

**A COMPARATIVE EVALUATION OF CHILD AND ADOLESCENT  
MENTAL HEALTH INTERVENTIONS IN THE UNITED KINGDOM  
AND SOUTH AFRICA**

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Unless specifically indicated to the contrary, this thesis is the result of my own work.

David John Edwards

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## **DEFINITIONS**

International comparative study: a study comparing an aspect across more than one country

Community psychology: psychology with, by and for the people beginning and ending within the community

Paradigms and models: ways of organizing knowledge

Child and adolescent mental health intervention: intervention offered to clients who are up to 18 years old

West Kent: an area within the United Kingdom which is located in the South East of England and is part of the County of Kent

Zululand: an area within South Africa which is in the KwaZulu-Natal Province and situated north of the Tugela River

England and Wales Youth Offending Services: A Youth Justice Board service which provides intervention to Youth Offending Service clients from the ages of 10 to 18

West Kent Youth Offending Service: A service which provides intervention to clients who live in the West Kent area

Zululand Mental Health Community Psychology Programme: a partnership between a number of health, education and business sectors within the Zululand area

Case study: a unit, which for example can be a person, people or intervention that is analyzed

## **ABSTRACT**

Ongoing global crises impact negatively on human health. International comparison studies may improve health promotion. A community psychology, appreciative inquiry was conducted into local staff perceptions of selected child and adolescent mental health interventions in the Kent and Zululand regions of the United Kingdom and South Africa respectively. The Kent findings, supported by a quasi-experimental investigation, indicated that intervention was beneficial, the mental health practitioner role had value and additional mental health practitioners should be employed. The Zululand findings, complemented by a single client case study, suggested that intervention provided a valuable people focused programme, and that additional emphasis should be placed on promoting the intervention, its structure and staffing. Evaluative comparisons thus illustrated the differential effectiveness of the respective interventions. The Kent service could learn from the way in which the Zululand intervention was people orientated and the Zululand programme could learn from the way in which the Kent intervention was structured and organized. Findings highlighted the ongoing need to evaluate existing models of community psychology, create new models, and the temporal and contextual nature of any such models.

## **SUMMARY**

Ongoing global crises are affecting humanity as a whole and specifically having a devastating impact on vulnerable groups such as children and adolescents. There is a need to carry out international comparison studies in order to share knowledge, promote and improve health, well-being and healing. This international comparative study of child and adolescent mental health interventions in the United Kingdom and South Africa was undertaken in order to make a contribution towards fulfilling this need. An opportunity arose to simultaneously compare and contrast the community interventions provided to children and adolescents by the West Kent Youth Offending Service (WKYOS) and Zululand Mental Health Community Psychology Programme (ZMHCPP). Paradigms and models, which are abstract representations of reality, are used to organize knowledge and inform interventions. WKYOS is based around various intervention models, but has traditionally been more mental health model and organizationally orientated. Equally, ZMHCPP, is based around various models, but during the apartheid era was relatively more liberatory and social action orientated.

It was identified that there was no published research on the effect of WKYOS child and adolescent mental health intervention on clients. Perceptions of WKYOS staff on child and adolescent mental health intervention had also not been collated. Previous ZMHCPP studies had not focused on practitioners' views of the child and adolescent mental health intervention provided by this service. The research design included outcome evaluation of these interventions through triangulated approaches which were theory driven, involved two case studies and used quantitative and qualitative components.

Results from the WKYOS quasi-experimental investigation suggested an overall improvement in emotional and mental health scores for clients who received intervention compared to a matched control sample of clients who did not receive intervention. An appreciative inquiry into perceptions of a selected sample of WKYOS staff revealed staff perceived child and adolescent mental health intervention to be beneficial to the young people and service as a whole. They recommended that the role continue to be valued and more WKYOS child and adolescent mental health practitioners be employed. An appreciative inquiry into perceptions of a selected group of ZMHCPP practitioners and a client study suggested that the programme provided a valuable service to children and adolescents from the local community, which is people focused. It was recommended that additional emphasis should be placed on increasing awareness of the service as well as on its structure and staffing.

Findings therefore contribute towards improved community interventions in United Kingdom and South Africa, by identifying the strengths and areas for improvement for these services as well as aspects which each service could learn from the other. The importance of undertaking international comparison studies is emphasized. Findings highlighted that the utilization of models is dependent upon time and context as well as the importance of creating new models and evaluating existing models. Findings reinforced the urgent need for child and adolescent mental health interventions in the United Kingdom and South Africa. The WKYOS service could learn from the way in which the ZMHCPP service is people orientated. The ZMHCPP service could learn from the way in which the WKYOS service is very structured and organized. Recommendations for future research are made.

## **CHAPTER ONE**

### **INTRODUCTION**

#### **1.1. Introduction**

This chapter introduces the components of this research, namely International Comparative Studies, the United Kingdom and South Africa, Community Psychology, Paradigms and Models, Children and Adolescents, the United Kingdom West Kent Youth Offending Service Child and Adolescent Mental Health Intervention, and South African Zululand Mental Health Community Psychology Programme Child and Adolescent Intervention. It furthermore provides the motivation, problem statement, aim, hypotheses and modus operandi for the study.

#### **1.2. International Comparison Studies**

Endemic human destructiveness continues to have an effect on humanity in the global village on planet earth. There is great need for comparative research and intervention for humanity to survive and flourish. International comparison studies typically compare and contrast an area of study in two or more countries. Such studies can be costly, time consuming and difficult to coordinate due to logistical issues. If they can be undertaken, they can be extremely beneficial in the generation and sharing of knowledge. Comparing areas from different countries provides international validation, integrity and strength to the overall investigation. Following the end of apartheid and international isolation it has been easier to undertake such

comparison studies between South Africa and other countries and these studies should be carried out whenever an opportunity arises.

### **1.3. United Kingdom and South Africa**

The United Kingdom and South Africa have strong historical links. The United Kingdom is located in the northern Hemisphere. South Africa is situated in the Southern Hemisphere. The United Kingdom is an economically developed country which has vast financial resources and structured health services. South Africa is an economically developing country which has less resource, and fewer and more unstructured health services. The United Kingdom and South Africa have much to learn from each other in terms of health service provision.

### **1.4. Community Psychology**

There are many definitions of community psychology. One way of describing community psychology is that it is psychology with the people, by the people and for the people. Community psychology is a sub discipline of psychology. Although it has existed in various forms for many years and while it pre dates some of the more conventional forms of clinical, counselling, education, research and organizational psychology in some developed and developing countries it has not been as formalized and organized in terms of learning, training, registration and practice as some of these other disciplines. Community psychology needs to be further developed as it has a major role to play in the current global crisis.

### **1.5. Paradigms and Models**



There are various paradigms and models which are used in clinical, counselling, education, research, organizational psychology as well as community psychology. In relation to its popular understanding, the term paradigm incorporates the term model in that it refers to a worldview which directs the quest for an increase in research, knowledge, learning and practice whereas the term model refers to an abstract representation of reality. Paradigms and models help communities to understanding how to raise awareness, create social actions, build relationships in industries, help the environment, enhance experiential relationships, reduce illness and increase health. Paradigms and models should be continuously developed, enhanced and evaluated.

### **1.6. Children and Adolescents**

Children and adolescents are in numerous ways more vulnerable than adults due to age, power imbalances and because they are still developing their coping skills. In a lot of ways they therefore require a great amount of care and support. Many children and adolescents around the world experience health and well-being problems such as mental health difficulties. There is a need for more interventions to be offered to young people and for existing interventions to be evaluated and improved.

### **1.7. West Kent Youth Offending Service Mental Health Intervention**

England and Wales has a Youth Justice Board and Youth Offending Services. West Kent Youth Offending Service manages offending behaviour in children and adolescents, from ages 10 to 18 years, who are residing in West Kent. The West Kent region is an area which is predominantly inhabited by “white” low to middle income families. In 2008, the YOS Kent

inspection report highlighted the need to have more YOS child and adolescent mental health practitioners (CAAMHPs) (also referred to as health workers) in Kent (Joint inspection of Youth Offending Teams of England and Wales. Report on: Kent Youth Offending Service, 2008). Following this report, CAAMHPs were employed not just in mid Kent, where there was a CAAMHP, but also in East and West Kent.

### **1.8. Zululand Mental Health Community Psychology Programme Child and Adolescent Intervention**

The South African apartheid era had an enormous impact on its people, including children and adolescents, the country as a whole and international relations. The Zululand Mental Health Community Psychology Programme is a partnership between the University of Zululand (UNIZUL) Psychology Department, Zululand Mental Health Society, local hospitals, schools, businesses and various rural community based projects. It developed due to the overwhelming need for community intervention within the rural and economically developing multi-ethnic, multi-cultural, multi-linguistic, Zululand area (Edwards, 2002a, 2002b). The majority of the people living in the Zululand region are “black” Africans. Young people in the Zululand area receive intervention across different ZMHCPP sites.

### **1.9. Motivation for the Study**

The motivation for this study was as follows. There was, and still is, a lack of international comparative studies. More studies were, and still are, required, and it was essential that this study was, and other studies are, undertaken for humanity to survive and flourish. United Kingdom and South Africa have strong historical links and since the end of apartheid it has

been easier to undertake comparison studies between these two countries. Community psychology is a growing area of psychology and should be further developed across the world in order to manage the global crisis. Paradigms and models are used to organize knowledge so that illnesses can be prevented, health can be promoted and interventions can be informed. Children and adolescents are highly vulnerable populations that require specialized input and care. Many children and adolescents who are managed by WKYOS and ZMHCPP are affected by complex difficulties, have vast needs and require in depth support. Following the WKYOS CAAMHP post having been operational for more than a year, there was a need to evaluate WKYOS child and adolescent mental health intervention (Edwards, 2009). There has been an increase in ZMHCPP staff, particularly at The University of Zululand since March 2007. Extensive research on the ZMHCPP had been undertaken through the UNIZUL Psychology Department (Edwards, 2011). One area that required research which was identified was that there had been a lack of exploration into practitioners' perceptions of the child and adolescent intervention provided by ZMHCPP.

#### **1.10. Problem Statement**

The rationales for this thesis were as follows. Firstly, comparative international studies benefit humanity, share knowledge and provide international authenticity to research. This project provided an opportunity to complete such a study. What would be the comparisons and contrasting factors between these two services, what would be the strengths and areas for improvement for each service and what aspects could each service learn from the other? Secondly, there was a need to evaluate WKYOS child and adolescent mental health intervention. Was the intervention useful and did staff perceive it to be valuable? Thirdly,

there was a need to appraise ZMHCPP practitioners' perceptions of the child and adolescent intervention offered by ZMHCPP. Did staff perceive this intervention to be helpful?

### **1.11. Aims**

The first aim of this research was to collect information on WKYOS staffs' perceptions of child and adolescent mental health intervention as well as collect post hoc pre and post outcome data on clients seen by the WKYOS CAAMHP and a matched control sample. The second aim was to collect information from ZMHCPP practitioners on child and adolescent intervention and a client case example. The third aim was to compare and contrast WKYOS and ZMHCPP child and adolescent mental health interventions.

### **1.12. Objectives**

The objectives of the study were to collect WKYOS and ZMHCPP data, to compare and contrast interventions, and to provide feedback to WKYOS, Youth Justice Board (YJB) and West Kent CAMHS managers as well as ZMHCPP partners on child and adolescent mental health interventions.

### **1.13. Hypotheses**

It was expected that there would be similarities and differences between the services. It was anticipated that the emotional and mental health scores for WKYOS clients who received child and adolescent mental health intervention would improve in comparison to the scores of a matched control sample. It was expected that WKYOS staff would find value in having a

child and adolescent mental health practitioner, but that due to a single CAAMHP covering a large geographical area employing more WKYOS CAAMHPs would be recommended. It was anticipated that ZMHCPP practitioners would find value in ZMHCPP child and adolescent intervention but that they would suggest more focus should be placed on acquiring further funding for ZMHCPP in order for the programme to be more effective.

#### **1.14. Modus Operandi**

In order to investigate the questions raised in the problem statement the modus operandi adopted in this research was concerned with a triangulated approach involving two case studies with quantitative and qualitative components. Data and results from the WKYOS and ZMHCPP case studies were analysed and appraised, then combined and compared, thus providing international validation for the overall study. This is further discussed in chapter four.

#### **1.15. Résumé**

This chapter introduced the core areas of this research: International Comparative Studies, the United Kingdom and South Africa, Community Psychology, Paradigms and Models, Children and Adolescents, the United Kingdom West Kent Youth Offending Service Child and Adolescent Mental Health Intervention, and South African Zululand Mental Health Community Psychology Programme Child and Adolescent Intervention. It furthermore provided the motivation, problem statement, aim, hypotheses and modus operandi for the study. The next chapter is concerned with a literature review, following which the chapter on

methodology will return to directly address the design, development of the empirical investigation, intervention and appraisal.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1. Introduction**

This literature review chapter focuses on International Comparative Studies, the United Kingdom and South Africa, Community Psychology, Paradigms and Models, Children and Adolescents, the United Kingdom West Kent Youth Offending Service Child and Adolescent Mental Health Intervention, and South African Zululand Mental Health Community Psychology Programme Child and Adolescent Intervention.

