marais (1990), in archival research the data already exist and the researcher does not have to deal with the confounding impact of participants' reactions to the process of research.

Data Analysis: Descriptive Statistics

Descriptive statistics were employed to analyse the collected data. Descriptive statistics is concerned with description and summarisation of the data obtained for a group or individuals (Huysamen, 1990). Descriptive statistics deals with organising and summarising data to make them more intelligible (Singleton & Straits, 2005). The data were organised using tables and graphs to indicate the demographic profile of the client population in terms of age, gender and presenting problems. A second order analysis was attempted by inferring possible reasons for the findings.

Research Process

The Itsoseng clinic comprises students enrolled for a masters degree in clinical and counselling psychology and two intern psychologists. Each month every therapist compiles a statistics form to indicate the number of clients he or she treated in that month. The form includes information pertaining to the client's gender, age and presenting problem. These

statistics are submitted to the Department of Psychology on a monthly basis for administrative and control purposes. This gives the department a general idea of how many clients are treated each month. The information is retained in the department files for future use and for record-keeping purposes in case information is needed for specific clients.

The data for this study were drawn from the archives after permission to do so was obtained from the department. After the data were collected, copies were made from the original materials, and the process of sorting the data commenced according to month and year. The information was stored in files under each therapists' name; which simplified the matter of obtaining the necessary data. During 2005, approximately 210 files were created, while in 2006 nearly 200 files were created. Each of these client files was analysed in terms of the three variables of gender, age and presenting problems. After categorising the data according to the three variables, the variables were compared.

In terms of age, the category ranges from preschool age to 60 years; and information pertaining to those who sought therapeutic intervention in these age groups during the period of 2005 and 2006 was extracted from this. This comparison provides a picture of the age groups who were most commonly seen at the clinic. The second variable examined is presenting problems. The numerous problems that were treated at Itsoseng clinic in 2005 and 2006 were reduced to main categories (see chapter 4). The most and least prominent presenting problems are identified, providing solid information on the main kinds of problems experienced, referred to and treated at the clinic. The third and final variable is gender, which is analysed in terms of the frequency with which each sex was treated at the clinic in 2005 and 2006. Chapter 4 presents the results of the analyses, which are depicted in the form of graphs.

Ethical Considerations

Permission to make use of the clinic records was obtained from the Itsoseng clinic director, Dr. Linda Eskell-Blokland, and appears in Appendix 1. The nature of these records is that they reflect only the names of the attending therapists and certain monthly service delivery details (e.g., gender, age and presenting problem of clients). Examples of the monthly service delivery record sheets appears in Appendices 2 and 3. Identifying information of individual clients or therapists was withheld, and no personal information pertaining to any client or therapist was disclosed.

Conclusion

This chapter discussed the research methodology in terms of its epistemological and theoretical foundation as well as the chosen research design. Community psychology was explored in terms of the principles adopted by Itsoseng Clinic and adhered to this dissertation. Archival research as the research method was explained, and the research population and process of data collection was briefly outlined. Chapter 4 presents the results of the data analysis.

CHAPTER 4

PRESENTATION AND DISCUSSION OF THE RESULTS

Introduction

This chapter presents the results of the data analysis and provides an overview of the clients and problems most frequently treated at Itsoseng Clinic. The results are presented in the form of graphs. This is followed by a discussion of the findings. Chapter 5 discusses the implications of the findings in more detail. The first part of this chapter describes the age variables, and indicates which age groups were most frequently seen at the clinic in the period 2005 and 2006. The second part addresses gender, and the final section refers to the presenting problems commonly seen at the clinic over the designated time period.

This chapter also touches on trends that emerged during the analysis, and whether these tie in with the goals and aims of Itsoseng Clinic as explored in earlier chapters, so as to arrive at a clearer understanding of the service delivery of Itsoseng. These results are integrated and examined in terms of their possible implications for future planning and service delivery at Itsoseng Clinic.

The data used in the analysis were taken from monthly therapy records (see examples thereof in Appendix 2 and 3) compiled by therapists who worked at Itsoseng psychology clinic during period of Jan to November 2005 and Jan to September of 2006.

Reporting on Trends Vs Explaining the Trends

This study aims to report on certain trends that became apparent during the analysis of the clinic records. The design does not lend itself to provide reasons for the trends and any attempts in this chapter to explain certain trends should be regarded as intelligent speculation and not the result of a research process to establish causal factors for the trends.

Research Question

This study investigates the profile of the client population of Itsoseng psychology clinic during 2005 and 2006, with the research question being: What did the client population

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look like in terms of age, gender and presenting problems during 2005 and 2006 at Itsoseng clinic in Mamelodi? To answer this research question, I have used tabulated the distributions of age, gender and presenting problems, followed by a short explanation of how the contents of the table should be read. At times the discussion of trends visible in the tables is augmented by reports of findings of similar studies done by other researchers that were deemed relevant to the particular sections.

Tables 4.1 and 4.2 represent a summarised version of my answer to the research question in table format. The rest of this chapter is dedicated to discussions of the three variables (age, gender and presenting problems) respectively.

Table 4.1 Data table indicating the number of clients seen in 2005, broken down in terms of presenting problem, gender and age on a month-to-month basis

2005														
PRESENTING PROBLEM	ABREV	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTALS	% OF TOTAL (314)
ALCOHOL ABUSE	AA	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**1**	**2**	**0**	**0**	**0**	5	1.6
ABORTION	AB	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	2	0.6
BEREAVEMENT COUNSELLING	BC	**0**	**1**	**0**	**5**	**3**	**0**	**2**	**2**	**3**	**1**	**0**	**0**	17	5.4
BEHAVIOUR PROBLEMS	BP	**0**	**2**	**4**	**6**	**5**	**3**	**0**	**1**	**1**	**0**	**0**	**0**	22	7
CAREER GUIDANCE	CG	**3**	**1**	**0**	**0**	**14**	**0**	**4**	**3**	**5**	**1**	**0**	**0**	31	9.9
DEPRESSION	DP	**1**	**0**	**2**	**2**	**2**	**0**	**3**	**6**	**9**	**6**	**5**	**0**	36	11.5
FAMILY PROBLEMS	FP	**3**	**0**	**0**	**3**	**3**	**0**	**1**	**6**	**1**	**1**	**1**	**0**	19	6.1
HIV	HIV	**0**	**0**	**3**	**2**	**8**	**0**	**4**	**0**	**1**	**0**	**0**	**0**	18	5.7
LEARNING DIFFICULTIES	LD	**10**	**5**	**7**	**8**	**8**	**5**	**7**	**8**	**15**	**8**	**12**	**0**	93	29.6
MENTAL IMPAIRMENT	MI	**3**	**1**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	5	1.6
MARITAL PROBLEMS	MP	**1**	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**3**	**1**	**0**	**0**	7	2.2
PERSONALITY DISORDERS	PD	**0**	**0**	**0**	**0**	**1**	**1**	**0**	**0**	**1**	**0**	**1**	**0**	4	1.3
RAPE	RA	**0**	**1**	**0**	**0**	**1**	**1**	**1**	**1**	**3**	**0**	**0**	**0**	8	2.5
RELATIONSHIP PROBLEMS	RP	**0**	**5**	**3**	**6**	**3**	**0**	**1**	**4**	**0**	**3**	**1**	**0**	26	8.3
SEXUAL ABUSE	SA	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	0	0
SCHOOL READINESS	SR	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**6**	**0**	**0**	**0**	7	2.2
TRUAMA	T	**0**	**0**	**0**	**1**	**3**	**3**	**1**	**4**	**3**	**0**	**0**	**0**	15	4.8
TOTALS		24	17	19	33	52	13	24	37	53	22	20	0	314	100
GENDER		JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTALS	% OF TOTAL (314)
MALE		**18**	**7**	**9**	**14**	**21**	**8**	**14**	**17**	**28**	**11**	**15**	**0**	162	51.6
FEMALE		**6**	**10**	**10**	**19**	**31**	**5**	**10**	**20**	**25**	**11**	**5**	**0**	152	48.4
TOTALS		24	17	19	33	52	13	24	37	53	22	20	0	314	100
MALE %		75	41.2	47.4	42.4	40.4	61.5	58.3	45.9	52.8	50	75	0		
FEMALE %		25	58.8	52.6	57.6	59.6	38.5	41.7	54.1	47.2	50	25	0		
AGE		JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTALS	% OF TOTAL (314)
0-6		**1**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**2**	**0**	**0**	**0**	4	1.3
7-14		**13**	**3**	**7**	**10**	**8**	**5**	**7**	**7**	**16**	**5**	**8**	**0**	89	28.3
15-20		**6**	**6**	**6**	**12**	**11**	**3**	**9**	**12**	**9**	**6**	**7**	**0**	87	27.7
21-30		**2**	**5**	**6**	**8**	**29**	**4**	**7**	**9**	**7**	**7**	**3**	**0**	87	27.7
31-40		**0**	**0**	**0**	**2**	**2**	**0**	**0**	**2**	**15**	**4**	**0**	**0**	25	8
41-50		**2**	**2**	**0**	**1**	**2**	**0**	**1**	**5**	**3**	**0**	**2**	**0**	18	5.7
51-60		**0**	**1**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	2	0.6
61+		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**1**	**0**	**0**	**0**	2	0.6

TOTALS		24	17	19	33	52	13	24	37	53	22	20	0	314	100

Table 4.2 Data table indicating the number of clients seen in 2006, broken down in terms of presenting problem, gender and age on a month-to-month basis

2006															
PRESENTING PROBLEM	ABREV	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTALS	% OF TOTAL (240)
ALCOHOL ABUSE	AA	**0**	**0**	**0**	**2**	**1**	**0**	**0**	**1**	**1**	**0**	**0**	**0**	5	2.1
ABORTION	AB	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	0	0
BEREAVEMENT COUNSELLING	BC	**1**	**1**	**1**	**2**	**1**	**1**	**4**	**0**	**1**	**0**	**0**	**0**	12	5
BEHAVIOUR PROBLEMS	BP	**2**	**1**	**3**	**1**	**2**	**2**	**0**	**0**	**1**	**0**	**0**	**0**	12	5
CAREER GUIDANCE	CG	**1**	**3**	**0**	**4**	**5**	**2**	**1**	**3**	**0**	**0**	**0**	**0**	19	7.9
DEPRESSION	DP	**1**	**2**	**4**	**0**	**3**	**4**	**3**	**3**	**1**	**0**	**0**	**0**	21	8.8
FAMILY PROBLEMS	FP	**1**	**0**	**4**	**0**	**1**	**2**	**0**	**0**	**5**	**0**	**0**	**0**	13	5.4
HIV	HIV	**1**	**4**	**7**	**0**	**5**	**2**	**5**	**6**	**2**	**0**	**0**	**0**	32	13.3
LEARNING DIFFICULTIES	LD	**4**	**7**	**5**	**3**	**6**	**16**	**5**	**6**	**3**	**0**	**0**	**0**	55	22.9
MENTAL IMPAIRMENT	MI	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	0	0
MARITAL PROBLEMS	MP	**0**	**0**	**1**	**0**	**1**	**1**	**1**	**5**	**1**	**0**	**0**	**0**	10	4.2
PERSONALITY DISORDERS	PD	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	1	0.4
RAPE	RA	**0**	**1**	**1**	**1**	**3**	**1**	**0**	**1**	**0**	**0**	**0**	**0**	8	3.3
RELATIONSHIP PROBLEMS	RP	**1**	**5**	**9**	**8**	**2**	**1**	**2**	**4**	**3**	**0**	**0**	**0**	35	14.6
SEXUAL ABUSE	SA	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	1	0.4
SCHOOL READINESS	SR	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	1	0.4
TRUAMA	T	**2**	**0**	**1**	**1**	**3**	**1**	**3**	**1**	**3**	**0**	**0**	**0**	15	6.3
TOTALS		16	24	36	22	34	33	24	30	21	0	0	0	240	100
GENDER		JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTALS	% OF TOTAL (240)
MALE		**7**	**9**	**12**	**10**	**14**	**16**	**9**	**14**	**7**	**0**	**0**	**0**	98	40.8
FEMALE		**9**	**15**	**24**	**12**	**20**	**17**	**15**	**16**	**14**	**0**	**0**	**0**	142	59.2
TOTALS		16	24	36	22	34	33	24	30	21	0	0	0	240	100
MALE %		43.8	37.5	33.3	45.5	41.2	48.5	37.5	46.7	33.3	0	0	0		
FEMALE %		56.3	62.5	66.7	54.5	58.8	51.5	62.5	53.3	66.7	0	0	0		
AGE		JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTALS	% OF TOTAL (240)
0-6		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	1	0.4
7-14		**1**	**8**	**4**	**4**	**8**	**6**	**3**	**10**	**1**	**0**	**0**	**0**	45	18.8
15-20		**8**	**2**	**6**	**2**	**8**	**18**	**10**	**1**	**9**	**0**	**0**	**0**	64	26.7
21-30		**5**	**10**	**17**	**13**	**13**	**8**	**8**	**11**	**7**	**0**	**0**	**0**	92	38.3
31-40		**2**	**4**	**7**	**1**	**2**	**0**	**1**	**3**	**1**	**0**	**0**	**0**	21	8.8
41-50		**0**	**0**	**1**	**2**	**1**	**1**	**1**	**4**	**1**	**0**	**0**	**0**	11	4.6
51-60		**0**	**0**	**1**	**0**	**1**	**0**	**1**	**0**	**1**	**0**	**0**	**0**	4	1.7
61+		**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	2	0.8
TOTALS		16	24	36	22	34	33	24	30	21	0	0	0	240	100