#### **2.2. International Comparative Studies**

The world is in disparity. There has been an increase in disease, poverty, financial crisis, natural disasters, rioting, crime and violence. Such factors are having an enormous impact on vulnerable groups such as children and adolescents who in numerous ways cannot cope with these factors as well as adults can.

Many international and national organizations are making a contribution towards these crises and supporting the most vulnerable. Examples include the work by the United Nations and African Union. In 2005 the World Health Organization (WHO) report focused on child health, in 2006 on shortage of health care professionals, in 2007 increases in disease and natural disasters, in 2008 on globalization affecting health systems and renewal of primary care services (WHO, 2011). In many countries the focus is on financial gain and there has

been a neglect of health, well-being, care and support for the general population and the most vulnerable.

The World Health Organization defined health as not only the absence of illness but a complete state of mental, physical and social well-being (World Health Organization, 1946). Owing to the global crises, integrative approaches (Wilber, 2000), which are important for increasing health and well-being, are needed now more than ever.

International comparative studies encompass this ethos by generating knowledge on illness prevention, health and well-being promotion in diverse settings. International comparative studies cover international, national, societal, cultural, contextual, disciplinary and interdisciplinary aspects (Hantias, 2009). Such research compares and contrasts an area of study in two or more countries. The aim of international comparative studies is to observe similarities and differences, for knowledge generation to take place and for international learning to occur. Comparing two programmes from different countries provides international validation, integrity and strength to the overall investigation. These studies can inform policy and decision making.

Such studies can be financially constraining and time consuming. They can be difficult to synchronize due to logistical issues. However if they can be undertaken they can be extremely beneficial in contributing towards humanity. The world has become a global village in terms of joint resources, cellular/mobile phones, internet, email and information can be shared more readily and therefore, while still challenging, such studies have become less problematic to coordinate. Following the end of apartheid and international isolation it



has been easier to undertake comparison studies between South Africa and other countries such as the United Kingdom.

### **2.3. The United Kingdom and South Africa**

The United Kingdom and South Africa have strong historical links dating back to the eighteenth century. The United Kingdom is located in the northern Hemisphere and is made up of four countries which are England, Northern Ireland, Scotland and Wales. The United Kingdom is an economically developed country with vast resources, a large national health service, modern technology systems and a structured and organized health approach is employed and focused upon.

South Africa is in the Southern Hemisphere and is located on the bottom of Africa. In comparison to the United Kingdom, South Africa is an economically developing country where there are less financial resources, a less structured approach, fewer employed health care professionals in the national health system and where a greater number of traditional health methods are utilized.

### **2.4. Community Psychology**

Community psychology is defined by Trickett (1996) in terms of being a context of diversity within a diversity of contexts. Community psychology is a science of community behaviour which involves research and action (Edwards, 2011). It has existed in natural forms for thousands of years but in recent times, in some ways, it has had less focus than other

established disciplines of psychology. It is a developing category of psychology which is growing due to the global crises which are being experienced.

Community psychology focuses on communal aspects of living, compared to “traditional psychology” which generally concentrates more on the “individual client” (Pillay, 2003). As a discipline it conceptualizes community functioning in terms of various paradigms and seeks to improve the daily life of communities by implementing social and developmental programmes, which utilize existing resources in a meaningful and productive manner to improve skills (Edwards, 2002b; Marais, Donson, Naidoo & Nortjie, 2007). It thus essentially seeks to be an empowering, enriching and advocacy process (Balcazar, Garate-Serafini & Keys, 2004).

#### **2.4.1. Community Psychologists**

The community psychologist should therefore not portray him/herself as an outside expert who is coming into the community to provide all the knowledge, experience and understanding. S/he is there to facilitate and assist community members. The programme, intervention and skills are ultimately generated by the community for the community and it is essential that community members own the process.

Interrelated with practice is research. The role of the community psychologists as a practitioner and researcher is seemingly inseparable. For a start, community psychologists research other researcher’s work in order to practice. Information generated during community psychology interventions and programmes is in one form or another research in itself. Such investigations are often formulated into outputs and presented in various ways to

the greater research, scientific community. It is such outputs, which can assist key areas that require attention such as child abuse, trauma, Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) and human rights. Research informs future community interventions and policy development. However it is not always an easy process. A variety of social, cultural, political, professional factors have an impact on the success of community psychology practice and research.

In theory and practice it is important to try, as much as possible, to understand the community and its members' existence and perspective (Owusu-Bempah & Howitt, 2002). It is valuable to learn about the reason why a particular person, be s/he an adult, child and adolescent, may be experiencing distress and presenting in a certain manner. For example there are various culturally approved ways of being ill (Ngcobo & Edwards, 2008). In professional clinical training, transcultural, cross cultural and multicultural factors are important teaching, learning components which require ongoing awareness and continued training. A good cultural model of understating illness is Ivey's respectful model (Ivey, D'Andrea, Ivey & Simek-Morgan, 2002). This model focuses on aspects such as spiritual identity, ethnicity and language. Key multicultural counselling competencies include understanding, respect, tolerance and trust (Ngcobo & Edwards, 2008). Research into cultural dynamics is an important area of focus. Ensuing knowledge should be applied practically (Wallis & Brit, 2003).

It is important that assessment, intervention and management models fit the community, groups, families and individual clients (Owusu-Bempah & Howitt, 2002). Due to diversity, there are cultural ways of understanding and experiencing distress (Mkhize, 2003). These can include more cognitive, emotional, behaviour or psychosomatic ways of pathologizing and feeling unwell. If a psychologist understands the aetiology of the distress, then the

practitioner and the people/person can form a shared understanding of the problem. Communities and clients are often more responsive to professionals who have made an attempt to understand their culture. They appreciate culturally focused services and information about services being provided in various languages.

Competence in multicultural interviewing assessment, counselling and therapy is extremely important in providing effective services. For example it is essential to ensure that culturally fair psychological tests are used with clients (Ngcobo & Edwards, 2008). It is also essential to utilize culturally relevant norms when using psychometric assessments and to be aware of the impact of cultural factors, such as over representation of scores, on test taking (Furnham, Mkhize & Mndaweni, 2004).

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR being the latest edition) (American Psychiatric Association, 2000) and International Classification of Diseases (ICD-10 the latest version) (World Health Organization, 1992) are the two main diagnostic texts used by psychologists to diagnose mental health difficulties in adults, adolescents and children. The DSM authors have recognised the importance of cultural factors in diagnosis, evident in the inclusion of culture bound syndromes in the DSM-IV-TR, which is one of the main differences between the DSM-III and this latest edition. Culture is one topic currently on the DSM-V agenda, which is due to be released in 2012.

#### **2.4.1.1. Uniqueness**

Community psychologists would seemingly be in one of the best positions to assist programme implementation, knowledge collection and research generation for the betterment

of communities, societies and humanity. An enormous amount of valuable knowledge and experience, which has been passed down from generation to generation, exists within communities. This information could be the key to solving so many of the problems that exist within the world. Community psychologists have the opportunity to listen to the people and hear the voice which is sometimes not heard when it comes to policy decision making. Community psychologists are able to focus on human rights issues (Kinderman, 2007). Many try to identify the causes of problems, lobby and provide information, which has been generated through practice and research, in an attempt to end human suffering (Gibson & Swartz, 2008).

Three areas which community psychologists can have a particular effect on are child abuse, trauma and HIV/AIDS. Community psychologists can be the key leads in these areas. In relation to child abuse and trauma, community psychologists have the opportunity to undertake research, implement community programmes and act as consultants for organizations and National Government Organizations who are conducting important studies and implementing programmes to prevent child abuse and trauma (Kincaid et al., 1995). In relation to HIV/AIDS community psychologists can play a vital role, because many are working in rural community settings where there are various misconceptions, in providing information to community members. They can contribute towards knowledge generation and support communities to assist people living with HIV/AIDS (PLWHA). They can undertake needs assessments, develop and implement programmes for PLWHA (Edwards, 2004). Their practice and research outputs can have a positive effect on policy analysis and advocacy, which is an important component of social change (Bishop, Vicary, Browne & Guard, 2009; D'Augelli, 1990).

#### **2.4.1.2. Challenges**

As previously highlighted, there are numerous socio-cultural-political-professional factors, which can have an impact on community psychology practice and research. Community psychologists value the need for social action within communities and societies at large (Nation, 2008; Painter & Terre Blanche, 2004). However change can only occur when communities recognize, want and/or need change. Socio-cultural contexts have an enormous effect on community intervention developmental, implementation and evaluation (Pillay, 2003). It is essential that community psychologists understand the social systems within which communities exist (Hirsh, Levine & Miller, 2007; Kelly, 2007).

Because community psychologists often work within marginalized societies there are many factors such as poverty and lack of education which impact on the functioning of its members (Suarez-Balcazar & Kinney, 2006). This can have an impact on practice and research in numerous ways, two of which are availability of resources and priority which community members give to interventions. When working in rural areas one often has to undertake work with minimal resources (Helbok, 2003). With the demand to meet basic needs often so great, programmes and interventions are not always evaluated. It is important to observe whether change is really occurring in various previously disadvantaged communities (Edwards, 2002b).

Structural, systemic, revolutionary, reactive and process forms of power have major impacts on community psychology. These should be the subject of intensive investigation (Fisher & Sonn, 2007). Various forms of power can have an impact on the relationships between the community psychologist and the community, as well as the power dynamics that exist within

the community itself. Power dynamics have been highlighted in previous community research studies. As an example in relation to HIV vaccine trials researchers have not always been trusted (Lesch, Kafaar, Kagee & Swartz, 2006). Many communities that lack political, economic, social and material resources stand to benefit from community psychological processes such as empowerment, enrichment, advocacy and establishment of mutual support groups.

There are various challenges that exist for community psychologists when they are collecting research data. It is important for community psychologists to explain to the participants and community elders/leaders what the data is going to be used for and that it will be kept confidential. This is particularly evident when the community psychologist lives within the community. It is important for community psychologists to make good ethical decisions in relation to their professional and personal lives (Helbok, 2003). Another ethical dilemma could occur when community psychologists identify that something is wrong within the community setting. They may then feel the need to combine research with action, investigate and potentially undertake mediation within the community (Balcazar, Garate-Serafini & Keys, 2004).

#### **2.4.1.3. Solutions**

It is important for community psychologists to have a good understanding of the dynamics of the community within which they work, to remember that they are facilitators who assist community members to utilize existing resources and that all resources and outputs are for the people. While in its traditional form community psychology has existed for thousands of

years, because in some countries it is a relatively newly taught, researched discipline, community psychology should remain fairly flexible (Sigogo et al., 2004).

When it comes to practice and research, community psychologists must remember that their intervention is dependent upon community context (Edwards, 2002b). They should understand that community processes are important for implementing community programmes and interventions (Visser & Mundell, 2008). Community psychologists need to identify how politics creates individual differences amongst community members and seek to advocate for change when required (Gibson & Swartz, 2008). It is important to understand that existing methods should not be discarded but used and adapted as and when required (Lewis & Newmar, 2006). Community psychologists should not forget that local knowledge is invaluable, that communities have their own way of understanding challenges and that programmes should remain self sustaining and also be empowering for all community members both young and old (Von Moltzahn & Van der Riet, 2006).

At a structural level educational institutions such as universities can play a vital role in insuring that there is less of a power imbalance between educational establishments and the communities in which they reside (Mitchell & Humphries, 2007). There should be an increase in courses and programmes such as the PhD in Community Psychology at the University of Zululand, South Africa. It should be remembered that community psychology is undertaken constantly by various members of the community, such as mentors and lay counsellors who often have a very good relationship with communities members and can thus implement community programmes, and that collaboration with all community members is essential (Jansen van Rensburg, 2008).



It is important that both existing and newly generated knowledge is managed correctly (Noeth, 2006). Traditional methods of recording and distributing information through story telling over generations are vital and so are written artefacts such as scientific outputs. Various participatory actions methods such as appreciative inquiry can identify, create and sustain positive change (Boyd & Bright, 2007; Von Moltzahn & Van der Riet, 2006). It is valuable for the community psychologist to write on topics which can make a professional contribution (Edwards, 2010). Article construction can be utilized to increase subject knowledge, disseminate results and have a direct benefit on the lives of communities, societies and humanity (Lunt & Davidson, 2000).

## **2.5. Community Psychology Models**

There are a variety of paradigms and models used in community psychology. Models employed include the liberatory model (raising consciousness of community groups towards freedom from oppressive systems and destructive structures), social action model (social action resulting in community change), organizational model (building cohesiveness amongst employees of an organization), ecological model (caring and creating a harmonious relationship with the environment), phenomenological model (enhancing experiential relationships within communities) and the mental health model (which focuses both on prevention of illness and promotion of health and healing) (Edwards, 2002a).

All of these models are used to inform interventions in a variety of contexts in the United Kingdom and South Africa. Different models are used more at different times by various people (Edwards, 2002a, 2002b). The mental health and organizational models have been the models mostly focused on in community health and healing within the United Kingdom

context. However there is a movement towards use of other models such as raising consciousness through movements like the increase in mindfulness through programmes located at places like Bangor University in Wales. Particularly during the South Africa apartheid era, the liberatory and social action model was utilized to raise consciousness in various community groups towards freedom from oppression and in order to create community change. Since the end of apartheid and particularly more recently there has been more focus on other models like the organization model as the economic development of South Africa continues.