Age Graphs for 2005 and 2006

Age Categories

For the purpose of describing age as a variable, eight categories were created, namely preschool (0-6), primary school (7-14), high school (15-20), and adults in the age groups 21-30; 31-40; 41-50; 51-60; and 61+. Tables 4.3 and 4.4 show the actual number of clients that attended the clinic during 2005 and 2006

Table 4.3 Number of clients presenting at clinic according to age category and month during 2005

2005														
AGE	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**TOTALS**	**% OF TOTAL (3**
0-6	1	0	0	0	0	1	0	0	2	0	0	0	**4**	**1.3**
7-14	13	3	7	10	8	5	7	7	16	5	8	0	**89**	**28.3**
15-20	6	6	6	12	11	3	9	12	9	6	7	0	**87**	**27.7**
21-30	2	5	6	8	29	4	7	9	7	7	3	0	**87**	**27.7**
31-40	0	0	0	2	2	0	0	2	15	4	0	0	**25**	**8**
41-50	2	2	0	1	2	0	1	5	3	0	2	0	**18**	**5.7**
51-60	0	1	0	0	0	0	0	1	0	0	0	0	**2**	**0.6**
61+	0	0	0	0	0	0	0	1	1	0	0	0	**2**	**0.6**
TOTALS	**24**	**17**	**19**	**33**	**52**	**13**	**24**	**37**	**53**	**22**	**20**	**0**	**314**	**100**

Table 4.4 Number of clients presenting at clinic according to age category and month

2006														
AGE	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**TOTALS**	**% OF TOTAL (2**
0-6	0	0	0	0	0	0	0	1	0	0	0	0	**1**	**0.4**
7-14	1	8	4	4	8	6	3	10	1	0	0	0	**45**	**18.8**
15-20	8	2	6	2	8	18	10	1	9	0	0	0	**64**	**26.7**
21-30	5	10	17	13	13	8	8	11	7	0	0	0	**92**	**38.3**
31-40	2	4	7	1	2	0	1	3	1	0	0	0	**21**	**8.8**
41-50	0	0	1	2	1	1	1	4	1	0	0	0	**11**	**4.6**
51-60	0	0	1	0	1	0	1	0	1	0	0	0	**4**	**1.7**
61+	0	0	0	0	1	0	0	0	1	0	0	0	**2**	**0.8**
TOTALS	**16**	**24**	**36**	**22**	**34**	**33**	**24**	**30**	**21**	**0**	**0**	**0**	**240**	**100**

Table 4.5 Age distribution of clients during 2005-2006

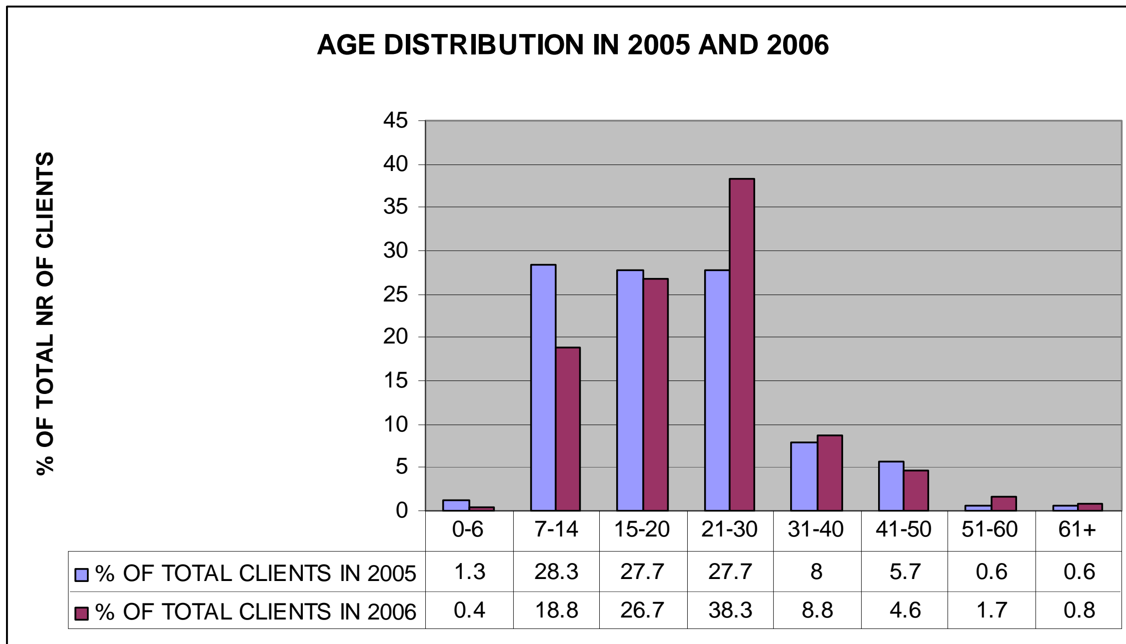


Table 4.3 provides a visual comparison between the various age groups in terms of attendance over the two years. It shows that the age groups that most consistently attended the clinic over the two years were primary school children (aged 7-14), high school children (aged 15-20), and young adults (aged 21-30).

Preschool Age (0-6)

Table 4.6 Preschool (0-6 years) age group attendance

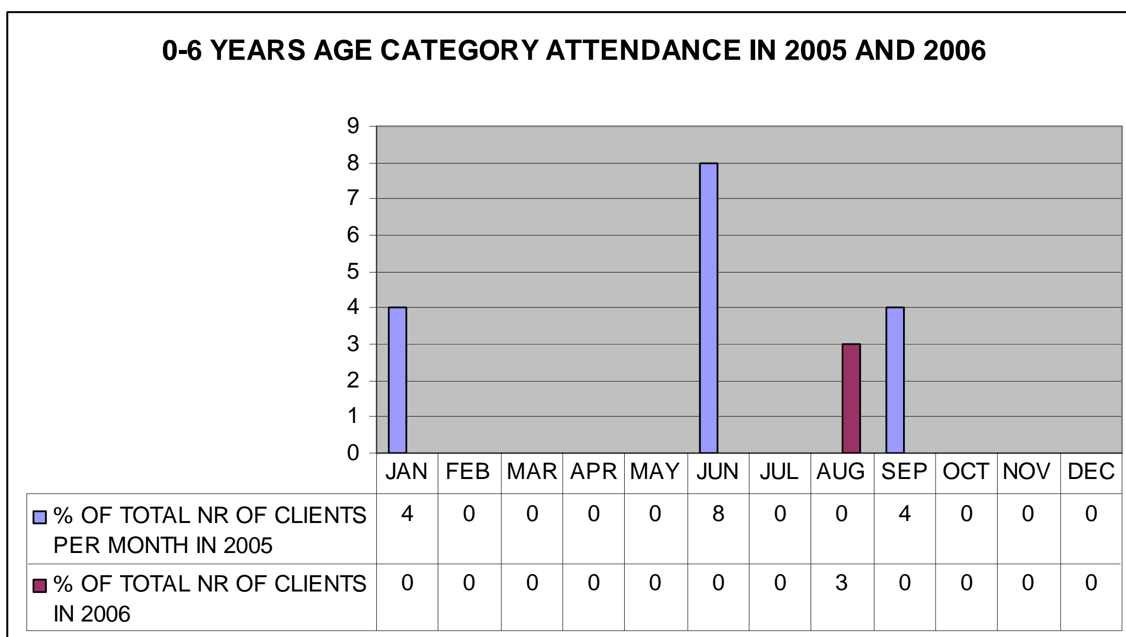


Table 4.6 shows the percentages of preschool children of the total number of clients seen at the clinic each month in 2005 (light colour) and 2006 (dark colour). For example, table 4.6 indicates that 4% (1 out of 24) of all clients seen in January 2005 fell in the age category 0-6 years. Likewise, 3% (one out of 30) of all clients seen in August 2006 were preschoolers.

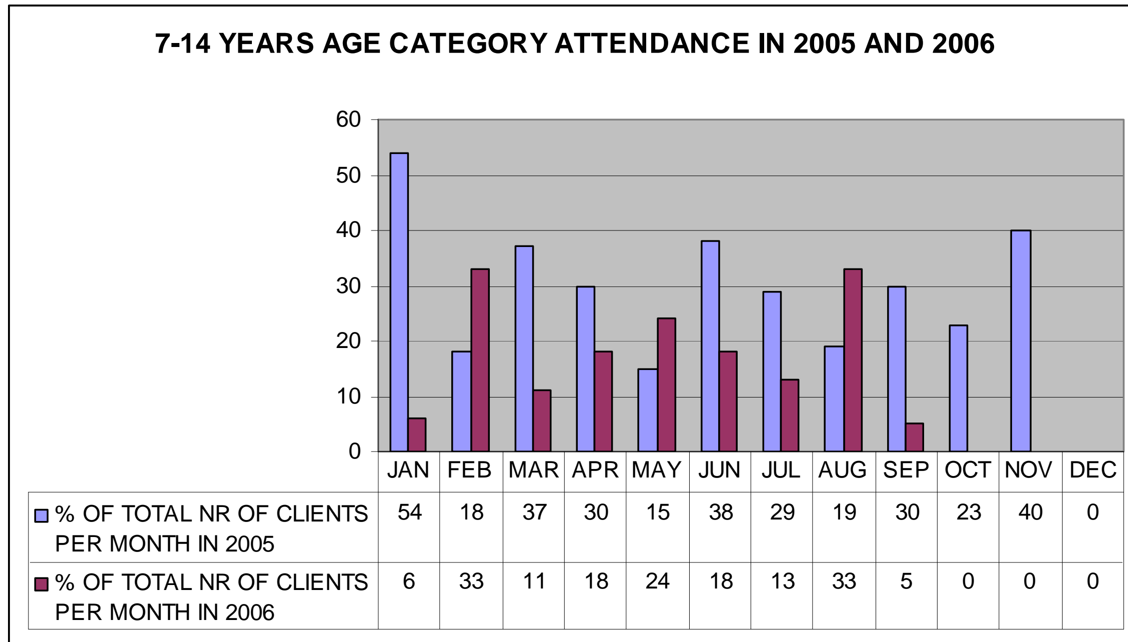
The total number of preschool children seen in 2005 was four out of a total of 314 clients, from which we can calculate that 1.3% of all clients seen in 2005 were preschool children (see table 4.3). Peak months are defined as those months in which the percentage of clients from this age group exceeds the overall percentage, namely 1.3%. In 2005 the peak months for attendance from this age group were January (4%), June (8%) and September (4%).

The total number of preschool children seen in 2006 was one out of a total of 240 clients, from which we can calculate that 0.4% of all clients seen in 2006 were preschool children (see table 4.4). Peak months are defined as those months in which the percentage of clients from this age group exceeds the overall percentage, namely 0.4%. In 2006 the peak month for attendance from this age group was August (3%).

When the numbers of preschoolers in 2005 and 2006 are compared, no pattern is apparent. This may be due to the relatively low numbers of preschoolers seen in total in 2005 and 2006. It is not clear what the possible reasons could be for the generally low attendance of clients from this age group. It is possible that the clinic was not adequately marketed to parents of preschoolers or referral agents involved with very young children, resulting in a lack of awareness of the clinic's existence and range of services.

Primary School (7-14)

Table 4.7 Primary school (7-14 years) age group attendance during 2005-2006



	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
% OF TOTAL NR OF CLIENTS PER MONTH IN 2005	54	18	37	30	15	38	29	19	30	23	40	0
% OF TOTAL NR OF CLIENTS PER MONTH IN 2006	6	33	11	18	24	18	13	33	5	0	0	0

Table 4.7 shows the percentages of primary school children out of the total number of clients seen at the clinic each month in 2005 (light colour) and 2006 (dark colour). For example, table 4.7 indicates that 54% (13 out of 24, see table 4.3) of all clients seen in January 2005 fell in the age category 7-14 years. Likewise, 33% (10 out of 30, see table 4.4) of all clients seen in August 2006 were in the age category 7-14 years.