## **2.6. Children and Adolescents**

Many children and adolescents in the United Kingdom and South Africa have a history of presenting with mental health problems and have been formally diagnosed and/or present with such diagnostic features outlined in the International Classification of Diseases (ICD-10) (World Health Organization, 1992) or Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (American Psychiatric Association, 2000) as disorders of learning, attention-deficit/hyperactivity, conduct, oppositional defiance, Asperger's, autistic, mood, anxiety, adjustment, substance abuse, prodromal psychosis and bereavement (Edwards, 2009; Meyer, 2008; Smith, 2005).

Sexual, physical, emotional abuse and neglect are having an enormous impact on children and adolescents. While useful, statistics do not appear to provide sufficient clarity on the prevalence of abuse, as many incidences are not reported with survivors often afraid or groomed by perpetrators not to disclose the abuse. To date, implemented interventions have been unable to create sufficient change to curb its epidemic proportion. The ravages of abuse

often leave physical, psychological and social scars, which require specialized in-depth treatment. Abuse can have a debilitating immediate and long term effect on a young person's bio-psycho-social-cultural-spiritual health and well-being.

Sexual abuse can result in the transmission of sexually transmitted infections including Human Immunodeficiency Virus (HIV) leading to Acquired Immune Deficiency Syndrome (AIDS). Over the last three decades the Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) has had a devastating effect on the world's population and specifically on Southern African humanity, children and adolescents (UNAIDS, 2004; UNICEF, UNSAID & UNAIDS, 2002; UNICEF & USAID, 2000; Van Dyk, 2004; Wild, 2001).

Sexual abuse can result in the development of Acute Stress Disorder (ASD) which can progress into Post Traumatic Stress Disorder (PTSD), experiences of excarnation, feelings of dissociation, unplanned pregnancy, economic deprivation, and a decrease in scholastic performance (American Psychiatric Association, 2000; Edwards, 2006, 2007; World Health Organization, 1992). The manifestation of sexual abuse can have a negative effect on the child and adolescent victim, family, community and treatment team. Sexual abuse can have a negative impact on the survivor's family structure and may result in family relational problems, family disintegration and transgenerational trauma. Sexual abuse often causes anxiety and persistent fear in community members.

## **2.7. West Kent Youth Offending Service Child and Adolescent Mental Health Intervention**

### **2.7.1. West Kent Youth Offending Service (WKYOS)**

The England and Wales Youth Offending Service is a local authority service i.e. part of county council services, which is a division of the Youth Justice Board, which has now been subsumed under the Ministry of Justice. Youth Offending Services were established following the 1998 Crime and Disorder Act (Crime and Disorder Act, 1998). Their purpose is to reduce offending behaviour in youths, from the ages of 10 to 18 years, to manage whenever possible their behaviour in the community and to provide them with access to various educational, health, social and employment resources for the betterment of themselves, their families and the communities in which they reside.

Youth Offending Services, like the one in West Kent, are comprised of statutory employees such as youth offending officers, social workers, senior practitioners, practice supervisors and team leaders. YOSs furthermore include seconded workers from agencies such as the police, probation, ISSP (intensive supervision and surveillance programme), youth crime prevention, mediation, health, education, drug and alcohol as well as mentoring.

The West Kent Youth Offending Service manages clients living in the West Kent Area and has two offices, one covering South West Kent and one managing North West Kent. The 2008 YOS Kent inspection report highlighted a lack of child and adolescent mental health practitioners (CAAMHP) and outlined the need for an increase in child and adolescent mental health intervention across Kent (Kent Joint inspection of Youth Offending Teams of England and Wales. Report on: Kent Youth Offending Service, 2008). After this inspection, a child and adolescent mental health practitioner (CAAMHPs) was employed, not just in mid Kent

but also, in West and East Kent. These positions were funded by the Kent and Medway National Health Service (NHS) and Social Care Partnership Trust.

### **2.7.2. Emotional and Mental Health in WKYOS Clients**

Emotional and mental health in YOS clients is an aspect which is being particularly focused on in counties across England and Wales, including West Kent. YOS clients are at risk of emotional and mental health problems due to various compounding factors which can include poor early attachments, family relationship difficulties, abuse, trauma, not being in education and substance misuse (Key Elements of Effective Practice - Mental Health, Youth Justice Board, 2008). YOS clients are three times more likely to experience mental health difficulties when compared to other young people in their age group (Key Elements of Effective Practice - Mental Health, Youth Justice Board, 2008). Numerous clients being managed by Youth Offending Services have a history of presenting with mental health problems and have been formally diagnosed and/or present with such diagnostic features outlined in the International Classification of Diseases (ICD-10) (World Health Organization, 1992) or Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (American Psychiatric Association, 2000) (Edwards, 2009; Meyer, 2008; Smith, 2005).

### **2.7.3. Use of the Mental Health Model within WKYOS**

Within the United Kingdom context the models ranked from the mostly widely used to least mostly used would probably be: the mental health, organization, ecological, phenomenological, social action and liberatory model. While other community psychology paradigms are utilized in YOS the mental health model is the most appropriate paradigm to

explain the overall mental health management, which occurs within Youth Offending Services and WKYOS. Use of the mental health model within YOS will be outlined.

The mental health model focuses on primary, secondary and tertiary prevention as well as primary, secondary and tertiary promotion (Edwards, 2002a). YOS interventions are applied at all of the above mentioned prevention and promotion levels. An example of primary prevention is encouraging safe sex practices whereby YOS clients are accompanied to sexual health clinics by YOS workers and are able to collect condoms from the YOS office. An illustration of secondary prevention is early detection of abuse and referral to Children and Families (Social Care, Social Services) Departments. This can help to reduce the long term effects of abuse, on a client's bio-psycho-social-cultural-spiritual health and well-being, which can include transmission of sexually transmitted infections (STIs), development of anxiety disorders such as acute stress disorder (ASD), which can progress into post traumatic stress disorder (PTSD) (DSM-IV-TR) (American Psychiatric Association, 2000), a breakdown in intra and inter personal relationships such as the experience of excarnation, dissociation and social isolation (Edwards, 2006, 2007). An exemplar of tertiary prevention is treating mental health problems in YOS clients. One of the main roles of YOS CAAMHPs is to manage such mental health difficulties at a tertiary prevention level and to try and reduce the impact of mental health problems on clients, by helping them to cope with past and present distress through utilizing coping mechanisms, techniques and skills.

An example of primary promotion is physical activity programmes for young people, evident in the link between some YOSs and football clubs (Bartlett, 2006). An illustration of secondary promotion is empowerment and building relationships. Many YOS clients have an enormous impact on the communities in which they reside (Miller, 2002). YOS consultation

has been a key part of programmes that empower communities and bring people together from different ethnic backgrounds (Mickel, 2008). This can involve the use of restorative justice and apologies to victims (A sorry state of affairs, 2009). An exemplar of tertiary promotion is the increase of high level functioning needs of YOS clients, with further provision being made available for additional CAAMHPs in counties across England and Wales to undertake this work as was evident with the employment of the West and East Kent CAAMHPs.

#### **2.7.4. Multidisciplinary Team Mental Health Management Approach in WKYOS**

The utilization of a multidisciplinary team, mental health, management approach in various settings, such as WKYOS, is an established international health management strategy. While single discipline management is beneficial for clients, because of the bio-psycho-social complexity of many of the difficulties which YOS young people experience, the need for internal and external multiagency and multi-professional management is essential. Like in West Kent, the CAAMHP forms part of the multi-disciplinary YOS team who manage mental health in clients within this setting and with the help of other external mental health professionals and agencies.

Child and Adolescent Mental Health Services (CAMHS) were established in 1995. YOS CAAMHPs, like the WKYOS position, generally manage mental health difficulties in YOS clients at a National Health CAMHS Tier 2 level (Tier 1 services involve individual generic workers such as general practitioners providing mental health input, Tier 2 services are mental health practitioners including psychologists, Tier 3 services have multi disciplinary

mental health teams which are usually comprised of psychiatrists, psychologists and family therapists, and Tier 4 services are typically multi disciplinary team inpatient units).

Client management within YOS is undertaken with professionals from these different CAMHS Tier Level Services, Adult Community Mental Health Teams (CMHTs), Increasing Access to Psychological Therapy (IAPT) Services, Early Intervention Psychosis Services, and Dual Diagnosis and Substance Misuse Services (Edwards, 2009; YOT Substance Misuse Worker, 2010). It is essential to monitor care and transition between services (Key Elements of Effective Practice - Mental Health, Youth Justice Board, 2008; Perry, Gilbody, Akers & Light, 2008).

#### **2.7.5. WKYOS Client and Adolescent Mental Health Assessment**

CAAMHP roles include assessing client risk in terms of violence, self-harm, suicide and mental health risk factors which may increase the chance of behavioural difficulties that can impact upon the client and others (Perry, Gilbody, Akers & Light, 2008). Logistically, clients are seen at various County Council (CC), NHS locations, schools, home settings, as was evident with the WKYOS post which covered the whole of South and North West Kent, with emergency client management, i.e. for suicidal ideation and psychotic presentation, undertaken telephonically across various sites.

Unless there is significant risk to self or others, management from the YOS CAAMHP is generally conducted on a voluntary basis with clients who are receiving various YOS interventions ranging from Final Warnings to Detention and Training Orders. Many clients do not have social support and are scared of health, social and police services (In too deep



with the wrong crowd, 2007). To ensure that clients are informed and to help overcome stigma, the role of health within YOS is fully explained to clients and their significant others.

During assessment and intervention it is essential to take into account factors such as a client's age, gender, ethnicity and culture. It is important to be mindful that females will generally display more depressive characteristics and males more conduct features. It is vital to be aware if clients are using substances and have a dual diagnosis. It is important to recognise if clients have learning disabilities and whether they can consent to treatment by themselves. The legal age for consent for YOS clients is 16. If clients are below this age a responsible adult will generally need to give consent. However if they are younger than 16 they can still give consent in certain situations in which case it is important to assess if they are Fraser competent (previously known as Gillick Competence) i.e. despite being younger than 16 are able to comprehend the treatment which they are consenting to (Key Elements of Effective Practice - Mental Health, Youth Justice Board, 2008; Perry, Gilbody, Akers & Light, 2008).

Clients are screened and assessed using interviews and measures such as the clinical intake, Section 8 of the YOS Asset Assessment Tool which covers Emotional and Mental Health, The Mental Health Screening Interview for Adolescents (SIFA), The Mental Health Screening Questionnaire for Adolescents (SQIFA), Child Behaviour Checklist, Child and Adolescent Functional Assessment Scale, The Youth Inventories for Children and Adolescents and The Resiliency Scales for Children and Adolescents, with it being important that these assessments are coordinated (Beck, Beck, Jolly & Steer, 2005; Goodman, Ford, Simmons, Gatward, Meltzer, 2003; Key Elements of Effective Practice - Mental Health,

Youth Justice Board, 2008; Perry, Gilbody, Akers & Light, 2008; Prince-Embury, 2007). It is equally essential to monitor and evaluate intervention using such measures.

#### **2.7.6. WKYOS Client and Adolescent Mental Health Intervention**

Therapeutic interventions with YOS clients range from a single session to multiple sessions over a period of months depending upon factors such as the client's needs, therapeutic approach and length of YOS intervention order. In terms of service delivery it is necessary for intervention to be matched with the young person's needs and to try to engage young people and their families. Service delivery should include elements of previously successful interventions. It is important to be aware that clients who experience anxiety and depressive features are more likely to continue with psychotherapeutic interventions than clients with conduct symptoms (Key Elements of Effective Practice - Mental Health, Youth Justice Board, 2008; Perry, Gilbody, Akers & Light, 2008). The termination of therapy is a planned process and encourages YOS clients to continue to use the skills and resources, which existed and which they had accessed and learnt during sessions, in their community settings.

The purpose of psychotherapeutic interventions is to provide a safe, caring environment, to build, maintain a trusting relationship and to facilitate healing (Edwards, 2006). As discussed, because some clients are fearful of mental health services, Rogers' (1961) values of empathy, warmth, genuineness are key elements used to build trusting therapeutic relationships with YOS clients. There are various types of therapeutic approaches which are undertaken within YOS and WKYOS. Therapeutic modalities based on the literature of the bracketed authors, which are modified in various ways, are utilized within YOS and can include crisis, insight intervention, person centered, cognitive behavioural, trauma therapy, psychodynamic group

work, family skills training, family solutions programme, family empowerment intervention and multi-systemic interventions (Allan, 1988; Axline, 1947; Eagle, 1998; Hagan & Smail, 1997a, 1997b; Jacobson, 1976; Key Elements of Effective Practice - Mental Health (KEEP), Youth Justice Board, 2008; Meichenbaum, 1985; Ndlovu, 2001; Perry, Gilbody, Akers & Light, 2008; Reid, 1989; Rogers, 1961; Sherwood, 2004, 2007a, 2007b; Tagar, 1996a, 1996b, 1998, 2001). Three of the most used YOS child and adolescent mental health interventions will be discussed: crisis intervention, cognitive behavioural therapy and trauma therapy.

#### **2.7.6.1. Crisis Intervention**

Due to various compounding psychosocial factors many YOS clients present as being in a constant state of crisis. These extraneous variables can include breakdown in parent, family, partner and friend relationships, poor living conditions, eviction from accommodation, poverty and loss of income support. Crisis intervention helps clients to cope in different settings (Key Elements of Effective Practice - Mental Health, Youth Justice Board, 2008). Crisis intervention methods, particularly those which include arousal control, can provide immediate relief to the client by rapidly decreasing his/her emotional distress.

Intervention to increase insight is one method used to reduce suicidal ideation in depressed, anxious and traumatized young people. Insight intervention assists clients to understand their behaviour and the impact of their behaviour on themselves and on others. A practical example is workshops outlining the effect of carrying knives and other sharp weapons (Hunter, 2006). Once acute symptomology has decreased further long term intervention models and therapy techniques can be implemented to address residual symptoms and manage the long term impact of the YOS client's emotional and mental health difficulties.

### **2.7.6.2. Cognitive Behavioural Therapy**

Cognitive behavioural therapy (CBT) interventions aim to improve client presentations by rewarding positive behaviour and correcting negative behaviour. The National Institute for Health and Clinical Excellence (NICE) recommends CBT be the main therapeutic method for managing anxiety and depression. CBT in young people requires support from family members and caregivers, however because many YOS clients grow up in chaotic environments they often have limited social support and their behaviour is often only noticed when they do something wrong (Francis, 2008). If family members do not want to engage, CBT with YOS clients is an individual process.

Various CBT training techniques can be used to reduce past and present distress in YOS clients. For example client's can be taught to overcome their anxiety by ensuring that when required they can relax themselves by modify their breathing and making their out-breath longer than their in-breath. To further reduce anxiety, progressive relaxation such as the method developed by Jacobson (1976), which involves tensing then relaxing specific muscle groups until all major areas are relaxed, can be practiced with clients.

The following method can be utilised to correct negative thought patterns in YOS clients. When they experience a negative thought they should identify that thought and say a key word such as "stop". This first step is called thought stopping (Meichenbaum, 1985). The second step is for clients to change their manner of thinking from negative to positive by creating an upward spiral of constructive thinking. This method should be used in conjunction with other techniques such as meditation and mental imagery which involves

relaxing the body, clearing negative unwanted thoughts and focusing the mind on positive aspects (Reid, 1989).

#### **2.7.6.3. Trauma Therapy**

The utilization of specific therapeutic trauma interventions is dependent on the nature, severity and context of the YOS client's presentation (Axline, 1947; Eagle, 1998; Hagan & Smail, 1997a, 1997b; Ndlovu, 2001; Sherwood, 2004, 2007a, 2007b; Tagar, 1996a, 1996b, 1998, 2001). Trauma therapy is a vitally important part of YOS client intervention and various models are used. One example is the Wits Trauma Intervention Model - grounded upon psychodynamic and cognitive behavioural theory principles – which is a five stage therapeutic process, which assists clients to recognize and treat their trauma symptoms. It includes telling/retelling the experience, normalizing symptomology, addressing survivor guilt/self blame, encouraging mastery and facilitating the creation of meaning (Eagle, 1998). It can be adapted for use with various traumatized YOS clients with progression through therapeutic phases occurring systematically or concurrently.

#### **2.7.7. Secondary Traumatization**

As previously discussed many clients being managed by YOS have experienced various forms of abuse and trauma. This can have an impact on YOS CAAMHPs during therapy. During therapy, transference and counter transference may be experienced by the therapist. These refer to the processes of energy and emotional exchange between client and therapist and therapist and client (Freud, 1961/1923). Transference can result in secondary traumatization, which is often a common feature for practitioners who are working

intensively with severely traumatised clients over a long period time (Steed & Downing, 1998). There are various methods which can be used to overcome secondary traumatisation before, during and after sessions. It is essential to plan sessions. It is important to be objective and reflective. It is valuable to use mediums to expel the transference such as exercise, relaxation, mindfulness and meditation.

### **2.7.8. Training**

It is important for YOS CAAMHPs to do training themselves and train YOS staff on child and adolescent mental health assessment, intervention and management (Key Elements of Effective Practice - Mental Health, Youth Justice Board, 2008; Perry, Gilbody, Akers & Light, 2008). For example in WKYOS workshops are often undertaken with YOS staff on child and adolescent DSM-IV-TR and ICD-10 disorders. In addition training on suicide case management, autism and Aspergers is undertaken with mentors, anger management in young people with police services as well as the role of CAAMHPs within YOS with magistrates is sometimes undertaken (Edwards, 2009).

### **2.7.9. Research on YOS Child and Adolescent Mental Health Intervention**

There have not been a lot of studies into YOS Mental Health Intervention. Many previous studies have been undertaken in secure settings, as oppose to community YOSs, with small samples. The following is from more recent studies which have been undertaken. These were: Harrington, et al. (2005), which was summarised as The Mental Health Needs and Provision, Summary, a Report by Manchester University on mental health needs and provision (2010), and The Health Needs Assessment of Young People in London with complex emotional,

behavioural and mental health problems who are or may be at risk of committing a serious crime (2010).

These studies suggested that there is growing literature on the high levels of complex, learning and mental health difficulties in YOS clients. Asset assessment tools are not always completed. Interventions are frequently not multidisciplinary, interagency working and continuous care is a problem but has been somewhat better since the introduction of care plan assessments (CPAs) in 1991 which can be standard or enhanced. There is often a lack of provision for clients between the ages of 16 and 18 years. During intervention it is important to take various factors into account. YOSs need local mental health strategies, intervention pathways, multi-modal approaches, evidence based interventions, tailored interventions including outreach for clients, and more outcome measures for assessing interventions. CAAMHPs are valued but there are too few CAAMHPs and they have inadequate supervision.

There has been no published research on WKYOS child and adolescent mental health interventions other than the Edwards (2009) paper which focused on providing an overview of WKYOS interventions, but not the effect of client intervention compared to a matched control sample and which did not involve an appreciative inquiry of WKYOS staff's perceptions on WKYOS CAAMHP intervention.

## **2.8. Zululand Mental Health Community Psychology Programme**

The Zululand Mental Health Community Psychology Programme (ZMHCPP) developed due to the overwhelming need for community intervention and support within the Zululand region

during and following the lengthy South African apartheid era. It included movements for democracy and democratic change in a multicultural society, consideration of human rights and need to enhance human rights for all members, the desire to decrease illness, promote healing and well-being, the need to bring together and empower indigenous community forms of health systems, and form collaborations between various sectors (Edwards, 2011). It involved a number of community based projects being established in the Zululand area (Edwards, 2002a, 2002b).

ZMHCPP is concerned with working in, with, through and for the community so that community psychology is owned by its members. ZMHCPP recognizes that compared to the relatively small numbers of registered psychologists, there are a large number of medical practitioners, social workers and nurses, and an vast number of traditional doctors, diviners, faith healers, African Indigenous Church Members.

ZMHCPP is a partnership between the University of Zululand (UNIZUL) Psychology Department, Zululand Mental Health Society, local hospitals including Ngwelezane, schools such as Empangeni Remedial Centre, businesses like The Zululand Chamber of Business Foundation (ZCBF) and various rural community based projects. It included the establishment of clinical psychology internships in 1993 and the PhD in Community Psychology at the University of Zululand in 1998, which was the first of its kind in South Africa. Over the last 10 years there have been 82 masters and 48 doctoral students who have graduated from these programmes (Edwards, 2011).

Honours students, masters psychology students, intern psychologists and community service psychologists are based within the Zululand area at these different centres, hospital and



business sites. They receive support and supervision from UNIZUL Psychology Department staff and together with other multidisciplinary staff and community members they provide psychological intervention to the local community through research, involving various community psychology models and paradigms, interventions and therapies.

The aims of the ZMHCPP are to improve the theory and practice of community psychology in order to enhance the life of community members which were so affected by apartheid and various other forms of violence and crime, to heal unjust divisions, improve health and social well-being and relationships in the rural Zululand region (Edwards, 2011). One of the key elements is to also maintain and enhance indigenous knowledge systems by assisting community members to record and hand down this knowledge (Edwards, 2011).

### **2.8.1. Use of the Liberatory Model within ZMHCPP**

Due to the impact of the apartheid era, the models most utilized to inform interventions within the ZMHCPP context could likely be ranked from most to least employed in the following order: liberatory, social action, phenomenological, ecology, mental health and organizational model (Edwards, 2002a, 2002b).

Use of the liberatory model within the ZMHCPP will be outlined. This model involved raising consciousness of community groups towards freedom from oppressive systems and destructive structures (Edwards, 2002a). One of the aims of the ZMHCPP was to assist the process of ending apartheid by increases consciousness of communities within Zululand so that people could feel free from the oppressive systems which were in operation during the apartheid era through building human relationships, overcoming boundaries and making

optimal use of community resources and education on health and well-being. This has been discussed in previous research on evaluating models of community psychology and social transformation within South Africa (Edwards, 2002a, 2002b).

### **2.8.2. Sexual Abuse, HIV/AIDS and Trauma in Children and Adolescents**

Political, economic, social and psychological factors have resulted in a high rate of child sexual abuse, trauma and HIV/AIDS in Southern Africa with one area which has been particularly affected being the Zululand region (Ndlovu, 2001). Reasons for the high rate include: rape myths, alcohol and drug abuse as well as power imbalances.

The Zululand area also has a history of violence and trauma which has had an impact on health and well-being such as the high level of HIV/AIDS (Edwards, 2010). Management effectiveness is dependent upon intervention efficiency, economic resources and the availability of various health professionals. The multidisciplinary team management approach is part of a greater public health model. Work is undertaken at HIV/AIDS centres and crisis centre around the Zululand area. The construction of crisis centres is a vitally important public health strategy in the community's struggle against sexual abuse. Crisis centres are currently being equipped with the latest biomedical technology and multidisciplinary teams who address the overall negative impact of sexual abuse and provide medical, social and psychological support. Without these services child and adolescent sexual abuse survivors, families and communities would be unable to receive the specialized treatment they require.

#### **2.8.2.1. Community Psychology for Child and Adolescent Sexual Abuse and Trauma**

Psychological management of child and adolescent sexual abuse attempts to harmonize interpersonal relationships, optimize and mobilize family and community support and resources. While individual therapy is highly effective, community interventions are an important part of the management process in educating the public about sexual abuse. Community programmes can include presentations and workshops to local schools and health organisations in order to cascade information on sexual abuse.

The utilization of specific therapeutic trauma interventions is dependent on the nature, severity and context of the sexual abuse. Whenever possible, these therapeutic interventions should extend over a number of sessions so that any more deep-seated unconscious memories and emotions can be healed. The termination of therapy is a planned process with an open-door/walk-in service provided. This encourages patients to continue using the skills and resources accessed during the therapy sessions in their community setting, and to return to therapy if/when deemed necessary. Owing to the overwhelming psychological impact of sexual abuse, survivors sometimes return for therapy during various stages of their lives.

From a psychological perspective there are various long established psychotherapy treatment approaches, models as well as relatively newer dynamic techniques, which can be used in the management of sexual abuse. These include Cognitive Behavioural and Psychodynamic Psychotherapy, the Wits Trauma Intervention Model and Power Mapping as well as Expressive Therapies (Axline, 1947; Eagle, 1998; Hagan & Smail, 1997a, 1997b; Hajiyanis & Robertson, 1999; Ndlovu, 2001; Sherwood, 2004, 2007a, 2007b; Tagar, 1996a, 1996b, 1998, 2001). While all of the above interventions are effective, due to its body based emphasis, the expressive therapy, phonophenics, is one of the current, increasingly more recognised, techniques used to heal traumatised sexual abuse victims. For many African

people the experience of an emotion and feeling is as important as the cognitions associated with that emotion and feeling.

#### **2.8.2.2. Expressive Therapy**

Expressive therapy is one technique used to heal sexually abused and traumatised children and adolescents who find it difficult to verbally express their emotions to other people. The role of the therapist is to guide the client through the expressive therapy process. Art therapy, including Jungian serial drawing, uses common themes to map client's emotions over the intervention process from start to finish (Allan, 1988). Clay therapy utilizes the medium of clay to create flexibility, produce inner development and heal the trauma (Sherwood, 2004, 2007a, 2007b). Philophonetics incorporates the expression of breath, sound, and emotions which are associated with sound. It can be used to correct negative emotions, which have been paired with traumatic experiences (Sherwood, 2004, 2007a, 2007b; Tagar, 1996a, 1996b, 1998, 2001). Following trauma, energy and breath can become "trapped" in places within the client's body and can leave what is called an "imprint". Due to trauma a victim's breath may become constricted when they experience the trauma. Breath is the vital force that harmonizes one with one's surrounding and is an essential aspect of existence (Loehr & Migdow, 1999; Reid, 1989). Expressive therapy may utilize Jung's archetypes to ward off various dangers and cope with future traumas (Jung, 1961; Sherwood, 2004, 2007a, 2007b).

One of the central tendencies of trauma is that it is located within the body (P. Sherwood, personal communication, 11 February 2008). While many talk therapies, particularly when used in traditional form, are effective in intervening with sexual abuse victims, these

techniques appear to treat more of the cognitive trauma and are possibly not as successful in healing the victim's psycho-physical distress.