The number of primary school children seen in 2005 totalled 89 out of 314 clients, from which we can calculate that 28.3% of all clients seen in 2005 were primary school children (see table 4.3). Peak months are defined as those months in which the percentage of clients from this age group exceeds the overall percentage, namely 28.3%. In 2005 the peak months for attendance from this age group were January (54%), March (37%), April (30%), June (38%), July (29%), September (30%) and November (40%).

The total number of primary school children seen in 2006 was 45 out of a total of 240 clients, from which we can calculate that 18.8% of all clients seen in 2006 were primary school children (see table 4.4). Peak months are defined as those months in which the percentage of clients from this age group exceeds the overall percentage, namely 18.8%.

In 2006 the peak months for attendance from this age group were February (33%), May (24%) and August (33%).

Compared to the preschool age group, the primary school age group shows a consistent flow of clients for most months during both 2005 and 2006. As in the preschool category, more primary school children were seen in 2005 than in 2006. The peak months could be explained by the fact that in January, most clients were adjusting to the school setting or curriculum issues. As a result, they may have been more likely to seek a therapy consultation to assist in developing coping mechanisms. The April increase in intake could be explained in terms of the identification of learning difficulties by school teachers or parents, which usually occurs a little way into the school year. The November increase may be caused by clients who find difficult to cope with end-of-year tests or exams and clients who are struggling to meet the outcomes required in order to be promoted to the next grade.

The fluctuation in client numbers in both 2005 and 2006 could be affected by the availability of student therapists during the year. Student therapists are available from February to June, take a break for the winter holidays, and resume in late July through September, take a short break and then resume work until November. In the absence of students therapists clients are seen by the intern psychologists, who cannot support the same client load. This the availability of student therapists is likely to impact on client intake. It may be useful in future studies to examine ways and strategies to sustain the consistent flow of clients.

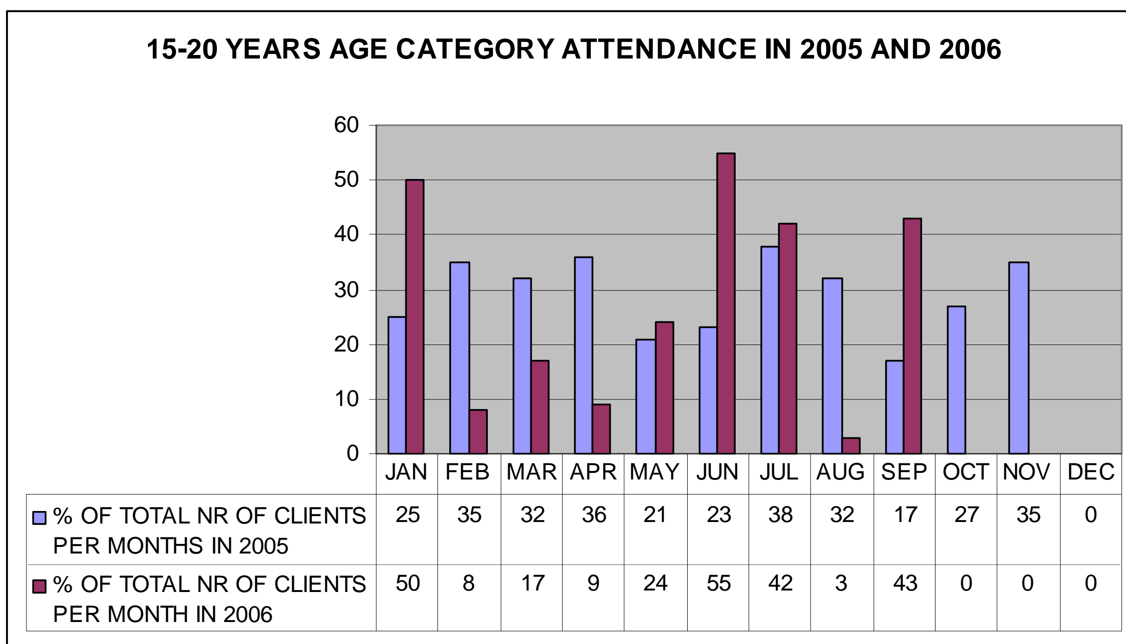
The primary school category makes up the third largest group of all the age categories. The relatively large numbers of primary school children seeking assistance from the clinic may have an influence on the type of therapy and assessments that the clinic should provide, and suggests that it may be important to focus on training and programmes that are geared to addressing the psychological needs of this age group. A study by Taylor (2003) on American teenagers revealed that children between the ages of 10 and 15 commonly experience psychological problems, and reports that 20% of teenagers are referred for therapy either by the school or the parents.

Studies done by Duncan and Rock (cited in Seedat et al., 1994) found that most children and youths who are likely to see or be referred to a therapist range in age from 14 to 20.

The primary school and high school age categories combined represent the largest group of clients seen at Itsoseng, which echoes the findings of the Duncan and Rock study. This suggests that the psychological needs of children in the Mamelodi area are similar to those in other regions. This is very relevant in light of the lack of psychological services and facilities available in the township compared to other urban centres in Gauteng.

High School Age (15-20)

Table 4.8 High school (15-20 years) age group attendance during 2005-2006



	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
% OF TOTAL NR OF CLIENTS PER MONTHS IN 2005	25	35	32	36	21	23	38	32	17	27	35	0
% OF TOTAL NR OF CLIENTS PER MONTH IN 2006	50	8	17	9	24	55	42	3	43	0	0	0

Table 4.8 shows the percentages of high school children out of the total number of clients seen at the clinic each month in 2005 (light colour) and 2006 (dark colour). For example, Table 4.8 indicates that 38% (9 out of 24, see table 4.3) of all clients seen in July 2005 were in the age category 15-20 years. Likewise, 55% (18 out of 33, see table 4.4) of all clients seen in June 2006 were in the age category 15-20 years.

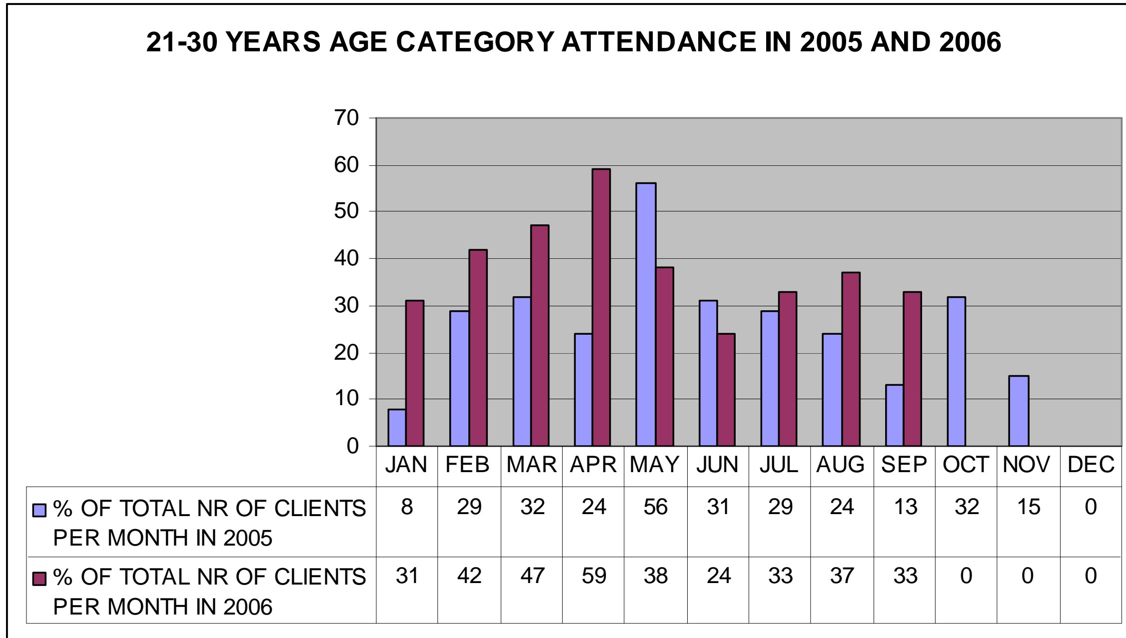
The number of high school children seen in 2005 totalled 87 out of 314 clients, from which we can calculate that 27.7% of all clients seen in 2005 were high school children (see table 4.3). Peak months are defined as those months in which the percentage of clients from this age group exceeds the overall percentage, namely 27.7%. In 2005 the peak months for attendance from this age group were February (35%), March (32%), April (36%), July (38%) and November (35%).

The total number of high school clients seen in 2006 was 64 out of a total of 240, from which we can calculate that 26.7% of all clients seen in 2006 were from this age category (see table 4.4). Peak months are defined as those months in which the percentage of clients from this age group exceeds the overall percentage, namely 26.7%. In 2006 the peak months for attendance from this age group were January (50%), June (55%), July (42%) and September (43%).

This age group is the second largest group that was treated at Itsoseng clinic in 2005 and 2006. These results yield interesting findings with regard to the distribution of clients from this age group over the two years. Unlike the younger age groups, every month of 2005 and 2006 is well represented. Also unlike the younger age groups, the number of high school clients seen in 2006 is very close to the number presenting to the clinic in 2005, with marginally more being seen in 2005. The previous groups show far larger numbers being seen in 2006. A possible reason for this may be that the marketing done by the masters students in 2006 targeted more high schools than primary schools, and that the marketing was more consistently directed towards these age groups each year. It may also be that the local high schools are more aware of the existence of the clinic, and thus more likely to refer clients. This hypothesis seems reasonable given that Itsoseng has presented life skills workshops to local high schools in the past, and thus has formed closer alliances with them than with some other referral agencies.

Age Category of 21-30 Years

Table 4.9 Age category of 21-30 years attendance during 2005-2006



	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
% OF TOTAL NR OF CLIENTS PER MONTH IN 2005	8	29	32	24	56	31	29	24	13	32	15	0
% OF TOTAL NR OF CLIENTS PER MONTH IN 2006	31	42	47	59	38	24	33	37	33	0	0	0

Table 4.9 shows the percentages of clients from the 21-30 age category from the total number of clients seen at the clinic each month in 2005 (light colour) and 2006 (dark colour). For example, table 4.9 indicates that 56% (29 out of 52, see table 4.3) of all clients seen in May 2005 were in the age category 21-30 years. Likewise, 59% (13 out of 22, see table 4.4) of all clients seen in April 2006 were in the age category 21-30 years.

The total number of clients from the 21-30 age category seen in 2005 was 87 out of a total of 314, from which we can calculate that 27.7% of all clients seen in 2005 fell into the 21-30 age category (see table 4.3). Peak months are defined as those months in which the percentage of clients from this age group exceeds the overall percentage, namely 27.7%. In 2005 the peak months for attendance from this age group were February (29%), March (32%), May (56%), June (31%), July (29%) and October (32%).

The total number of clients from the 21-30 age category seen in 2006 was 92 out of a total of 240, from which we can calculate that 38.3% of all clients seen in 2006 were from this age category (see table 4.4). Peak months are defined as those months in which the percentage of clients from this age group exceeds the overall percentage, namely 38.3%.

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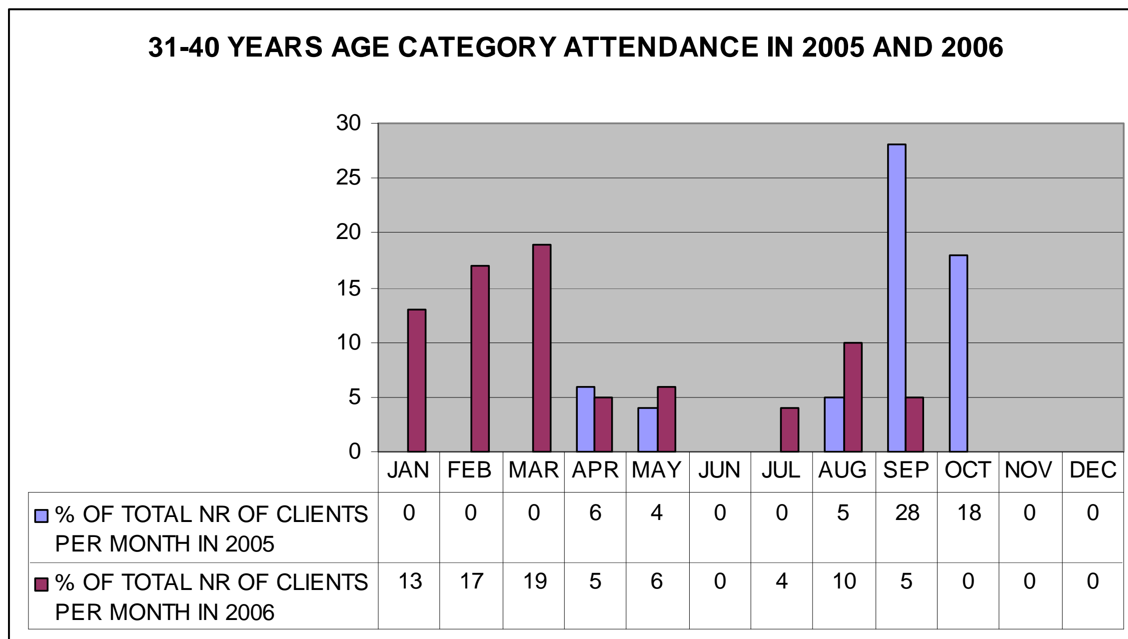
In 2006 the peak months for attendance from this age group were February (42%), March (47%) and April (59%).