Sexual abuse can affect a person's energy, breath and sound. It can have a negative effect on his/her level of physical energy (Edwards, 2007; Sherwood, 2004, 2007a, 2007b). There is a natural flow of energy which circulates the human body. Overstimulation or understimulation of energy can have an impact on human functioning (Yerkes & Dodson, 1908). Following sexual abuse, victims sometimes experience a decrease in energy, which is one mood feature linked to post traumatic anxiety disorders (American Psychiatric Association, 2000; World Health Organization, 1992). They may also develop an increase in mood resulting in manic features. Fluctuations in energy can cause an individual to experience difficulty with his/her sleep and appetite, which may exacerbate the post traumatic symptoms of hypervigilance, nightmares and flashbacks.

Traumatic events such as sexual abuse can result in short, sharp breaths and panic attack like symptoms (American Psychiatric Association, 2000; World Health Organization, 1992). This shortness of breath can also have an impact on confidence and relationships with others. During and after sexual abuse people will often let out a cry, scream and/or shout. This may be a result of feelings of anger towards the perpetrator, feelings of frustration towards the self and questioning why this has happened. These sounds are often paired with the negative experience and the subsequent verbalization of such a sound may cause the person to re-experience the event.

#### **2.8.2.2.1. Theory of Phonophenetics**

Philophonetics is a body based therapy, which focuses on aspects such as energy, breath and sound (Sherwood, 2004, 2007a, 2007b; Tagar, 1996a, 1996b, 1998, 2001). While there are some similarities between philophonetics and traditional talk therapies, such as the intake used to acquire information and creating a space for clients to work through their trauma, it is predominantly body orientated and requires more physical movement than verbal dialogue.

Philophonetics is based upon Steiner's fourfold model, which has been build upon by subsequent practitioners. This model postulates the existence of four distinguishable and interpenetrating energetic layers, levels, sheaths or bodies as in the rings of an onion. The first includes physical bodily experiences, including that which we can see, feel and touch, as well as all natural aspects of existence. Secondly, the etheric or life body is responsible for the functioning of the physical body. When the life body is working optimally it is then that we are perceived by ourselves and are seen by others to be well. The astral body refers to the lower levels of one's consciousness, which help one experience our senses and make initial meaning of that information. Finally the creative higher level of personal consciousness that more truly heals the self is called the I AM (Sherwood, 2004, 2007a, 2007b; Steiner, 1994; 1998; Tagar, 1996a, 1996b, 1998, 2001).

As a process, philophonetics involves a number of treatment steps. It can incorporate other expressive therapy mediums such as art and clay, to concretize the client's experiences (Steiner, 1994, 1998). It may utilize Jung's archetypes in order to protect the client from further external traumas (Jung, 1961; Sherwood, 2004, 2007a, 2007b).

#### **2.8.2.2.2. Philophonetics for Sexual Abuse and Trauma Victims**

The main reason why philophonetics is so effective in managing sexual abuse and trauma is that it allows clients to enter into their experience, identify where the trauma is located within the body, and heal their disjointed energy, breath and sound. This leaves the client feeling harmonized and ready to face the world. Philophonetics however should not be undertaken with sexual abuse clients who are experiencing psychosis. Clients must be also old enough to understand the process.

The nature of the therapeutic approach is discussed with the client from the onset as this technique is slightly different from traditional psychotherapeutic methods (J. Thwala, personal communication, 4 May 2009). A noise proof area is ideal as this will provide the client with the opportunity for both verbal and nonverbal expression of sounds without feeling hampered. It is important to ensure that one has the chosen mediums such as clay or art, or whatever medium is suitable and available for the client.

When undertaking philophonetics the traditional use of an initial interview is conducted in order to acquire pertinent background information on the client and allow him/her to briefly verbally express the incident. A 'behold' and 'landing area' can be demarked for the client. The therapist and client will discuss the steps in the behold space and the client will "step into" the experience by moving onto the landing area. As discussed, philophonetics is a sequence of steps, which is embarked upon with the client and the following is one example of how it can be conducted with sexual abuse victims. There is an entry, exit and behold sequence that is undertaken with the client, which provides steps for the therapy (Tagar, 1996a, 1996b, 1998, 2001). Once the client is ready s/he will be asked briefly to discuss the sexual abuse incident, "step into" into the event, experience the traumatic incident and then step out. When stepping out the client will complete the bamboo sequence which involves

shaking off this experience (Sherwood, 2004, 2007a, 2007b). S/he will then be asked to re-enter this experience, identify and step-out with an imprint. S/he will then either draw the imprint on a piece of paper or construct it in clay in order to make it tangible (Sherwood, 2004, 2007a, 2007b). Once this is concretised the client can again step in and find the sound which s/he made during/following the sexual abuse experience. S/he will then step out and again draw or mould it. The client will then step in for a last time and identify the sound, which s/he would like to use to ward off the sexual abuse incursion. It should be a strong sound particularly when managing sexual abuse cases. The client will then step out again and can practice pushing the sexual abuse trauma away against an open space using the sound, until s/he feels comfortable enough that this and other traumas can no longer hurt him/her. Another technique which can be undertaken is to breathe into the imprint caused by the sexual abuse in order to heal it. The client may choose archetypes and also practice placing a protective layer around him/her self which can be used to ward off future dangers.

The role of the therapist is to guide the client through the process. Because it is an energy and body based therapy the practitioner has to ensure that their own energy, cognitions and speech do not impact on the client's experience. The therapist is there to "walk" with the client. One will often demonstrate various aspects of the process with the client and ensure that they understand the steps. One might need to repeat certain aspects of the process a number of times until the client feels happy and has successfully undertaken individual stages and the process as a whole.

### **2.8.3. Secondary Traumatization**



As previously discussed many clients being managed by community psychologists have experienced various forms of abuse. With the energy, breath and sound being so evident in philophonetics particularly with sexual abuse victims the therapeutic space can become filled with emotions. There are various methods which can be used to help overcome secondary traumatisation when doing philophonetics. Before undertaking the process the therapist can place his/her archetype and a “protective layer” around him/herself. During sessions it is essential to be mindful of the process. Following sessions it is important to reflect. It is vitally important to remain objective and to seek supervision regarding therapy.

The benefit of operating in a multidisciplinary community capacity is that it affords the opportunity for professions to receive trauma debriefing and express their emotions in a cathartic healing manner, thereby healing their own vicarious trauma and resulting in improved interpersonal, intra-personal relationships and management of clients (Edwards, 2006). It allows staff to gain effective coping solutions and set personal goals in an empowering environment.

#### **2.8.4. Research at ZMHCPP**

Extensive research into the Zululand Mental Health Community Psychology Programme has been undertaken through the UNIZUL Psychology Department, and research has included an appreciative inquiry into and improvement of psychological well-being programmes (Edwards, 2010; Molekwa, 2004). A pre and post test psychological well-being study revealed significant changes for clients who received intervention (Sibiya, 2006). A holistic appreciative inquiry into the ZMHCPP was recently undertaken with staff from the health, education and business partnership centres (Meyer, 2008). Findings were generally positive,

reflected that the programme benefitted the wider community with follow-up research recommended.

There had been a lack of ZMHCPP studies which had focused specifically on practitioner's views of intervention which they provided to children and adolescents. Many children and adolescents in the Zululand area present with emotional and mental health needs compounded by biological, psychological and social factors and research on ZMHCPP child and adolescent mental health intervention was identified as an area of need.

## **2.9. Résumé**

This chapter provided a review of the literature on International Comparative Studies, the United Kingdom and South Africa, Community Psychology, Paradigms and Models, Children and Adolescents, the United Kingdom West Kent Youth Offending Service Child and Adolescent Mental Health Intervention, and South African Zululand Mental Health Community Psychology Programme Child and Adolescent Intervention. The next chapter will cover the methodology of the study.

## **CHAPTER THREE**

### **METHODOLOGY**

#### **3.1. Introduction**

This methodology chapter is concerned with the design, measuring instruments, data analysis techniques and ethics of the study.

#### **3.2. Aim**

The aim of this research was to conduct an international comparative study of WKYOS and ZMHCPP child and adolescent mental health interventions.

#### **3.3. Objective**

The objective of the study was to provide feedback to WKYOS, Youth Justice Board (YJB) and West Kent CAMHS managers on WKYOS child and adolescent mental health intervention as well as to all ZMHCPP partners on ZMHCPP child and adolescent intervention.

#### **3.4. Research Design**

The theory driven research design involved two case studies, namely WKYOS Child and Adolescent Mental Health Intervention and ZMHCPP Child and Adolescent Intervention, and used a triangulated approach which incorporated quantitative and qualitative components.

### **3.5. International Comparative Case Studies**

#### **3.5.1. WKYOS Child and Adolescent Mental Health Intervention Case Study**

The WKYOS case study focused on the intervention rendered from July 2008 to August 2009 when the WKYOS CAAMHP was in post. Interventions included crisis intervention, CBT and trauma therapy. Cases were managed with multidisciplinary WKYOS staff and external mental health services. Training was provided to WKYOS staff, mentoring, police and magistrates. Table 1 is the tabulated account of the number of booked sessions, which the West Kent CAAMHP managed during a one year period from 21/07/2008 to 21/07/2009.

**Table 1. Booked session managed by the WKYOS CAAMHP**

<b>Time Frame</b>	<b>Booked Sessions</b>
21/07/2008 to 21/07/2009	592

##### **3.5.1.1. WKYOS Client Quasi Experimental Design**

The West Kent YOS purposive experimental group client sample consisted of 41 clients, between the ages of 13 and 18 years, who were managed by the WKYOS CAAMHP during the period from July 2008 to August 2009. The inclusion criterion for the experimental group was that each of these clients had received at least one session of intervention from the

WKYOS CAAMHP. A matched, for age and gender, control sample which consisted of 85 clients was used to compare the data. The inclusion criteria for the control sample were that their start Asset assessment date was matched as closely to July 2008 and their end Asset assessment date matched as closely to August 2009 as possible. The control sample received input from WKYOS staff, which covered emotional and mental health aspects, but not specific intervention from the WYKOS CAAMHP.

#### **3.5.1.2. WKYOS Staff**

For qualitative research purposes these participants were chosen on the basis of their established relationship with the researcher, experience of WKYOS, WKYOS client and adolescent mental health intervention, insight into and willingness to discuss their perceptions of WKYOS client and adolescent mental health intervention. The sample consisted of 5 WKYOS staff, 1 male and 4 female, between the reported ages of 30 and 46, whose education was up to masters level.

#### **3.5.2. Zululand Mental Health Community Psychology Child and Adolescent Intervention Case Study**

The Zululand Mental Health Community Psychology Child and Adolescent Intervention Case Study focused on intervention provided from March 2007 to end of data collection which was September 2011. Interventions included community interventions, client management at ZMHCPP sites, research and supervision.

##### **3.5.2.1. ZMHCPP Practitioners**

The ZMHCPP purposive practitioner sample consisted of staff that had been providing intervention at some point between March 2007 and September 2011. For qualitative research purposes these participants were chosen on the basis of their established relationship with the researcher, experience of ZMHCPP, ZMHCPP client and adolescent intervention, insight into and willingness to discuss their perceptions of ZMHCPP client and adolescent intervention. The sample consisted of 24 participants, males and females, from Black, White and Indian population groups, with a reported age range of 23 to 60, and education level from masters to doctorate level.

#### **3.5.2.2. ZMHCPP Client Case**

For qualitative research purposes an 18 year old female participant was chosen on the basis of her established relationship with the one of the ZMHCPP practitioners, experience of receiving ZMHCPP client and adolescent intervention, insight into and willingness to discuss her perceptions of ZMHCPP client and adolescent intervention.

### **3.6. Questionnaires**

#### **3.6.1. Asset Section 8 Emotional and Mental Health Subscale**

YOS key workers use the Asset to rate YOS clients at various points during management, which includes pre and post YOS intervention. The Asset has subsections that produce subscale scores and a total score. The Asset informs case management and referrals to seconded workers (Asset, 2006). Section 8 of the Asset, which is the Emotional and Mental

Health Subscale (Appendix A), was used in this research. Clients were given a Likert type Emotional and Mental Health Subscale rating score between 0 and 4 as follows:

- 0 - Experiencing no difficulties
- 1 - Experiencing mild difficulties
- 2 - Experiencing moderate difficulties
- 3 - Experiencing severe difficulties
- 4 - Experiencing profound difficulties

### **3.6.2. Appreciative Inquiry**

Solutions to the following three questions were elicited from the WKYOS staff (see Appendix D): What is your experience of YOS child and adolescent mental health interventions? What did you appreciate about YOS child and adolescent mental health interventions? How can YOS child and adolescent mental health interventions be improved?

Solutions to the following three questions were elicited from the ZMHCPP practitioners and client (see appendix I): What is your experience of the ZMHCPP intervention? What did you appreciate about the ZMHCPP intervention? How can the ZMHCPP intervention be improved?

### **3.7. Data Collection**

Biographical data was collected from all participants. The researcher collected the WKYOS experimental group clients' pre and post WKYOS CAAMHP child and adolescent mental

health intervention Asset Emotional and Mental Health subscale score data from the WKYOS client data base system. Kent YOS data analysis and performance staff collected the matched control pre and post intervention sample Asset Emotional and Mental Health subscale score data from the WKYOS client data base system. The researcher collected the WKYOS staff qualitative data during visits to the WKYOS offices. The researcher collected the ZMHCPP practitioners' qualitative data during visits to the University of Zululand Psychology Department. Information for the ZMHCPP client case was provided by one of these practitioners.