Table 4.5 shows that the category of clients aged between 21 and 30 years is the largest age group treated at Itsoseng clinic over the two years, representing 27% of the total number of clients in 2005 and 38% in 2006. Over the two years combined, this represents roughly a third of all clients seen at the clinic. This is not surprising given that the clinic is situated on a university campus for the benefit of the students. Clients in this category were seen consistently every month, unlike the school age groups, where client attendance sometimes fluctuated fairly dramatically from month to month. However, the two years show fairly different attendance patterns, with the bulk of clients in this age group being seen at different times in each year. This could perhaps reflect the different peak marketing times each year. The fact that this age group represents the largest number of clients seen at the clinic reflects the need for psychological interventions for this age group, and suggests that student therapists be given specific training in providing services for problems that most affect young adults, as well as training on how to deal with this age group.

Age category of 31-40 Years

Table 4.10 Age category of 31-40 years attendance during 2005-2006



	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
% OF TOTAL NR OF CLIENTS PER MONTH IN 2005	0	0	0	6	4	0	0	5	28	18	0	0
% OF TOTAL NR OF CLIENTS PER MONTH IN 2006	13	17	19	5	6	0	4	10	5	0	0	0

Table 4.10 shows the percentages of clients from the 31-40 age category of the total number of clients seen at the clinic each month in 2005 (light colour) and 2006 (dark colour). For example, table 4.10 indicates that 28% (15 out of 53, see table 4.3) of all clients seen in September 2005 were in the age category 31-40 years. Likewise, 19% (7 out of 36, see table 4.4) of all clients seen in March 2006 fell in the age category 31-40 years.

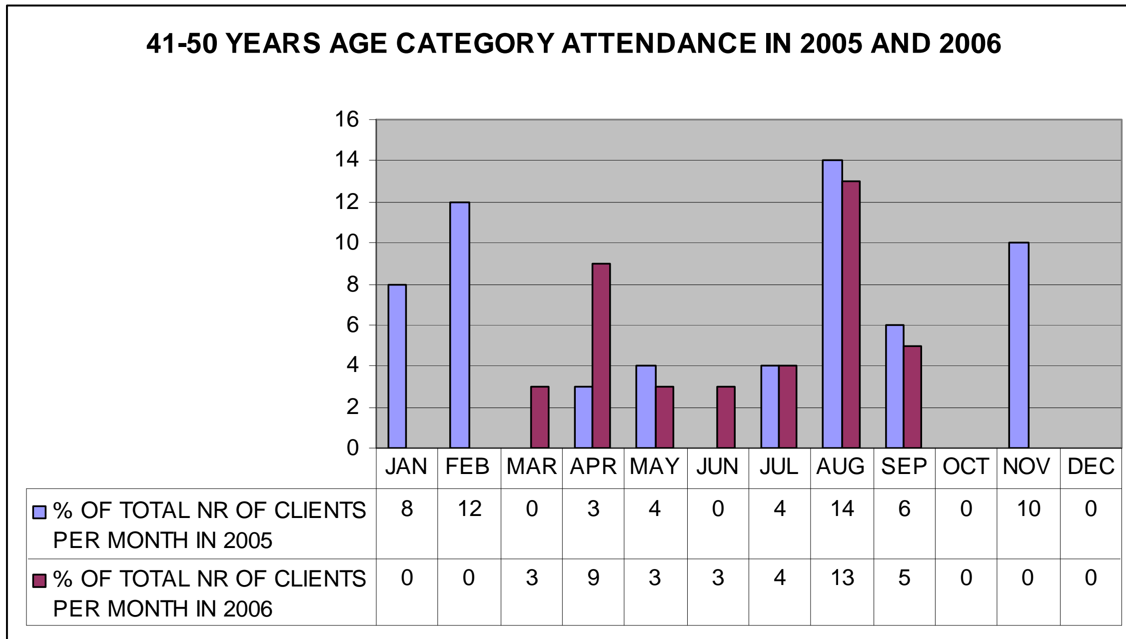
The total number of clients from the 31-40 age category seen in 2005 was 25 out of a total of 314, from which we can calculate that 8% of all clients seen in 2005 were clients from the 31-40 age category (see table 4.3). Peak months are defined as those months in which the percentage of clients from this age group exceeds the overall percentage, namely 8%. In 2005 the peak months for attendance from this age group were September (28%) and October (18%).

The total number of clients from the 31-40 age category seen in 2006 was 21 out of a total of 240 clients, from which we can calculate that 8.8% of all clients seen in 2006 were from this age category (see table 4.4). Peak months are defined as those months in which the percentage of clients from this age group exceeds the overall percentage, namely 8.8%. In 2006 the peak months for attendance from this age group were January (13%), February (17%), March (19%) and August (10%).

The pattern of attendance of clients aged 31 to 40 years differs somewhat from the previous age categories. One aspect immediately noticeable is the lack of a consistent monthly flow of clients and an absence of a pattern of attendance over the two years. For example, in 2005 no clients from this age group presented to the clinic for the first three months of the year. This is followed by a peak in September of 2005 with 28% of the group's total seeking assistance, followed by 18% in the following month, October. Very few clients from this age group were seen in April and August This differs from the attendance pattern of the previous age group (young adults) who showed generally higher attendance levels towards the middle of the year. These findings suggest that the clinic may need to examine its marketing strategy to potential clients of this age group, and expand its referral base to community organisations that have more contact with people in this age group.

Age Category of 41-50 Years

Table 4.11 Age category of 41-50 years attendance during 2005-2006



	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
% OF TOTAL NR OF CLIENTS PER MONTH IN 2005	8	12	0	3	4	0	4	14	6	0	10	0
% OF TOTAL NR OF CLIENTS PER MONTH IN 2006	0	0	3	9	3	3	4	13	5	0	0	0

Table 4.11 shows the percentages of clients from the 41-50 age category out of the total number of clients seen at the clinic each month in 2005 (light colour) and 2006 (dark colour). For example, table 4.11 indicates that 14% (5 out of 37, see table 4.3) of all clients seen in August 2005 were in the age category 41-50 years. Likewise, 13% (4 out of 30, see table 4.4) of all clients seen in August 2006 were in the age category 41-50 years.

The total number of clients from the 41-50 age category seen in 2005 was 18 out of a total of 314, from which we can calculate that 5.7% of all clients seen in 2005 represented the 41-50 age category (see table 4.3). Peak months are defined as those months in which the percentage of clients from this age group exceeds the overall percentage, namely 5.7%. In 2005 the peak months for attendance from this age group were January (8%), February (12%), August (14%), September (6%) and November (10%).

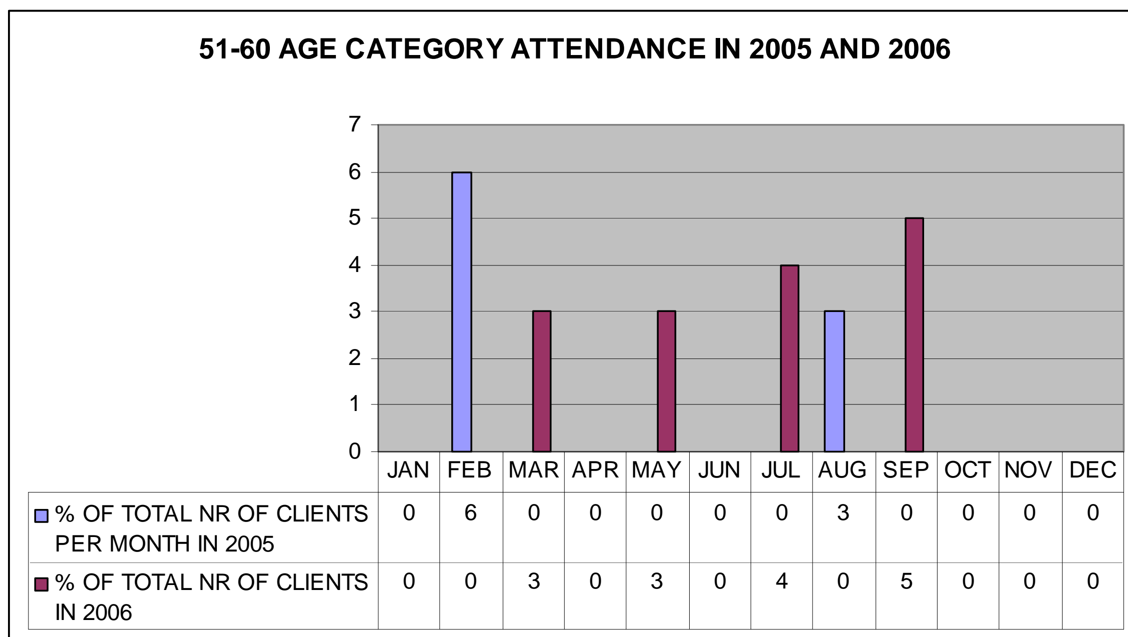
The total number of clients from the 41-50 age category seen in 2006 was 11 out of a total of 240, from which we can calculate that 4.6% of all clients seen in 2006 were from this age category (see table 4.4). Peak months are defined as those months in which the percentage of clients from this age group exceeds the overall percentage, namely 4.6%. In 2006 the peak months for attendance from this age group were April (9%), August (13%) and September (5%).

Table 4.11 indicates a slightly different pattern from the previous group, although again there was no consistent flow and pattern of clients when the two years are compared. As with the previous age category (31-40 years), the percentages for older clients are generally lower than for the younger groups. For instance, this group represents only 5.7% of the total number of clients seen in 2005, and 4.6% in 2006. Unlike some of the younger age groups, a similar number of clients were seen in both 2005 and 2006. As with the previous age group, these findings suggest that the marketing strategy at Itsoseng seems to be geared towards school-aged children and young adults more than the preschool or older adult populations.

A study done by the University of Cape Town in 2006 on psychological services rendered in the Drakenstein community revealed that out of the 774 clients seen, most were adults aged 21 years and older. Children between the ages of six and 12 represented 42% of the client population. These findings differ from those at Itsoseng clinic, where clients under the age of 21 years were more commonly seen. This gives some idea of the distribution of clients at community psychology clinics in other parts of the country.

Age Category of 51-60 Years

Table 4.12 Age category of 51-60 years attendance during 2005-2006



	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
% OF TOTAL NR OF CLIENTS PER MONTH IN 2005	0	6	0	0	0	0	0	3	0	0	0	0
% OF TOTAL NR OF CLIENTS IN 2006	0	0	3	0	3	0	4	0	5	0	0	0

Table 4.12 shows the percentages of clients from the 51-60 age category out of the total number of clients seen at the clinic each month in 2005 (light colour) and 2006 (dark

colour). For example, table 4.12 indicates that 6% (1 out of 17, see table 4.3) of all clients seen in February 2005 were in the age category 51-60 years. Likewise, 5% (1 out of 21, see table 4.4) of all clients seen in September 2006 were in the age category 51-60 years.

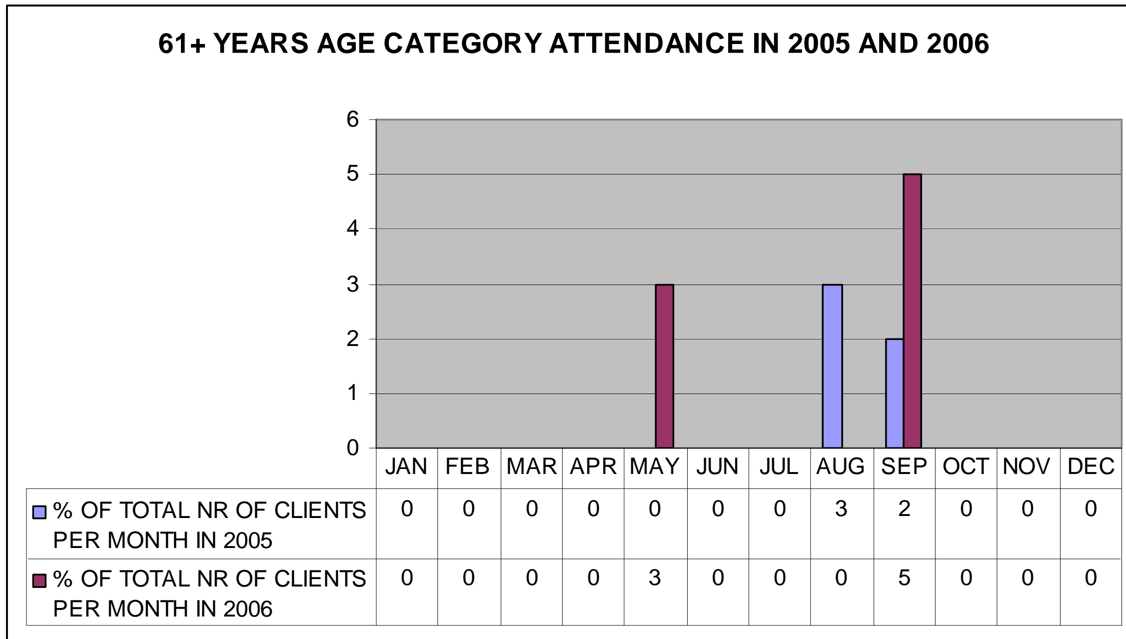
The total number of clients from the 51-60 age category seen in 2005 was two out of a total of 314 clients, from which we can calculate that 0.6% of all clients seen in 2005 were clients from the 51-60 age category (see table 4.3). Peak months are defined as those months in which the percentage of clients from this age group exceeds the overall percentage, namely 0.6%. In 2005 the peak months for attendance from this age group were February (6%) and August (3%).

The total number of clients from the 51-60 age category seen in 2006 was four out of a total of 240 clients, from which we can calculate that 1.7% of all clients seen in 2006 were from this age category (see table 4.4). Peak months are defined as those months in which the percentage of clients from this age group exceeds the overall percentage, namely 1.7%. In 2006 the peak months for attendance from this age group were March (3%), May (3%), July (4%) and September (5%).

Table 4.12 indicates the inconsistent attendance and low numbers of clients from this age group in both 2005 and 2006. In 2005, clients from this age group visited the clinic only in February and August. There was a wider distribution in 2006, with clients seeking therapy in five months of the year. These findings suggest that the clinic marketing, especially in 2005, was not geared to this client population, or was inadequate in reaching them. It may also indicate that far fewer people in this age group and demographic area seek psychotherapy.

Age Category of 61+ Years

Table 4.13 Age category of 61+ years attendance during 2005-2006



	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
% OF TOTAL NR OF CLIENTS PER MONTH IN 2005	0	0	0	0	0	0	0	3	2	0	0	0
% OF TOTAL NR OF CLIENTS PER MONTH IN 2006	0	0	0	0	3	0	0	0	5	0	0	0

Table 4.13 shows the percentages of clients from the 61+ age category out of the total number of clients seen at the clinic each month in 2005 (light colour) and 2006 (dark colour). For example, table 4.13 indicates that 3% (1 out of 37, see table 4.3) of all clients seen in August 2005 were in the age category 61+ years. Likewise, 5% (1 out of 21, see table 4.4) of all clients seen in September 2006 were in the age category 61+ years.

The total number of clients from the 61+ age category seen in 2005 was two of a total of 314, from which we can calculate that 0.6% of all clients seen in 2005 were clients from the 61+ age category (see table 4.3). Peak months are defined as those months in which the percentage of clients from this age group exceeds the overall percentage, namely 0.6%. In 2005 the peak months for attendance from this age group were August (3%) and September (2%).

The number of clients from the 61+ age category seen in 2006 was two out of a total of 240 clients, from which we can calculate that 0.8% of all clients seen in 2006 were from this age category (see table 4.4). Peak months are defined as those months in which the percentage of clients from this age group exceeds the overall percentage, namely 0.8%. In 2006 the peak months for attendance from this age group were May (3%) and September (5%).

Table 4.13 shows a very poor representation of this age group in using the psychological services at Itsoseng clinic. The total number of clients in this age category makes up only 0.7% (4 out of 554) of the total number of clients seen at Itsoseng over the two-year span that this study investigates.

A service delivery study at the University of Witwatersrand in Johannesburg on primary health care at the Schoongezicht clinic revealed that only 5% of people age 60 and above visited the clinic in 1992 (University of Witwatersrand Health Policy, 1991). This finding differs slightly from the current study's figure of 0.7%, although both are low, suggesting that older people may be generally less likely to seek psychological assistance.

A Summary of Age Group Attendance Over Two Years

Table 4.14 Prevalence of age groups as percentage of total clients during 2005-2006

	2005	*2006*	*2005+2006*	*2005+2006*
AGE	**TOTALS**	**TOTALS**	**TOTALS**	**%**
0-6	4	1	**5**	0.9%
7-14	89	45	**134**	24.2%
15-20	87	64	**151**	27.3%
21-30	87	92	**179**	32.3%
31-40	25	21	**46**	8.3%
41-50	18	11	**29**	5.2%
51-60	2	4	**6**	1.1%
61+	2	2	**4**	0.7%
TOTALS	**314**	**240**	**554**	**100.0%**

The aim of this study was to investigate the composition of the client population at Itsoseng in terms of gender, age and presenting problems, and to investigate possible trends on a month-to-month basis. This first section examined the client population in terms of age. The following section looks at the second variable, gender.

Gender Distribution

Gender refers to inherited or biological characteristics distinguishing one sex from another. Here we speak of males as distinct from females (Popenoe, 1980). The following two graphs indicate the number of males and females who consulted Itsoseng clinic in 2005

and 2006. The graphs provide an indication of the monthly distribution of men and women, with the aim of determining which gender made the most use of the clinic in the target period.

Table 4.15 Gender distributions during 2005

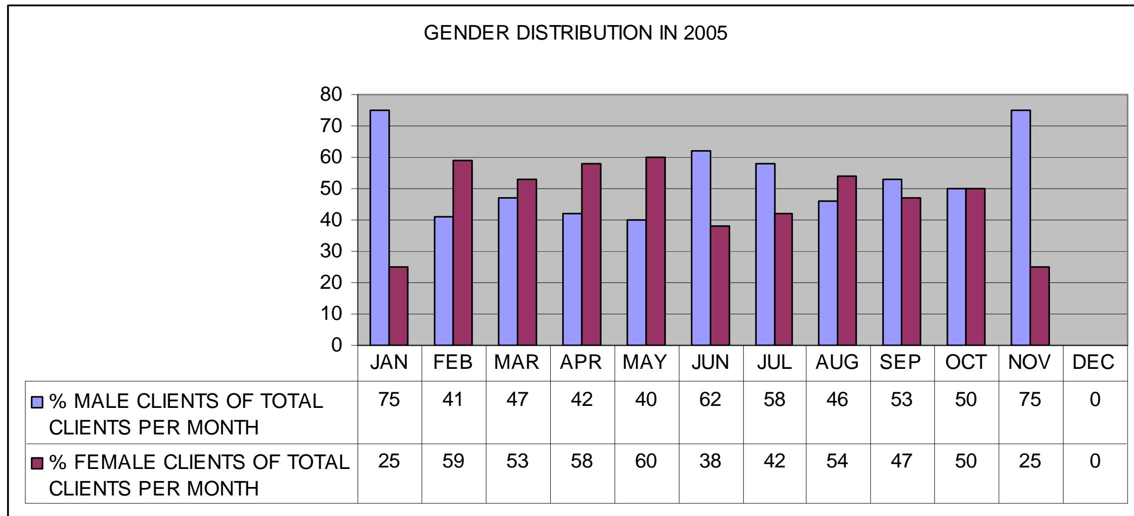


Table 4.16 Gender distributions during 2006

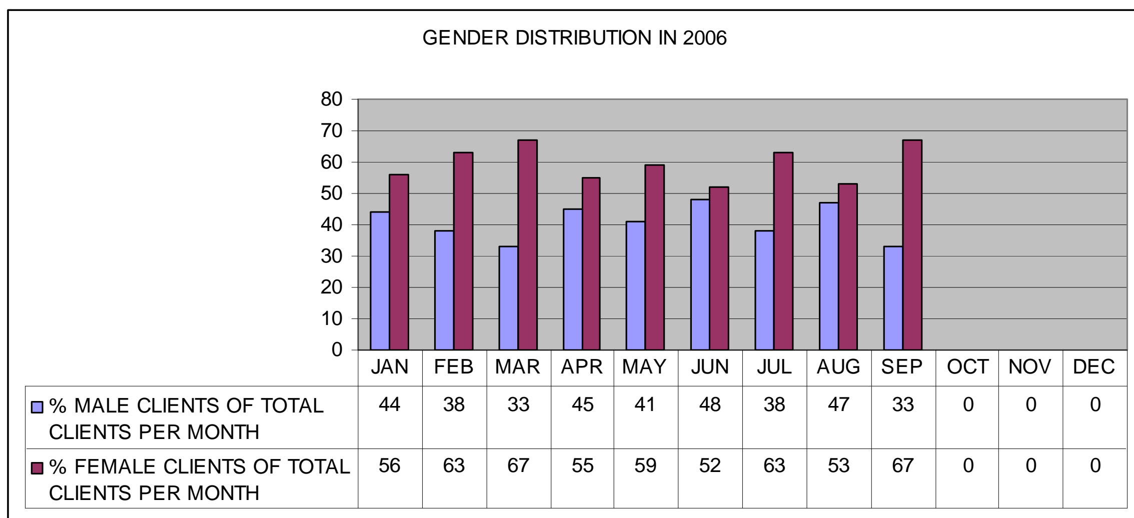


Table 4.17 Gender distributions as percentage of total over two-year period

	2005		***2006***		***2005+2006***	***2005+2006***
AGE	**TOTALS**	***% of total***	**TOTALS**	***% of total***	**TOTALS**	**%**
Male	162	51.6	98	40.8	**260**	46.9%
Female	152	48.4	142	59.2	**294**	53.1%
TOTALS	**314**	**100**	**240**	**100**	**554**	**100.0%**

Table 4.17 indicates that overall, more women (53.1%) than men (46.9%) presented for psychological help at Itsoseng clinic over the two-year period of this study. The year 2006 saw a marked gender difference in attendance from 2005. Table 4.17 shows an 10.8% increase of female attendance and a 10.8% decrease of male attendance from 2005 to 2006. In total, 62% of clients in 2005 were male, and 38% were female.

This is contrary to most the of findings regarding the gender distribution of clients presenting for therapy, which show that more females than males generally seek psychological help. For example, Willoughby and Ashdown's (2003) studies on gender and health found that more females than males seek psychological intervention when troubled or depressed. Markus, Parkers, Thomas and Johnston (1989) found that most people who are likely to access psychological or medical services are female, with only a small proportion of males consulting with psychologists. In his study of mental health services delivery in Botswana, Tovim (1987) discovered that at least 70% of females consult with either a medical doctor or a traditional healer compared to 38% of males. Studies done by the Witwatersrand Health Policy Unit (1991) at the Schoongezicht Clinic indicate that most people who visited the clinic were female, comprising 62% of clients and males only 38%. The New Zealand Health Survey Research Team did research in 1996 that found that 33% of females commonly reported psychological problems compared to 24,8% of males (Porter, Alder & Abraham, 1999). Bendelow, Carpenter, Vautier and Williams (2002) found that more females presented with depression and anxiety disorders, while more males presented with behavioural disorders such as alcohol and drug problems.

The current study echoes these findings for the two-year period; however, what might explain the higher number of men who presented for therapy in 2005? The above graph indicates that in January of 2005, 75% of the clients were male. A similar scenario occurred in November of that year, where again males made up 75% of the client population, with females representing only 25% of clients seen. The graph further indicates a strong and consistent flow of male clients throughout 2005. In total, 62% of clients in 2005 were male, and 38% were female. The difference between the current study's findings and those cited above may imply that the way men perceive psychological services or other forms of medical attention may slowly be changing. It is possible that the traditional and social view that teaches men that they are emotionally strong and therefore immune to psychological problems may slowly be giving way to a more balanced view of men as being as able as women to benefit from psychological assistance.

Presenting Problems

When clients present for therapy, they usually have a concrete explanation for what is wrong in their lives, whether they were self-referred or referred by another professional. As therapy commences, clients explain what they regard to be the problem. This is usually stated tentatively by the therapist as the presenting problem. In clinical settings it is useful to distinguish between presenting problem, diagnosis and therapeutic intervention. Unfortunately, when going through the clinic records of 2005 and 2006 it became apparent that student therapists used these terms interchangeably (for example, bereavement counselling and career guidance are not presenting problems but rather therapeutic interventions, while personality disorder is a diagnosis and not a presenting problem). For the sake of simplicity, I have decided to use the term presenting problem in this document to indicate any issue which was cited as the reason for the therapeutic relationship between a client and psychotherapist at Itsoseng.