### **3.8. Data Analysis**

The quantitative and qualitative data analysis of the triangulated approach is described below.

#### **3.8.1. Quantitative Data Analysis Method**

The following is an account of how the quantitative data was analyzed. Although the sample size was satisfied for parametric analysis, the population group was not normally distributed and parametric analysis of variance with repeated measures and paired samples t-tests could therefore not be undertaken effectively. Parametric statistics should not have been undertaken with the sample data as it was non-normally distributed and the probability of a Type 1 error would have been larger than the alpha level utilized (Heiman, 1996; Vickers, 2005). Non-parametric testing can yield valuable results. In such cases it cannot be assumed that the sample is normally distributed or representative of the population. Non parametric tests are distribution free tests (Kirkpatrick, 1981). Mann-Witney (non-parametric equivalent of t-test for two independent samples) and Wilcoxon Signed Ranks Tests (non-parametric equivalent



of t-test for dependent samples) was used to analyze the WKYOS experimental client groups' pre and post intervention Asset emotional and mental health subscale scores and the matched control sample Asset emotional and mental health subscale scores. All the quantitative data was analyzed using the SPSS statistical data analysis package.

### **3.8.2. Qualitative Data Analysis Method**

The qualitative data elicited through appreciative inquiry was explicated using content analysis. This method of appreciative inquiry was developed in the 1980s by David Cooperrider and his colleagues (Finegold, Holland & Lingham, 2002). It has subsequently been updated and utilized by researchers in various settings including multiagency health and social care environments and undertaken with individual, groups and communities (Carter, Cummings & Cooper, 2007; Graham-Pole & Lander, 2009; Madsen, 2009; McAdam & Mirza, 2009; Read, Pearson, Douglas, Swinburne & Wilding, 2002).

In terms of theoretical underpinnings appreciative inquiry is built upon postmodern social constructionist principles (Yoder, 2005). As a process it can be incorporated into various aspects of community psychology such as illness prevention and health promotion. It is an action based approach that values diversity and information sharing in the pursuit of a common goal (Boyd & Bright, 2007). It nourishes growth and development by enhancing capacity and optimal performance (Willoughby & Tosey, 2007). It allows for creativity and looks for new solutions. It focuses on strengths, is motivational and generates a feeling that change is important (Brenner, 2009; Michael, 2005). It shifts thinking from a negatives stance to a positive point of view so that solutions to problems can be found, thus changing the

manner in which systems operate (Bright, 2009; Moore, 2008). By creating positive change it helps people to reflect and prevent future negative shifts (Challis, 2009; Havens, 2006).

In this research positively phrased questions were asked of the 5 WKYOS staff, 24 ZMHCPP practitioners and ZMHCPP client. The qualitative data from the WKYOS staff and ZMHCPP and practitioners was coded and analyzed using content analysis. The major communication units, which were identified in this study, were meanings articulated in recorded words. Through content analysis counting (frequencies) was used to understand how frequently responses or pieces of information occurred within the qualitative data. A frequency of one indicated that the identified theme had occurred once within the data, a frequency of two twice etc.

The positively phrased questions from the ZMHCPP client was used in the client example and then incorporated into the WKYOS and ZMHCPP comparison.

### **3.9. Ethical Considerations**

Proper care was exercised with regard to ethical clearance from Kent County Council Ethics Committee in relation to collection of YOS staff and client data which was assisted by the Kent YOS data analysis and performance staff, University of Zululand Ethics Committee in relation to collection of ZMHCPP staff and client data with the client providing consent for her confidential report to be used, and necessary and appropriate ethical considerations such as information to participants, informed consent, confidentiality of client and staff communicated information and records. See appendices B, C, E, F, G and H. The questionnaires and data are securely kept. No names were divulged and each participant's

data was coded. Quantitative results were presented only in group format. All information was kept and presented in a confidential manner.

### **3.10. Résumé**

This methodology chapter is concerned with the design, measuring instruments, data analysis techniques and ethics of the study. The next chapter will cover the results of the study.

## CHAPTER FOUR

### RESULTS

#### 4.1. Introduction

This chapter provides the results of the theory driven research. It is divided into the case studies and comparison study sections.

#### 4.2. WKYOS Child and Adolescent Mental health Intervention Case Study

##### 4.2.1. YOS Child and Adolescent Mental Health Intervention Experimental and Control Group

**Table 2. Mean age pre and post intervention (comparative data) – experimental and control group (n=126)**

	Pre intervention		Post intervention	
	Mean	SD	Mean	SD
<b>Experimental group</b>	15.95	1.45	16.34	1.41
<b>Control group</b>	15.28	1.24	15.58	1.34

Table 2 refers to the age means and standard deviations for the experimental and matched control samples pre and post intervention. The experimental group had a total of 41 participants, which was comprised of 34 males and 7 females, compared to the control group who had a total of 85 participants, composed of 68 males and 17 females.

**Table 3. Pre and post intervention emotional and mental health scores (comparative data) - Mann-Witney Test for experimental and control group (n=126)**

	Pre intervention		Post intervention	
	Mean	SD	Mean	SD
<b>Experimental group</b>	2.12*	1.27	1.85	1.04
<b>Control group</b>	1.60	1.11	1.71	1.07

\* p<.05, \*\* p<.01

Table 3 refers to the means and standard deviations of the 41 experimental and 85 control group participants. Results compare pre and post test Asset emotional and mental health subscale score data. The Mann-Witney Test indicated significant differences at the 5% alpha level between experimental and control groups on pre test Asset emotional and mental health subscale scores ( $p = 0.019$ ). The Mann-Witney Test indicated no significant differences at the 5% alpha level between experimental and control groups on post test scores ( $p = 0.497$ ).

**Table 4. Pre and post intervention emotional and mental health scores - Wilcoxon Signed Ranks Test for experimental group (n=41)**

	Pre intervention		Post intervention	
	Mean	SD	Mean	SD
<b>Emotional and mental health score</b>	2.12	1.27	1.85	1.04

\* p<.05, \*\* p<.01

Table 4 refers to the means and standard deviations of the 41 experimental group participants pre and post intervention Asset emotional and mental health subscale scores. The Wilcoxon Signed Ranks Test indicated no significance at the 1% alpha level between pre and post intervention ( $p = 0.245$ ).

**Table 5. Pre and post intervention emotional and mental health scores - Wilcoxon Signed Ranks Test for control group (n=85)**

	Pre intervention		Post intervention	
	Mean	SD	Mean	SD
Emotional and mental health score	1.60	1.11	1.71	1.07

\* p<.05, \*\* p<.01

Table 5 refers to the means and standard deviations of the 85 control group participants' pre and post intervention Asset emotional and mental health subscale scores. The Wilcoxon Signed Ranks Test indicated no significance at the 1% alpha level between pre and post intervention ( $p = 0.264$ ).

#### **4.2.2. YOS Child and Adolescent Mental health Intervention Staff Interviews**

The following were the three appreciative inquiry questions which the WKYOS staff were asked to answer.

##### **4.2.2.1. What is your experience of YOS child and adolescent mental health intervention?**

A1. I have been on mental health training, so I feel I am able to recognize some forms of mental health, but generally I would refer a young person to our health worker to access their mental state of mind and take appropriate action. If we do not have a health worker I would refer to CAMHS.

A2. I have 6 years experience of working in the youth offending service. For the majority of this period in YOS there has not been a mental health worker, however for a period of 12 –

18 months there has been a health worker which has enabled me to make appropriate referrals and access health services.

A3. Referring young people as a professional.

A4. As a service we work closely with CAMHS – however intervention is vastly improved when a mental health worker is allocated to the team. As an educational officer I have worked closely with the mental health worker – supporting strategies suggested – especially when there are often links between education and health for example – personal management, cognitive behavioural therapy.

A5. As a case holder I referred many low level final warning cases to our allocated worker, all of which were followed up. The work that was done was excellent regarding safeguarding and movement on to other services.

**Table 6. What is your experience of YOS child and adolescent mental health intervention? (n = 5)**

Component	Response	Frequency
What is your experience of YOS child and adolescent mental health intervention?	➤ Much of the time before there was no health worker so accessed CAMHS directly	2
	➤ Referred to health worker	4
	➤ Work follow-up by health worker	1
	➤ Assessment	1
	➤ Safeguarding	1
	➤ Intervention and management	1
	➤ Worked closely with health worker	4
	➤ Accessing other health services improved	1

Table 6 refers to the 5 WKYOS staff's perceptions of YOS child and adolescent mental health intervention. Staff described that for a long time there was no CAAMHP so they accessed support directly from CAMHS. Since the introduction of a CAAMHP they referred clients to the CAAMHP and referrals were followed up in relation to assessment, safeguarding, intervention and management. Staff worked closely with the CAAMHP and access to other services also improved.

**4.2.2.2. What did you appreciate about YOS child and adolescent mental health intervention?**

A1. Knowing there is someone to share your concerns with, who can access further and offer a service to our young people and help support them in difficult times.

A2. I found that having a dedicated worker, who was not distracted by the criminal justice issues/workload was extremely beneficial. It was helpful that the health worker could provide specific assessments and then fast track referral to CAMHS, which is a particularly difficult service to access.

A3. Speed at getting support that is needed.

A4. I appreciate the support and understanding of behavioural/mental health issues. It allowed for clarity and consolidated professional knowledge. Joint visits/appointments with clients appeared to have more of an impact with regard to the young person's outcomes.

A5. Having someone to refer to in an area of expertise.



**Table 7. What did you appreciate about YOS child and adolescent mental health intervention? (N =5)**

Component	Response	Frequency
What did you appreciate about YOS child and adolescent mental health intervention?	➤ Dedicated health worker who can offer a service	2
	➤ Someone with expertise to share your concerns with	5
	➤ Joint visits had a positive impact	1
	➤ Someone to help you access other mental health services	3

Table 7 refers to the 5 WKYOS staff's perceptions of what they appreciated about WKYOS child and adolescent mental health intervention. Staff reported that they appreciated having a dedicated worker who could offer a service and someone who they could share their concerns with. They found joint visits to be beneficial. Staff appreciated having someone who could help them to access other mental health services.

#### **4.2.2.3. How can YOS child and adolescent mental health intervention be improved?**

A1. Have more workers across West Kent on a full time basis.

A2. I think having one worker per team, rather than sharing across two sites, is of great benefit to the service. The other way of improving the service would be through closer access to CAMHS a more immediate response to referrals from CAMHS service as it still seems there is a long waiting list for appointments.

A3. Helping young people to manage their situation. Need to not "label", thereby giving a name for behaviour or failure.

A4. To continue to value the role of mental health intervention which is essential for our young people. The knowledge of the mental health worker also allows for effective staff training/understanding of mental health issues which is essential for all involved in working with our clientele.

A5. By offering ongoing staff and supporting YOT in a partnership approach.

**Table 8. How can YOS child and adolescent mental health intervention be improved?**

(N = 5)

Component	Response	Frequency
How can YOS child and adolescent mental health intervention be improved?	➤ Continue to value the essential role and have ongoing health worker staff	2
	➤ More health workers across West Kent	2
	➤ Ongoing WKYOS staff training is essential	1
	➤ Closer access and more immediate response from CAMHS	2
	➤ Helping clients to manage situation without necessarily labelling them with a diagnoses	2

Table 8 refers to the 5 WKYOS staff's perceptions of how they felt WKYOS child and adolescent mental health intervention could be improved. They reported that they would like the role to continue to be valued, have ongoing staff seconded into WKYOS and increase staff numbers. Staff felt ongoing staff training on child and adolescent mental health was important. They reported that there should be even closer links with local CAMHS services and that client behaviour should be managed without it necessarily having to be labelled with a diagnosis.

#### **4.3. Zululand Mental Health Community Psychology Programme Case Study**

#### **4.3.1. Appreciative Inquiry of WKYOS Practitioners**

The following is the three appreciative inquiry questions which the WKYOS practitioners were asked to answer.

##### **4.3.1.1. What is your experience of ZMHCPP intervention?**

B1. I was part of the founding group of the ZMHCP. It was very successful in terms of social justice and human rights advocacy against the Apartheid system. The programme bridged segregation of previously and disadvantaged communities. It was effective for counselling and health promotion.

B2. My perception is that, it is helpful and it gives more exposure to psychological problems that need psychological interventions. However, it lacks proper supervision and structure in which psychological interventions are rendered.

B3. It is accessible and fairly reasonable!

B4. I've tried to make the most of this experience, although it's been very frustrating. The lack of organisation + the frustration levels have been difficult. The language barrier has been extremely challenging (I can't speak much Zulu).

B5. I really do not have experience of ZMHCPP interventions however from my observations it is scarce and limited to certain parts and areas e.g. in urban schools, university students

visit schools as part of their academic requirement, and in rural areas, unfortunately if there is no university nearby, they will not be visited.

B6. It is effective although I personally think it is not well marketed and communities are not well informed about it. Instead a number of people that have access, especially at (Unizul Community Psychology Clinic) are likely to be referred from Primary Health Care Services (i.e. Ngwelezane district hospital). There are few self referrals.

B7. The service is poor at times. Many more community members do not know about the services offered. It is, however a much needed service and people have benefitted from it.

B8. I have done my practicals as a student psychologist.

B9. I do not have any experience of the ZMHCPP.

B10. I think that the ZMHCPP has tried to formulate intervention strategies that meet the needs of our clients although there will always be gaps resulting from cultural differences, age differences, gender related issues and levels of knowledge in our communities.

B11. Honestly I perceive the service as being very poor, a lot of education is still required to broaden the understanding of these services specifically in rural areas. It seemed that the professionals are not quite happy with most if the remuneration.

B12. Rushed (needing to “do tests” to comply with university course requirements). Not well prepared enough both practically and academically. I have enjoyed being pro-active though. It has taught me better internal locus of control and I have enjoyed my supervisors a lot.

B13. There is a need to market services/clinics to the students and community at large. The clinic is not properly managed.

B14. It is very disorganized and under staffed. Facilities such as a basic chair and table are scarce. Sometimes it's very frustrating and a lot of ethical issues come up. I feel like I have learnt more about how to diagnose than intervene.

B15. Sometimes there was a language barrier (predominantly Zulu speaking clients) which makes interviewing difficult (English speaking student psychologist). Those whom we have intervened with, have been of benefit to us (academically) and to them....

B16. I worked with children in schools, as a counselling psychologist and, as a supervisor for psychology students that went to schools for psychological practicals.

B17. It has been quite comprehensive in terms of rendering service to the community and promotion of mental health.

B18. I don't have much experience of it, but know what I have observed is that we need a structured programme whereby people will be informed about the programme. I think even students know the university should utilize the clinic for their well-being purposes.

B19. Highly informative.

B20. My experience of the ZMHVPP is that, I have been exposed to quite a lot of their work specifically when suicide is dealt with. It's comprised of different professionals e.g. social workers, psychology and then those people deal together with child and adolescent problems.

B21. It is a very good programme that is aimed at helping people who are disadvantaged communicate by exposing them or raising their awareness when it comes to utilization of mental health services.

B22. No experience. I am not aware of its existence.

B23. I have not had much exposure to this.

B24. I have a feeling that it is really working and knowledge should be spread to the community about these services offered. I still feel that people are still ignorant and do not know exactly what the programme entails. But personally, I think it is a good and valuable programme that still needs to improve.

**Table 9. What is your experience of ZMHCPP intervention? (n = 24)**

Component	Response	Frequency
➤ What is your experience of ZMHCPP intervention?	➤ Part of founding group	1
	➤ ZMHCPP successful in terms of social justice and human rights advocacy during the Apartheid system	1
	➤ Bridged segregation of previously and disadvantaged communities	1
	➤ Comprised of multi-professionals	1
	➤ Effective counselling, psychological intervention, health promotion	4
	➤ Much needed service and people have benefitted from it	9
	➤ Children in schools	2
	➤ Increased my internal locus of control and being proactive	4
	➤ Done my practicals as a student psychologist	1
	➤ Expose to suicide work	1
	➤ Ethics issues arise	1
	➤ Tried to make most of my experience, however it has been frustrating	2
	➤ Sometimes a language barrier which makes interviewing difficult	2
	➤ ZMHCPP tried to formulate intervention strategies that meet needs of clients although there will always be gaps due to culture, age, gender and knowledge differences.	1
	➤ Students should use it for well being purposes	1
	➤ Still needs improvement	1
	➤ Not well marketed and communities not informed	8
	➤ Referrals from primary health care services and few self referrals	2
	➤ Lacks structure, organization and staffing	8
	➤ Lacks proper supervision	2
	➤ Learnt more about diagnosis than treatment	1
	➤ Poor services at times	2
	➤ Professionals not happy with remuneration	1
	➤ Limited, no experience of ZMHCPP interventions	6

Table 9 refers to the 24 ZMHCPP practitioners' perceptions of their experience of ZMHCPP in relation to child and adolescent mental health intervention. Practitioners spoke about the establishment of the programme to address previous injustices and bridge communities. They perceived it to be a multi-agency programme which was needed and effective, and benefited areas such as schools. They spoke about the work resulting in increased knowledge on aspects like managing suicidal clients in the community. Practitioners reported that ethical issues arose during practice. They mentioned that it was at times frustrating and that a language barrier was one aspect of difficulty. Practitioners said that there were gaps in the service, students should use it more and there was room for improvement with regards to structure, staffing, referrals and supervision. Diagnosis was sometimes over emphasised rather than treatment. They spoke about the service being poor at times and some staff members were not happy with remuneration. Although working within the ZMHCPP, some practitioners didn't know that this was the case or had limited understanding that this was the area they were actually working in.

#### **4.3.1.2. What did you appreciate about ZMHCPP intervention?**

B1. For many years the programme functioned very effectively as a community partnership intervention concerned with contexts of diversity within a diversity of contexts. It empowered, enriched and healed split + divided communities. Intern partnerships received great current training.

B2. It is accessible by the community, and the community is getting services they need. It has qualified professionals who are willing to help the community. We have the human resources that need to be structured well.



B3. It has a cultural relevance flavour in it and it is holistic.

B4. I think the difficult circumstances in Zululand force + encourage us to think out of the box in terms of intervention – I've learnt to appreciate this. I appreciate the cultural aspects of Zululand intervention.

B5. Not much since I personally lack the experience.

B6. It is reaching out to disadvantaged communities that could not access/afford costly sessions at Private Psych. rooms. I appreciate the fact that it also groom interns by exposing them so that I can learn the importance of considering the community & its needs.

B7. Community members who are in need of psychological services can get assistance at low or no cost.

B8. Other disciplines or professionals are always willing to help.

B9. The staff are mostly friendly and appreciative of what they are doing. So even when you do not get help you still feel important.

B10. The formulation differs in relation to age. This means appreciating differences in cognition and information processing of different individuals.

B11. The perseverance of the clients seeking help, although they notice the poor service from the places they still have faith that they will be assisted.

B12. Helping people in need. Making a difference, even if it seems small. Learning how to adapt and cope in situations where adequate resources are minimal. Experiencing more rural community based problems – grass roots understanding.

B13. There is a clinic & services available.

B14. I got quite a bit of insight about how things work in government settings. I got to interact and work with people of different races and cultural orientation.

B15. Exposure to a variety of clients – from hospitals through to children's homes

B16. It gives opportunity for the children that cannot afford private care (by psychologists) to get an opportunity to undergo professional therapeutic intervention.

B17. Is that is able to mutually tolerate cultural sensitive issues and also feeling the gap between psychology as a profession and descriptions of client's problems.

B18. The most thing I like about it is that to a certain extent it reaches some children around Zululand.

B19. The interaction with the people, and seeing psychology and the humanities live through the lecturers and visiting. Extra training in the clinical background esp. neuropsychology.

B20. Collaboration between the involved professionals from different professions.

B21. It helps disadvantages communities become aware of the mental health services that they can utilize when needed.

B22. No response.

B23. No response.

B24. It helps one gain insight about their problems which are not only unique but may be shared by other people in the same geographical or cultural milieu. So this programme helped promote insight to me about some of the challenges one has which this help also needs to spread to the general community.

**Table 10. What did you appreciate about ZMHCPP intervention? (n =24)**

Component	Response	Frequency
What did you appreciate about ZMHCPP intervention?	➤ Many years functioned very effectively as a community partnership intervention	2
	➤ Concerned with contexts of diversity and diversity of contexts	9
	➤ Focus on people	3
	➤ Reaching out to disadvantaged communities and children who couldn't access or afford sessions	9
	➤ Qualified professionals who are willing to help	4
	➤ Perseverance and faith of clients in service even if it is poor	1
	➤ Grooms interns to consider community and its needs	4
	➤ Cope in situations with minimal resources	2
	➤ Insight and working in hospitals, clinical to children's homes	3
	➤ Additional training re: neuropsychology	2
	➤ Human resources which need to be well structured	1
	➤ Gap between psychology as profession and description of client's problems	1
	➤ Lack the experience	1

Table 10 refers to the 24 ZMHCPP practitioners' perceptions of what they appreciated about ZMHCPP in relation to child and adolescent mental health intervention. Staff appreciated that for many years it had worked effectively, was concerned with culture and contexts, focused on people and reached out to the community who would not otherwise have had access to services. They reported that professionals wanted to help clients and clients and patients had faith in the service. They said that the ZMHCPP helps students to consider the community, cope in difficult situations, understand settings, gain experience, understand the value of

structure, and recognize gaps in knowledge and practice. Some practitioners reported that they had little experience of it.

#### **4.3.1.3. How can ZMHCPP be improved?**

B1. Somehow the basic community psychology principles of psychology by, with, of and for the community became less emphasized as focus turned more to professional, political and economic issues. However recently there has been a resurgence towards and more humane moral and ethical relationships and standards. This should always be a main/core/essential focus, the focus should be on ubunhlobonhlobo (diversity in all its relatedness) and ingqikithi (essential context). With more coordination and improved infrastructure the ZMHCPP should go from strength to strength. From its inception it was concerned with development and empowerment of rural, disadvantaged area from 1982 onwards. Once established as a recognized training programme for clinical and counselling psychologists as from 1993 it later lead to the development of the PhD in Community Psychology.

B2. The programme needs to be introduced to other health facilities/departments (e.g. Department of Health) and to be marketed.

B3. By formally including some of the qualified indigenous/traditional healers in the teaching team. It should also be well advertised for the benefit of the society especially peoples from disadvantaged backgrounds.

B4. It could be improved if the facilities were more organised and if the people (lectures, hospital staff) were more motivated. Also if the clinic was more organized and it had more structure.

B5. The government should provide resources and hopefully employ psychologist so that there are as many as there are teachers and nurses.

B6. Be advertised more. Access shouldn't be limited, i.e. it can be opened 24 hours, where intern and masters students can be allocated times for their duty. This can work as 24 hour crisis line. Campus students hardly know about it, this is why they go to primary health care and sometimes do not get their problems solved.

B7. More tests are needed at the psychology clinic. It is not as accessible to the community as needed.

B8. The facilities and resources could be improved. There could be more rooms that are conducive for conducting therapy and psychological assessment.

B9. Well I think the government has to offer more resources in terms of training, provision of services. It must also get to be advertised in order for the communities to be aware that those services are available.

B10. Our interventions are still culturally unfair, most of the methods used are western, and when being translated, lose original meaning, or becomes unable to meet the standards of certain clients.

B11. More qualified professionals must be provided. The government must spend money to save the nation.

B12. Better organization of the university clinic (at present we “look for” our own clients) (the secretary is frequently out and we don’t get clients). Government organization i.e. attention to the working conditions in government hospitals.

B13. Need to market services to community/university. Need for a full-time staff member who is readily available and answers incoming calls from the community. There is a need for a manager who will be responsible for the clinic management. Play room for play therapy to be established.

B14. More structure should be provided so that students get a better understanding of how to intervene and what is expected of them.

B15. By having an always available secretary.....someone manning the phone.

B16. This can be improved if support services for adults/parents can be provided alongside with these of young people.

B17. By outreach programmes focusing on community mental health programmes/model. Provision of resources. Also include masters students for participation.

B18. It should not be more theoretical. There should be a community outreach programme so that people will know about the services offered in the clinic. Intern psychologists should

conduct workshops to inform university students about the services offered because there are a number of students experiencing emotional and psychological challenges but are not getting help.

B19. More structure, better organization, more communication with students from lecturers. A formal detailed schedule made available at the beginning of the year to students regarding what they will study.

B20. Must be advertised.

B21. It can be improved by doing a lot of awareness around communities so that people know that help is available if they have issues around mental health problems.

B22. No response.

B23. More awareness needs to be done to promote this programme. The one for Unizul is not well structured and promoted. I don't think it is serving its purpose.

B24. I still feel that people around KwaDlangezwa and Esikhawini still needs more psychoeducation and be taught about the importance of these programmes and how they can actually benefit from them. There's still a stigma around accessing or asking for psychological services. So until we reach out to the communities and educate them about psychological services, then and only then the programme is going to improve because it's actually for the people.



**Table 11. How can ZMHCPP be improved? (N =24)**

Component	Response	Frequency
How can ZMHCPP be improved?	➤ Emphasis shifted from more community focused to economic focused, but Resurgence towards moral and ethical relationships and principles which should always be main focus and main focus should also be on diversity in all its relatedness and context as from inception was concerned with development and empowerment	1
	➤ Recognised as professional and PhD training programmes	1
	➤ Programme needs to be introduced to other facilities/departments	3
	➤ Support services for adults/parents alongside children services	1
	➤ Should be well advertised	16
	➤ Open 24 hours	1
	➤ More organized	7
	➤ More tests and facilities needed in clinic	5
	➤ Government funding	3
	➤ More qualified professionals	8
	➤ Interventions still western orientated and culturally unfair	1
	➤ Introduce qualified indigenous/traditional healers into teaching programme	1
	➤ Not be more theoretical	1

Table 11 refers to the 24 ZMHCPP practitioners' perceptions of what could be improved in relation to ZMHCPP child and adolescent intervention. Staff reported that the programme became more economically focused but has shifted back to being for the people. They felt that programme should grow and develop and that there needs to be an increased awareness of the programme. Practitioners reported that more structure and physical resources are needed. They thought that more funding and staffing are required. Practitioners felt that the programme must continue to be culturally and practically focused.