Table 4.16 presents the list of 17 categories of presenting problems used in this study. These categories are my own creation and were not available to the student therapists to use when they completed their statistic forms of therapy cases each month. These categories represent the presenting problems of all the clients seen at Itsoseng during 2005 and 2006.

Table 4.18 Presenting problems and their abbreviations for the purposes of this study

PRESENTING PROBLEM	ABBREVIATION
ABORTION	AB
ALCOHOL ABUSE	AA
BEHAVIOUR PROBLEMS	BP
BEREAVEMENT COUNSELLING	BC
CAREER GUIDANCE	CG
DEPRESSION	DP
FAMILY PROBLEMS	FP
HIV	HIV
LEARNING DIFFICULTIES	LD
MARITAL PROBLEMS	MP
MENTAL IMPAIRMENT	MI
PERSONALITY DISORDERS	PD
RAPE	RA
RELATIONSHIP PROBLEMS	RP
SCHOOL READINESS	SR
SEXUAL ABUSE	SA
TRAUMA	T

The following two tables provide an overview of the varying incidence of problems (expressed as a percentage of the total client population) that clients presented with at Itsoseng clinic during 2005 and 2006.

Table 4.19 Presenting problem distribution during 2005

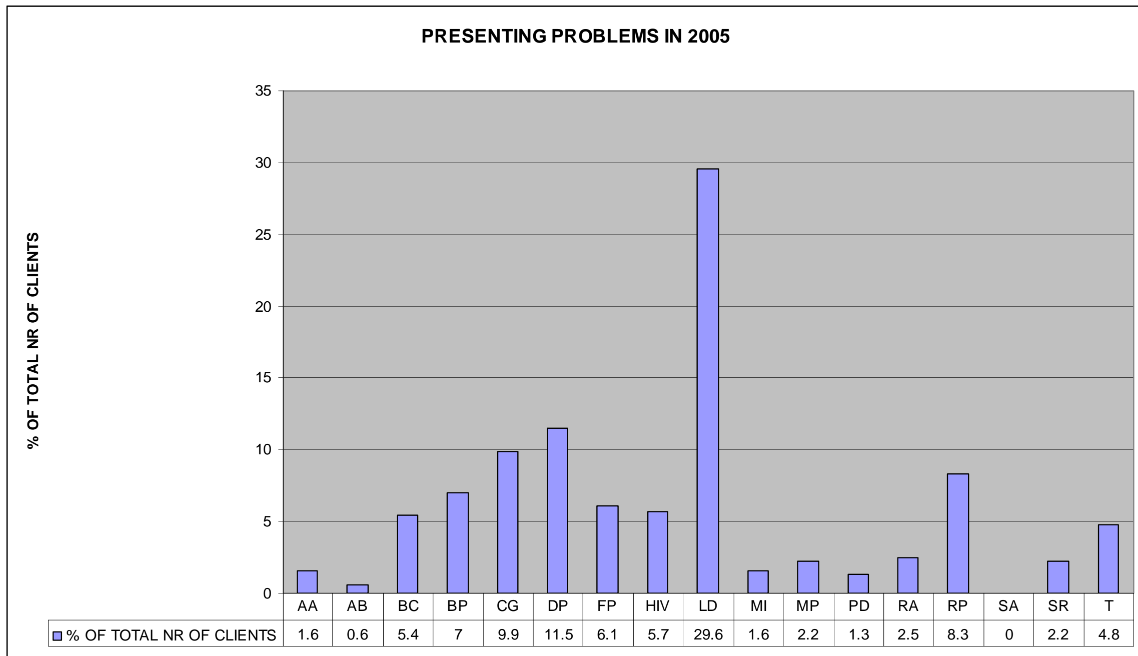


Table 4.19 indicates the percentage of the total number of clients seen in 2005 that presented with a particular concern. For example, clients presenting with learning difficulties made up 29.6% (almost a third) of all clients seen in 2005.

Table 4.20 Presenting problem distribution during 2006

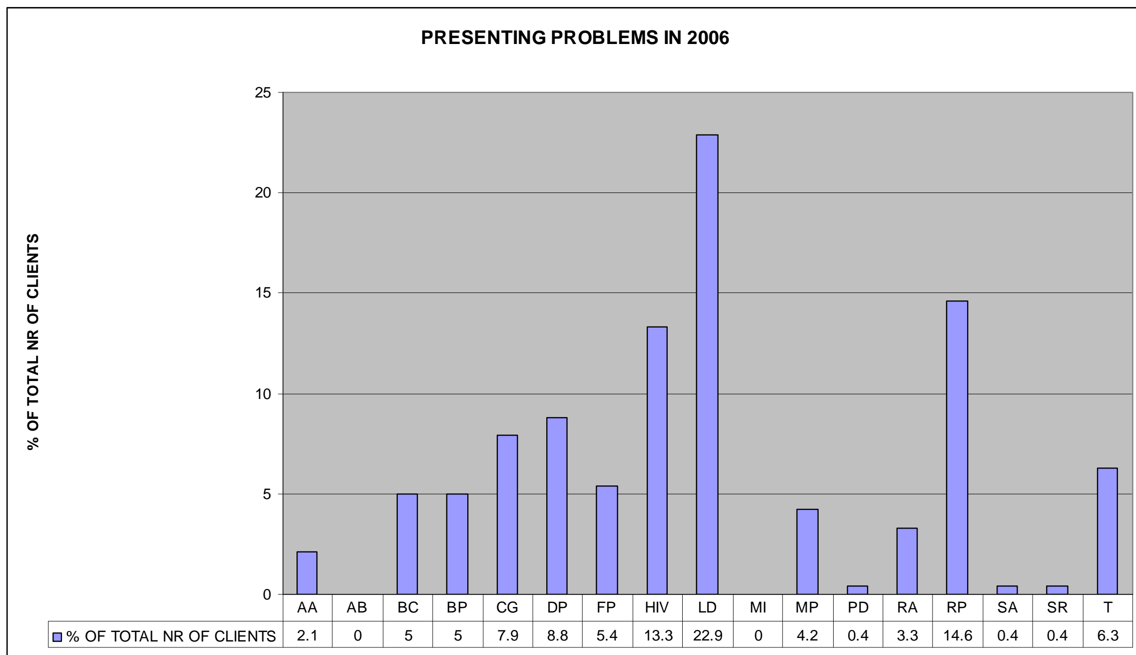


Table 4.20 indicates the percentage of the total number of clients seen in 2006 that presented with a particular concern. For example, clients presenting with relationship problems made up 14.6% (almost a seventh) of all clients seen in 2005.

Table 4.21 Presenting problems in order of prevalence over the two-year period

		2005	*2006*	*2005+2006*	*2005+2006*
PRESENTING PROBLEM	**ABREV**	**TOTALS**	**TOTALS**	**TOTALS**	**%**
LEARNING DIFFICULTIES	**LD**	93	55	**148**	26.7%
RELATIONSHIP PROBLEMS	**RP**	26	35	**61**	11.0%
DEPRESSION	**DP**	36	21	**57**	10.3%
CAREER GUIDANCE	**CG**	31	19	**50**	9.0%
HIV	**HIV**	18	32	**50**	9.0%
BEHAVIOUR PROBLEMS	**BP**	22	12	**34**	6.1%
FAMILY PROBLEMS	**FP**	19	13	**32**	5.8%
TRAUMA	**T**	15	15	**30**	5.4%
BEREAVEMENT COUNSELLING	**BC**	17	12	**29**	5.2%
MARITAL PROBLEMS	**MP**	7	10	**17**	3.1%
RAPE	**RA**	8	8	**16**	2.9%
ALCOHOL ABUSE	**AA**	5	5	**10**	1.8%
SCHOOL READINESS	**SR**	7	1	**8**	1.4%
MENTAL IMPAIRMENT	**MI**	5	0	**5**	0.9%
PERSONALITY DISORDERS	**PD**	4	1	**5**	0.9%
ABORTION	**AB**	2	0	**2**	0.4%
SEXUAL ABUSE	**SA**	0	1	**1**	0.2%
TOTALS		**314**	**240**	**554**	**100.0%**

Discussion: Presenting Problems

The fundamental reason for the establishment of mental health clinics or programmes is to provide a professional environment in which psychological interventions may be implemented. According to Orford (1992), the aim of mental health is to promote physical or psychological well-being by alleviating already existing problems or by preventing them from happening. The following discussion describes the main presenting problems encountered at Itsoseng Clinic in 2005 and 2006. For the purpose of this study the presenting problems were organised into 17 categories. These are discussed below in rank order, starting with the most common presenting problem and ending with the least commonly encountered problem.

Learning Difficulties

Almost a third (26.7%, see table 4.21) of all clients seen at Itsoseng during 2005 and 2006 presented with some form of learning difficulty. If we distinguish learning difficulties from career guidance then we can assume that it is mostly the children of schoolgoing age (7-14 and 15-20 age categories) that would have presented with this concern. There was a marked decrease in this presenting problem from 2005 to 2006 (93 to 55).

The results for 2006 are that learning difficulties comprised 23% of the presenting problems. This represents a 6.5% decrease in the number of cases from 2005. There are a number of possible reasons for this. It may be that in 2005, the clinic therapists treated all cases of learning difficulties as they presented without probing further to see if the problems were not rather of an emotional nature. Another possibility, which has already been mentioned, is that the marketing strategies differed in 2005 and 2006, resulting in more children being seen in 2005.

Learning difficulties refers to problems encountered by a caregiver or teacher concerning the academic underperformance of a child. According to Prior (1996), learning difficulties include deficits in at least one area of academic achievement, such as reading, spelling, or mathematics. It could also refer to cognitive issues such as poor memory and thinking capacity. Possible causes for learning difficulties include cognitive impairments, genetic behavioural problems, and emotional problems; as well as systemic and environmental causes such as the classroom environment, conflict at home, and lack of support.

For a child to present with learning difficulties there are a few things that the therapist must consider. Firstly, the learning difficulties must interfere with the client at home, at school and in other major areas of his or her life, and school performance must be below the norm for the chronological age of the child. The results indicate that learning difficulties was the most commonly cited presenting problem at Itsoseng Clinic for both 2005 and 2006. In 2005 learning difficulties was presented by 29.6% of all clients seen at the clinic, compared to the next most common presenting problem, depression, which made up 11,5%. At at 23%, the 2006 figure for learning difficulties is also high. From these results it is clear that the clinic was much occupied with this presenting problem throughout the two years.

According to Taylor (2003), an American study found that at least one in five children experiences learning difficulties. This suggests that learning difficulties are a prominent reason for referral, a finding confirmed in this study. Closer to home, a study by Kokot (2006) on the nature and incidence of barriers to learning difficulties among Grade 3 learners in Tshwane found that a similarly high number of children are diagnosed with learning problems, and that most of these are diagnosed either with concentration problems or hyperactivity. These findings correspond with those of current study: at Itsoseng clinic most of the children who were diagnosed with learning difficulties exhibited one or more symptoms of hyperactivity. The Itsoseng findings also indicate a fair distribution in terms of gender, which differs slightly from the findings of the University of Cape Town (2004), who found that boys were more likely than girls to be diagnosed with learning and behavioural problems.

Relationship Problems

Table 4.21 indicates that 11% of all clients seen during 2005 and 2006 presented with some form of relationship problem. The results show an increase from 2005 (8.3%) to 2006 (14.6%) of clients presenting with this kind of problem (see table 4.1 and 4.2). This represents a 6.3% increase in the number of cases from 2005. There is a sizeable difference in the numbers of clients with this presenting problem between the two years. The difference in percentages could be attributed to marketing of the clinic services, which may have made the schools as well as other important stakeholders more aware of services.

The category of relationship problems is a very broad concept and includes relationship difficulties with caregivers, lovers or friends. However, Itsoseng clinic operates on university premises, with the result that many clients are students and young adults who are in the developmental phase of establishing relationships and exploring intimacy in relationships. Thus, many of the students who come to therapy complain of relationship problems with their boyfriend or girlfriend.

Depression

Table 4.21 indicates that 10.3% of all clients seen during 2005 and 2006 presented with depressive symptoms. The results show a decrease from 2005 (11.5%) to 2006 (8.8%) of clients presenting with this kind of problem (see table 4.1 and 4.2). This represents a 2.7% decrease in the number of cases from 2005.

Depression can be defined as a deviation from a normal way of experiencing emotions such as sorrow and sadness. Typically, symptoms of depression include changes in weight, appetite, and energy, suicidal ideation, and a diminished ability to think (Sue et al., 2000). These authors state that 12% of adults have or will have an episode of depression in their lifetime. This corresponds with the incidence for depression at Itsoseng Clinic reported here, where depression and stress-related problems constituted the second most common presenting problem for the two years combined, after learning problems. In 2005, depression accounted for 11.5% of problems, while in 2006 it dropped to third place (after HIV/AIDS) at 9%. Clients with a presenting problem of depression or stress were usually adults, with few children presenting at the clinic for this reason.

Career Guidance

Career guidance or counselling is relevant to clients who are either confused or overwhelmed by the decision of what career to follow. These clients are generally referred by parents or school because they cannot decide on a suitable career. Some of these clients are also students at the university who seek clarity, advice and counselling on career choice. Table 4.21 indicates that 9% of all clients seen during 2005 and 2006 presented with career and study-related concerns. The results show a 2% decrease from 2005 (9.9%) to 2006 (7.9%) in clients presenting with this kind of problem (see tables 4.1 and 4.2). The prominence of this kind of presenting problem is understandable considering that the clinic is situated on a university campus and has close ties with a number of high

schools in the area. It also resonates with the findings on the age groups that used the clinic most frequently (i.e., people aged 14 to 30), which represent the age categories in which most people are still confronted with the decision of choosing a career.

HIV and AIDS

Table 4.21 indicates that 9% of all clients seen during 2005 and 2006 presented with HIV and Aids-related concerns. The results show an increase from 2005 (5.7%) to 2006 (13.3%) in clients presenting with this kind of problem (see tables 4.1 and 4.2). This reflects a 7.6% increase in the number of cases between 2005 and 2006. Again, this might be due to different marketing strategies used each year; however, it might also reflect greater use of the VCT services at the university as awareness of the medical services offered at the campus from 2004 became more widely-known.

These findings reflect to some extent the seriousness and impact of the disease to people not only in Mamelodi, but throughout the country. Given this finding, relevant training is vital to understanding this disease and to offering appropriate therapy to people living with HIV/AIDS. According to the Annual Report on HIV/AIDS (Gauteng Department of Health, 2007), HIV/AIDS is one of the main challenges facing South Africa today. About 5.54 million people are estimated to be living with HIV in South Africa in 2005, with 18% of them being adults between the ages of 14 and 49 (Gauteng Department of Health, 2007).

According to Van Dyk (2001), stigma, fear and discrimination regarding issues around HIV and AIDS pose a serious challenge to people living with the illness. People are afraid to consult and seek professional intervention because of the fear of discrimination. Some clients may feel that talking about their illness may hold no benefits, or prefer to ignore their diagnosis. This could explain the relatively low representation of clients with HIV and AIDS at Itsoseng clinic. Also, many clients who come to therapy might not cite HIV or AIDS as a presenting concern, but rather issues related to and overlapping with HIV, such as depression, trauma and bereavement. These may have been listed as the presenting problem. In addition, children who are orphaned by HIV and AIDS might exhibit poor interpersonal skills and behavioural problems and are referred for these problems. As such, it can be expected that many clients presenting at the clinic may live with HIV without this being recorded as a presenting problem.

Behaviour Problems

Table 4.21 indicates that 6.1% of all clients seen during 2005 and 2006 presented with behaviour problems. The results show a decrease from 2005 (7%) to 2006 (5%) of clients presenting with this kind of problem (see table 4.1 and 4.2). This represents a 2% decrease in the number of cases from 2005.

A behavioural problem refers to any dysfunctional behaviour that an individual exhibits that affects his or her functioning at home, school, or at work. Such problems may include excessive use of alcohol, promiscuity, aggression, conduct problems, and so on. Haigin (2005) argues that behavioural problems depend on how society views them; some behaviours are accepted in certain societies while they are prohibited or frowned on in others. Behavioural problems as a presenting problem is therefore determined by the societal norms and values that prevail in that community. At Itsoseng, therapists also rely on collateral information from family, friends, school and community in determining the nature of the problem.

According to the findings in this study, behavioural problems comprised 7% of the total number of problems presenting at the clinic in 2005, while in 2006 this totalled 5%. This reflects a fairly stable rate over the two years, and suggests that this category of problems deserves attention in the training of psychotherapists.

Family Problems

Table 4.21 indicates that 5.8% of all clients seen during 2005 and 2006 presented with family-related problems. The results show a small decrease from 2005 (6.1%) to 2006 (5.4%) in clients presenting with this kind of problem (see table 4.1 and 4.2). This represents a 0.7% decrease in the number of cases from 2005.

Family problems occur typically where people have a dependant relative needing care, an absent or alcoholic caregiver, an abusive family member and so forth. Students from the Mamelodi campus often presented with difficult home circumstances (poverty; a single caregiver who becomes sick and cannot take care for his or her dependants), which resulted in them having to make the difficult decision to terminate their studies to help at home, or risk failing their course while trying to juggle responsibilities.

Family problems also include domestic violence. This is a prominent problem in South Africa, and is a type of violence that involves people within the same household. It usually entails physical or verbal abuse, or mistreatment of children. Often people find it difficult to distinguish between domestic violence and other forms of abuse or violence. Also, many victims are afraid to report these kinds of cases for fear of being victimised by the perpetrator.

Trauma-related Problems

Table 4.21 indicates that 5.4% of all clients seen during 2005 and 2006 presented with trauma-related problems. The results show an increase from 2005 (4.8%) to 2006 (6.3%) in clients presenting with this kind of problem (see table 4.1 and 4.2). This represents a 1.5% increase in the number of cases from 2005.

A wide range of events may result in psychological trauma, including violent crime such as armed robbery and rape, as well as near-death experiences such as motor vehicle or other accidents, and so on. According to Rosen, Bloom and Williams (cited in Bloom, 1996), traumatic experiences usually involve the fear of one's own death, or the death of another, or serious physical or emotional injury; and the experience exceeds an individual's ability to cope with it. Large cities such as Pretoria (of which Mamelodi is a part) experience higher crime rates than rural settings, which renders the community afraid and susceptible to criminal activities. Trauma counselling is therefore an area of counselling that requires particular emphasis and specific training.

Bereavement

Table 4.21 indicates that 5.2% of all clients seen during 2005 and 2006 presented with bereavement. The results show a decrease from 2005 (5.4%) to 2006 (5%) in clients presenting with this kind of problem (see table 4.1 and 4.2). This represents a 0.4% decrease in the number of cases from 2005.

Bereavement counselling is offered when clients who have lost a loved one through death struggle to come to terms with the loss, and resort to professional help. The death of a loved one can be overwhelming and hard to bear. Bereavement counselling not only

involves coming to terms with death but also with the very personal loss of someone valuable and meaningful to the individual. Ongoing emotional support from the therapist can be very helpful in this process. Bereavement may further be complicated by the nature of the case and the severity of the problem. The findings in the current study, namely that only 5.2% of people presented with this problem, suggests that people manage the process of grief without professional support, It may also be that many people do not recognise the impact of the process of bereavement and ignore its implications. Some cultures do not consider it relevant to seek professional help in the event of death, turning rather to spiritual and religious leaders.

Marital Problems

Table 4.21 indicates that 3.1% of all clients seen during 2005 and 2006 presented with marital problems. The results show an increase from 2005 (2.2%) to 2006 (4.2%) of clients presenting with this kind of problem (see table 4.1 and 4.2). This represents a 2% increase in the number of cases from 2005. Marital problems are fairly common in most Western societies. Couples presenting for marital therapy are most often married or engaged to be get married.

Rape

Table 4.21 indicates that 2.9% of all clients seen during 2005 and 2006 presented with trauma symptoms due to a rape incident and the consequences thereof. The results show an increase from 2005 (2.5%) to 2006 (3.3%) of clients presenting with this kind of problem (see table 4.1 and 4.2). This represents a 0.8% increase in the number of cases from 2005.

Alcohol Abuse

Table 4.21 indicates that 1.8% of all clients seen during 2005 and 2006 presented with problems related to alcohol abuse. The results show an increase from 2005 (1.6%) to 2006 (2.1%) in clients presenting with this kind of problem (see table 4.1 and 4.2). This represents a 0.5% increase in the number of cases from 2005.

Alcohol abuse refers to the excessive consumption of alcohol and reliance on alcohol as a coping mechanism. As a result, the person becomes dependant on the substance in order to cope or function on a day-to-day basis. Since alcohol abuse produces a physical and

psychological dependence, it become difficult to function effectively, affecting important areas of life such as work, social life or academic performance (Rencken, 1989).

School Readiness

Table 4.21 indicates that 1.4% of all clients seen during 2005 and 2006 presented with a request for a school readiness assessment. The results show a decrease from 2005 (2.2%) to 2006 (0.4%) in clients presenting with this kind of problem (see table 4.1 and 4.2). This represents a 1.8% decrease in the number of cases from 2005.

In such cases, parents usually bring their child to therapy for an evaluation of whether the child is ready and capable to enter into a formal schooling environment. Schools may also require the services of Itsoseng clinic. School readiness entails an emotional and cognitive assessment as well as fine and gross motor skills. Therapists may use different psychometric tests to determine the child's school readiness.

Mental Impairment

Table 4.21 indicates that 0.9% of all clients seen during 2005 and 2006 presented with issues related to mental impairment. The results show a decrease from 2005 (1.6%) to 2006 (0%) in clients presenting with this kind of problem (see table 4.1 and 4.2). This represents a 1.6% decrease in the number of cases from 2005, with no cases of mental impairments cases seen at Itsoseng clinic in 2006. In many communities there exists a stigma attached to mental impairment, and people may be reluctant to consult a therapist due to embarrassment and fear of stigma.

Mental impairment refers to cognitive or mental delays caused by brain trauma, heredity, and genetic or environmental factors, and is categorised according to severity and nature of the impairment. These factors result in below-average performance in major life areas such as academic, social and interpersonal life.

Personality Disorders

Table 4.21 indicates that 0.9% of all clients seen during 2005 and 2006 presented with personality disorders. The results show a decrease from 2005 (1.3%) to 2006 (0.4%) in

clients presenting with this kind of problem (see table 4.1 and 4.2). This represents a 0.9% decrease in the number of cases from 2005.

Personality disorders typically involve inconsistent behaviour, instability and detected emotional components, dependency type of behaviour, socially withdrawn behaviour, and so on. These are often difficult to diagnose, and are more often listed as a diagnosis rather than a presenting problem, as therapists typically must use their clinical judgement and skills to identify a personality disorder.

Abortion

Table 4.21 indicates that 0.4% of all clients seen during 2005 and 2006 presented with issues related to abortion. The results show a decrease from 2005 (0.6%) to 2006 (0%) in clients presenting with this kind of problem (see table 4.1 and 4.2). This represents a 0.6% decrease in the number of cases from 2005.

Abortion is a sensitive issue in most communities and cultures in South Africa, since it entails entrenched societal values and norms. The decision to terminate a pregnancy may be informed by, among other things, lack of resources, money, support, pressure from family, or even poor relationships between the parents-to-be. In South Africa, clinics offering this service are obliged to offer counselling to the woman. This may explain the low incidence of this presenting problem at a general psychology clinic such as Itsoseng.

Sexual Abuse

Table 4.21 indicates that 0.2% of all clients seen during 2005 and 2006 presented with issues related to sexual abuse. The results show an increase from 2005 (0%) to 2006 (0.4%) in clients presenting with this kind of problem (see table 4.1 and 4.2). This represents a 0.4% increase in the number of cases from 2005

Sexual abuse is similar to rape, but the difference occurs in how it is presented and by whom. With rape, clients usually present themselves for help after the occurrence of a single traumatic incidence where sexual contact was forced. In the case of sexual abuse, the clients are usually younger, and the abuse has often occurred repeatedly over a period

of time. It is also often not the survivors of sexual abuse themselves who present for therapy, but a concerned family member.

Integration and Overview of the Results

The primary aim of this study was to investigate the services at Itsoseng psychology clinic in Mamelodi. The aim was also to analyse the client population at Itsoseng psychology clinic during 2005/ 2006 in terms of age, gender and presenting problems. The results indicate that the age group that was most often treated at Itsoseng clinic was the 21-30 category, with 28% of clients in 2005 and 38% in 2006 representing this age group. This was followed by the 14-20 age group, with 28% in 2005 and 19% in 2006. The most common presenting problems were those most often experience by people in these age groups, namely, learning difficulties (most common) and depression (third most common), with career-related problems also featuring prominently.

Relationship problems and depression were found to be the second and third most common presenting problems, respectively. People whose ages range from 20 to 30 are in an active and productive life phase. As a result, they are more likely to be affected by stress, depression and other problems. According to societal expectations, people from this age group are expected to be productive and either married or in a stable relationship. When people fail to achieve or meet these expectations, depression and low self-esteem may result. It is also during this period that stable, long-term relationships form a primary focus.

The five most common presenting problems seen over the two-year period were learning difficulties, relationship problems, depression, career concerns and HIV related problems. Considering the type and location of the clinic, as well as its connections with certain local organisations such as schools, these results are not surprising. Most of the clients who come to the clinic are of schoolgoing age; they are most often referred either by the school or their parents.

The results indicate that overall, more women than men presented for therapy, although in 2005 more men than women were treated. The literature and research indicates that women are more likely to seek therapy. These findings concur with the findings done at Itsoseng psychology clinic in Mamelodi overall and in 2006, but not for 2005. The

difference between the current study's 2005 findings and those cited in the literature may imply that the way men perceive psychological services may slowly be changing.

CHAPTER 5

IMPLICATIONS OF RESULTS AND RECOMMENDATIONS

Aims and Objectives of This Study

The aim of this study was to evaluate the service delivery function of the Itsoseng psychology clinic through investigating the demographic profile of the client population that Itsoseng clinic served in terms of age, gender and presenting problems during the period January 2005 to November 2006. The results of the evaluation could prove useful in informing strategic decisions regarding marketing the clinic, offering relevant training content to the students as well as recruiting other professionals for whom a need is indicated (e.g., educational psychology students, occupational therapy students, social work students, etc). Even though the results would speak very directly to the functioning of Itsoseng psychology, as mentioned before, its application and potential relevance exceeds the boundaries of Itsoseng clinic and Mamelodi, and extends to similar programmes offered elsewhere in South Africa.

A secondary aim of this study was to evaluate the usefulness of the existing service delivery recording methods. Of particular interest is the complex issue of ascribing a category to a presenting problem, since this is sometimes made on the basis of a psychiatric diagnosis in the presence of minimum symptoms and sometimes on the basis of a client's description of a particular complaint (e.g. depression – a psychiatric diagnosis; or domestic violence – complaint regarding the effect of a family member's abusive behaviour). Summaries of the findings are tabulated below.

Evaluation of the Service Delivery Functioning of the Clinic

Summarised Results

Top three age groups

Age group	Ages	% of total nr of clients
Young adults	21-30 years	32.3%
High school	15-20 years	27.3%

Primary school	7-14 years	24.2%

Top five presenting problems

Presenting problems	% of total no. of clients
Learning difficulties	26.7%
Relationship problems	11.0%
Depression	10.3%
Career guidance	9.0%
HIV	9.0%

Gender results

The findings concur with the literature that females are more likely than their males counterparts to seek professional and therapeutic intervention.

Comparison of Findings with Local and International Research

The results indicate that in for the two years combined, more females than males presented for therapy. Most studies done both abroad and locally indicate a similar pattern. Visser (2007) argues that women are more likely to seek professional intervention, and usually present with depression and anxiety disorders, while men more often present with substance abuse-related issues. According to the World Health Organisation (2001), the overall prevalence of mental and behavioural disorders is not significantly different for men and women. However, depression and anxiety are substantially more common among women, while men more commonly exhibit problems related to substance abuse and personality disorders. It was not possible to assess the findings on personality disorders in this study due to the low incidence of clients reporting with this problem. An international study by the World Health Organisation (1992) on women and health indicates that while most women present with emotional problems such as stress and depression, more women are resorting to drinking and substance abuse as a way of coping with these problems. De la Rey and Eagle (2007) remark that gender differences are a reflection and indication of historical changes and cultural formations, which lay down the social predispositions and blueprints for the development of pathology.

Floyd’s (1986) study on psychological problems presented to primary health care clinics in Soweto found that most people presented with anxiety, psychological trauma and stress-

related problems. This findings differs somewhat from those of the current study, where it was found that most clients presented with learning difficulties followed by depression. The difference in findings may be attributed to the location of the clinic, the contact with certain community organisations such as schools, the types of services rendered and the type of clients receiving the services.

Implications of Findings and Recommendations Regarding the Functioning of the Clinic

Marketing

This study clearly shows a strong need for psychological services to both the residents of Mamelodi and the students of University of Pretoria. The results suggest that a robust marketing strategy is needed to reach a wider number of residents in Mamelodi, and to make contact with a greater number of service delivery points, and not just primarily schools. Marketing should be done on a quarterly basis to ensure continuous accessibility and awareness of services by community members.

To market the clinic's services university students who are enrolled for marketing courses could become involved. The clinic marketing may be organised as a practical project that is given credit or marks in the course. Such a project may include the design of a workable strategy to increase awareness about the services rendered at the clinic to the community and other relevant stakeholders. It may also be used to mobilise or source sponsors for the clinic to buy equipment such as psychometric tests and other therapeutic tools, to ensure that appropriate services are rendered with good resources and facilities.

Networking

Networking is also important in ensuring adequate service delivery at Itsoseng clinic. The clinic needs to work closely with other stakeholders and psychology clinics, such as the Unisa Agape Community Clinic in Mamelodi. Secondly, the clinic would benefit from establishing a working relationship with community clinics and hospitals for referrals and marketing. This process may help in recruiting other relevant professionals, such as remedial therapists, occupational therapists and general practitioners to expand the services offered to the community and university students. As part of networking it is also advisable for the clinic to establish a working relationship with other relevant stakeholders such as community leaders, civil organisations, hospitals, schools, and clinics and youth or

church movements. This may increase the sense of ownership among people and promote community participation. Since people generally participate willingly when they feel important, recognised and appreciated, this is an important element to consider.

Offering Relevant Training

Louw and Edwards (1998) state that therapy is generally designed for middle-class people, with the result that most theories are eurocentric. Relevant training would take local community dynamics into consideration, rendering psychological services more relevant and effective to the community. The training should be localised to meet the community needs. As such, extensive training in community psychology, and practical participation in research on the same community that the trainees serve, would be beneficial to ascertain real needs and issues that the community encounters on a daily basis. The training would therefore place less emphasis on diagnosis and medicalisation of therapy; but would focus more on empowering the community to take responsibility for their lives.

Needs Assessment

It is recommended that the clinic conduct a small scale research project on community needs, which may serve as a guide to identifying focus areas, and may provide ideas on how to address these. This may also facilitate the process of getting to know the community that the students serve, and for helping the clinic to know what resources they have to provide for these needs, what services they can offer, and which ones may difficult to offer.

Developing Adequate Measures to Evaluate Current and Future Functioning

A lack of consistent record keeping in terms of agreed-upon categories of presenting problems made it difficult to classify some indicated problems. It is recommended that for the purpose of accurate statistical records therapists at Itsoseng clinic use a standard classification system such as the ICD-10 coding system.

Conclusion

This chapter discusses the implications of the main findings, namely that the Itsoseng psychology clinic's client population consisted of slightly more females than males, most of the clients range in age from 7 to 30, and most presented with the following problems in

order of prevalence: learning difficulties, relationship problems, depression, career guidance and HIV. The implications of these findings are discussed in this chapter and relate mostly to improved record keeping, marketing and psychotherapy training that is more directed towards the kinds of problems mostly commonly seen.

CHAPTER 6

PERSONAL REFLECTION ON THE RESEARCH PROCESS

Doing research could be a very exciting, adventurous process in which one searches constantly for new information. On the other hand, it may also be very difficult and complex, especially when the topic is unclear and ambiguous. As a psychology masters student, I was very excited at having completed my first year of masters training, and looked forward to registering for my research dissertation and commencing with research on my topic.

At the beginning I was apprehensive about what topic to choose, and eventually decided on a topic that was broad and interesting to me. I wanted to investigate the level of alcohol use among university students at the University of Pretoria. I thought extensively about the topic and discussed it with my supervisor, Mr. Willem Louw. After several consultations I realised that the topic was very broad, complex and unfeasible. With this in mind, I returned to my question of which topic to investigate, and read many books and research publications to gain a better understanding of what to do. I once again came up with several topics and had to decide which one would be most feasible and realistic. Upon my supervisor's recommendation, I decided to investigate the services rendered by Itsoseng clinic to Mamelodi community and university students. I was familiar with the clinic, having done my initial practical training there. The topic proved to be more complex than it sounded because I had to divide it into a number of subtopics in order to arrive at something concrete and relevant.

This topic elicited many challenges and frustration for me. Firstly, I had to think about the methodology that I would employ to investigate this topic, and where I would obtain sufficient information to substantiate my choice of topic. The librarian helped me to look for information, but I found little of relevance, and so I had to readjust this topic to suit the information that I had at my disposal. This topic also forced me to read more on community psychology and work done on the ground by community psychologists. The literature review chapter was also difficult because of a lack of information on the topic. This process helped me to learn to appreciate the information that I have with me, and to make good use of it.

Research is a process that needs full-time attention. I had to visit different libraries at different universities to read more and gain information so that I could reflect on this in my research. For me it was not about the quantity of work and the information I had, but rather about the quality of information and how I used it to strengthen my topic.

This process aided my personal development and growth. I had to learn to be patient with proceedings and people. The research process seldom goes as expected, and this has implications for students who are under pressure to submit a dissertation for examination by a certain time. As a result, patience was a virtue that I developed most recently in the course of this process. I also had to learn to persist even when the situation proved frustrating and disheartening. Sometimes I became discouraged and negative due to things not falling into place; but I learnt that if I wanted to finish I would have to persist.

When doing research, one talks and interacts with different people from different cultures, language and ethnicity, and even different academic backgrounds. I learnt during this process to harmonise these differences and turn them into something positive. I also had to adjust my interpersonal skills in order to facilitate the process of harmonising differences with other people. When seeking information at the library or from people a good approach is necessary to obtain their attention and help.

This process also contributed immensely to my academic writing skills because I had to write as often as I could for my research. As a result, my professional writing skills were developed and I now feel more equipped to deal with any research topic. I realised that professional writing is different from other types of writing. This type of writing allows people to incorporate different information into their lives. The struggle that I experienced in writing this dissertation also contributed to my development as therapist, as I had to think about the struggle and difficulties that our clients experience on a daily basis. As I was going through this process, I discovered many strengths and weaknesses within me that I was not aware of. The positive result of this discovery was that I was better able to incorporate my shortcomings and adapt.

Lastly, this was a robust learning process that required my full attention, commitment and dedication. Having to develop a concrete and workable research topic was difficult, but through extensive reading and consultation, the research process fell into place. I

acknowledge that the journey is far from over: as I became a researcher I discovered that I have a curiosity and eagerness to learn about and research further certain social problems or phenomena. When I reflect back, I notice that this has been an extensive process – but it was worth it.

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APPENDIX 1

PERMISSION LETTER TO CONDUCT RESEARCH ON ARCHIVAL MATERIAL

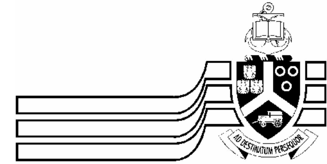
RESEARCH@ITSOSENG

UPLIFT YOURSELF

Theory-in-action

Valuing local relevant knowledge

Turning resources into assets



University of Pretoria

Department of Psychology

Mamelodi Campus

2007-08-28

PERMISSION TO USE CLINIC RECORDS FOR RESEARCH PURPOSES

I hereby give full permission to Mr Arnold Phala to use the service delivery records of the Itsoseng psychology clinic for the purposes of his research project conducted as part of his Masters degree in Counselling Psychology.

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Dr. Linda Eskell-Blokland
Head: Itsoseng Clinic

APPENDIX 2 & 3

EXAMPLES OF ARCHIVAL SERVICE DELIVERY RECORDS

ITSOSENG CLINIC

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____

PSYCHOTHERAPIST NAME & SURNAME:______________________________________ **MONTH:** ____________________

	Client Name & Surname	New Y/N	Age	M/F	1st Language	Presenting Problem	Referred by?	Assessments
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

Total Number of New intakes:	
Total Number of Clients Dealt with:	

ITSOSENG CLINIC

PSYCHOTHERAPIST NAME & SURNAME: Ms XXX
MONTH: November 2005

	Client Name & Surname*	New Y/N	Age	M/F	1st Language	Presenting Problem	Referred by?	Assessments
1	XXX	N	15	M	Sotho	• Learning difficulties	XXX	
2	XXX	N	25	F	Sepedi	• Personal growth	XXX	
3	XXX	N	13	M	Zulu	▪ Learning difficulties	XXX	
4	XXX	Y	22	M	N-Sotho	▪ Relationship	XXX	
5	XXX	Y	21	M	Zulu	• Relationship	XXX	
6	XXX	Y	22	F	N-Sotho	• Abortion	XXX	
7	XXX	Y	42	F	Tswana	• Work related	XXX	
8	XXX	Y	22	F	N-Sotho	▪ Family relationships	XXX	
9	XXX	N	22	M	Tsonga	▪ Relationship	XXX	
10								

Total Number of New intakes:	5
Total Number of Clients Dealt with:	9

* Names and referral agent have been removed for confidentiality purposes