#### **4.3.2. Client Case of Child and Adolescent Mental Health Intervention (Appendix J)**

Julia (pseudoname) was an 18 year old black Zulu female who had started studying nursing at UNIZUL who self referred to one of the ZMPCPP sites, the UNIZUL Community Psychology Clinic, due to symptoms of depression including suicidal ideation following the loss of her grandfather who she was close to. Julia lived with extended family who had their own difficulties. She reported having poor family and partner relationships and felt she had a lack of social support.

An Eclectic Approach was used to provide intervention to Julia. Through Rogerian Person Centered Therapy Julia was able to reflect on her grandfather's passing away as being a way of life and was able to understand her own life choices. The therapist displayed genuineness, unconditional positive regard, acceptance, accurate empathetic understanding, listening and "being" with her. An existential approach helped Julie to make life choices and develop in therapy and Cognitive Behavioural Therapy was used to assist Julie with her negative thinking patterns.

The following is Julia's appreciative inquiry of the ZMHCPP child and adolescent intervention which she received.

##### **4.3.2.1. What is your experience of the ZMHCPP?**

It has helped me to grow as a person. I feel I can be open and express my emotions during counselling. I can't do this with my friends and family.

#### 4.3.2.2. What did you appreciate about the ZMHCPP intervention?

It has helped me to become a less negative person about myself.

#### 4.3.2.3. What can the ZMHCPP intervention be improved?

Tell more people on campus that help is available.

**Table 12. International Comparison of Appreciative Inquiries (comparative data) - for WKYOS and ZMHCPP (n = 30)**

Component	WKYOS	ZMHCPP
What was your experience of the WKYOS child and adolescent mental health intervention/ZMHCPP?	<ul style="list-style-type: none"><li>➤ Much of the time there was no health worker so accessed CAMHS</li><li>➤ Referred and closing working, to health worker</li><li>➤ Assessment, intervention, management</li></ul>	<ul style="list-style-type: none"><li>➤ Reason for service</li><li>➤ Effective and needed</li><li>➤ Increased my internal locus of control</li><li>➤ Structure, staffing</li><li>➤ Not well marketed and communities not informed</li></ul>
What did you appreciate about the WKYOS child and adolescent mental health intervention /ZMHCPP intervention?	<ul style="list-style-type: none"><li>➤ Dedicated worker</li><li>➤ Share work</li><li>➤ Increase linking with other services</li></ul>	<ul style="list-style-type: none"><li>➤ Many years functioned very effectively</li><li>➤ Concerned with contexts of diversity and diversity of contexts</li><li>➤ Focus on people</li><li>➤ Training</li></ul>
What can the WKYOS child and adolescent mental health intervention/ ZMHCPP intervention be improved?	<ul style="list-style-type: none"><li>➤ Keep staff</li><li>➤ More staff</li><li>➤ Ongoing training</li><li>➤ More linking</li><li>➤ Shift away from diagnosis</li></ul>	<ul style="list-style-type: none"><li>➤ Focus should also be on people</li><li>➤ Develop</li><li>➤ Structure, advertise</li><li>➤ More qualified professionals</li></ul>

Table 12 is a comparison of the appreciative inquiries of the WKYOS staff on child and adolescent mental health intervention and ZMHCPP practitioners on child and adolescent intervention. The WKYOS staff reported that service did not have a long history of practitioners, the WKYOS CAAMHP did assessment and intervention and colleagues worked closely with the CAAMHP once the post was established. Links with other mental health

services were made, and the goal was to keep, increase and develop staff. The ZMHCPP practitioners reported that the programme grew out of the situation in Zululand during the apartheid era, was effective, focused on culture but was not well structured and people were not that well informed about the programme. They felt the goal was to remember to keep focusing on the people, develop the structure and staff and increase awareness of the ZMHCPP.

#### **4.4. Résumé**

This chapter provided the data results. The next chapter will integrate the results and present the discussion and conclusion of the study.

## **CHAPTER FIVE**

### **DISCUSSION AND CONCLUSION**

#### **5.1. Introduction**

This chapter provides the discussion and conclusion for the study, outlines the limitations, and suggests recommendations for future research.

#### **5.2. Discussion**

##### **5.2.1. Case study of West Kent YOS Child and Adolescent Mental Health Intervention**

###### **5.2.1.1. WKYOS CAAMHP Intervention Experimental and Matched Control Sample**

The quantitative results indicated significant differences between experimental and control groups on pre test Asset emotional and mental health subscale scores but no significant differences on post-test Asset emotional and mental health subscale scores. This was due to a decrease in pathology in terms of Asset emotional and mental health subscale scores for the experimental group at post test and a slight increase of the post test pathology in terms of Asset emotional and mental health subscale scores for the matched control sample. This is in keeping with the hypothesis that there would be a positive shift in Asset emotional and mental health subscale scores for the experimental group who received intervention. Previous literature has highlighted the benefit of having YOS CAAMHPs and YOS child and adolescent mental health interventions being provided (Edwards, 2009; Key Elements of

Effective Practice - Mental Health (KEEP), Smith, 2005; Youth Justice Board, 2008; Perry, Gilbody, Akers & Light, 2008). It supports the motivation to have a YOS West Kent CAAMHP and increase WKYOS Child and Adolescent Mental Health Intervention (Kent Joint inspection of Youth Offending Teams of England and Wales. Report on: Kent Youth Offending Service, 2008).

The results indicated no significant differences for Asset emotional and mental health subscale scores for the experimental group participants before and after the intervention period. This may have been due to the sample being of moderate size. As indicated in the literature it may have also been due to some clients experiencing difficulty in engaging with intervention and other clients still being affected by various extraneous bio-psycho-social-cultural stressors and factors at post testing (In too deep with the wrong crowd, 2007; Key Elements of Effective Practice - Mental Health, Youth Justice Board, 2008; Perry, Gilbody, Akers & Light, 2008).

The results indicated no significant differences for Asset emotional and mental health subscale scores for the control group participants before and after the intervention period. Results indicated a small increase in psychopathology in terms of overall Asset emotional and mental health subscale scores. This change might not have been evident had the sample size been larger. It does provide additional motivational for more WKYOS CAAMHPS to be employed and further staff training on child and adolescent mental health intervention to be undertaken.

#### **5.2.1.2. WKYOS Staff's Perceptions of YOS Child and Adolescent Mental Health Intervention**

Staff described that for a long time there was no WKYOS CAAMHP so they accessed support directly from CAMHS. This is in keeping with previous studies indicating a lack of YOS CAAMHPs (Harrington et al., 2005; Health Needs Assessment of Young People in London with complex emotional, behavioural and mental health problems who are or may be at risk of committing a serious crime, 2010; Kent Joint inspection of Youth Offending Teams of England and Wales. Report on: Kent Youth Offending Service, 2008). Following the introduction of a WKYOS CAAMHP in July 2008 staff referred clients to this CAAMHP and referrals were followed up in relation to assessment, safeguarding, intervention and management. This is an example of the utilization of the mental health model in practice. Staff worked closely with the CAAMHP and access to other services improved. Literature has highlighted the importance of joint service working and transition between services (Key Elements of Effective Practice - Mental Health, Youth Justice Board, 2008; Perry, Gilbody, Akers & Light, 2008).

WKYOS staff reported that they appreciated having a dedicated worker who could offer a service. This further justified having the WKYOS CAAMHP (Harrington et al., 2005; Health Needs Assessment of Young People in London with complex emotional, behavioural and mental health problems who are or may be at risk of committing a serious crime, 2010; Kent Joint inspection of Youth Offending Teams of England and Wales. Report on: Kent Youth Offending Service, 2008; Key Elements of Effective Practice - Mental Health, Youth Justice Board, 2008; Perry, Gilbody, Akers & Light, 2008). They appreciated having someone with whom they could share their concerns and do home visits. Joint input and multi disciplinary working is an important part of WKYOS CAAMHP input and WKYOS child and adolescent mental health intervention (Edwards, 2009). They appreciated having a practitioner who could help improve access to other mental health services. The importance of joint working

with other service is invaluable (Key Elements of Effective Practice - Mental Health, Youth Justice Board, 2008; Perry, Gilbody, Akers & Light, 2008).

WKYOS staff reported that they would like the CAAMHP role to continue to be valued, have ongoing staff seconded from the Kent and Medway National Health Service (NHS) and Social Care Partnership Trust into WKYOS and increase the number of WKYOS CAAMHPs. This is in keeping with the literature that YOS CAAMHPs are valued but that there are insufficient numbers of YOS CAAMHPs (Harrington, et al., 2005, which was summarised as The Mental Health Needs and Provision, Summary, a Report by Manchester University on mental health needs and provision, 2010; Health Needs Assessment of Young People in London with complex emotional, behavioural and mental health problems who are or may be at risk of committing a serious crime, 2010). Staff felt ongoing staff training on child and adolescent mental health intervention was important. This is similar to the literature on staff training undertaken by YOS CAAMHPs within YOS (Edwards, 2009). They reported that there should be even closer links with local CAMHS services. Studies have identified the importance of working with other mental health services (Key Elements of Effective Practice - Mental Health, Youth Justice Board, 2008; Perry, Gilbody, Akers & Light, 2008). Staff felt that behaviour should be managed without it necessarily having to be labelled as a diagnosis. As previously discussed understanding the person is an important aspect of community psychology (Owusu-Bempah & Howitt, 2002). This reflects the shift in some aspects of United Kingdom and WKYOS child and adolescent mental health intervention from being primarily focused on the mental health model to being concerned with other models like the phenomenological model of enhancing experiential relationships.

### **5.2.2. ZMHCPP Child and Adolescent Mental Health Intervention Case Study**



Practitioners appreciated the establishment of the programme to address previous injustices and bridge communities. This has been outlined in previous papers on the aim of the ZMHCPP (Edwards, 2002a, 2002b, 2011). It further highlights the use of the liberatory and social action models within the Zululand area during the apartheid era. Practitioners perceived it to be a multi-agency programme which was needed and effective and benefited areas such as schools. Various schools in the Zululand area are part of the ZMHCPP and play a key role in the development of emotional and mental health of children and adolescents in Zululand (Edwards, 2011). They spoke about ZMHCPP work resulting in increased knowledge on aspects like managing suicidal clients in the community. They discussed that ethical issues arise whilst working in the community. Community psychology ethics is an important part of practice where it is essential to be respectful (Ivey, D'Andrea, Ivey & Simek-Morgan, 2002; Ngcobo & Edwards, 2008). Practitioners mentioned that the work was sometimes frustrating and that a language barrier was one aspect of difficulty. Understanding language and culture are key components which psychologists face when working in the community (Hirsh, Levine & Miller, 2007; Kelly, 2007; Pillay, 2003).

Some practitioners felt that they learnt more about diagnosis than treatment. Other practitioners spoke about some staff not being happy with remuneration. Although working within the ZMHCPP a few practitioners didn't know that this was the case or had limited understanding that this was the area they were actually working in. These points reflect some shift towards increased usage of the mental health and organizational models in South Africa as the economy develops and somewhat of a shift away from the original aim of the ZMHCPP which was for it to be people focused.

ZMHCPP practitioners' appreciated that for many years the ZMHCPP had worked effectively, was concerned with culture and context, focused on people and reached out to the community who would not have otherwise had access to services. They highlighted how professionals are willing to help and clients have faith in the service. This is in keeping with previous literature and research on the establishment of the ZMCHPP (Edwards, 2002a, 2002b, 2011). They acknowledged that it helps students to understand the principles and practice of community psychology in relation to understanding settings, coping in diverse situations, working towards filling gaps in knowledge and community practice. This is similar to previous literature on how working in the community provides students the opportunity to understand communities and be people focused (Hirsh, Levine & Miller, 2007; Kelly, 2007; Pillay, 2003).

The ZMHCPP practitioners reported that it became more economically orientated and then returned to being people orientated. This shift back indicates how the use of paradigms and models to inform intervention is dependent upon context, time and the people involved. They felt that the programme should grow and develop through increased awareness, more structure and physical resources, further funding and additional staffing. Practitioners also stated that it needs to remain appropriately culturally and practically focused. These were and should remain the key elements of the programme (Edwards, 2002a, 2002b, 2011).

Julia's case example demonstrated the benefit which clients received from receiving ZMHCPP child and adolescent intervention and the various intervention techniques which can be employed. This is in keeping with previous research on community psychology, interventions and practice (Axline, 1947; Eagle, 1998; Edwards, 2002a, 2002b, 2011; Hagan & Smail, 1997a, 1997b; Hajiyanis & Robertson, 1999; Jacobson, 1976; Loehr & Migdow,

1999; Meichenbaum, 1985; Ndlovu, 2001; Reid, 1989; Sherwood, 2004, 2007a, 2007b; Tagar, 1996a, 1996b, 1998, 2001).

### **5.2.3. International Comparative Studies**

There are a number of similarities between the services. ZMHCPP and WKYOS are community interventions, which use a variety of paradigms and models to inform intervention, and offer a service to vulnerable children and adolescents.

In terms of differences the WKYOS service has traditionally operated more from a mental health model but there is a shift towards other models also being utilized. It does not have a long history of CAAMHP practitioners. The aim was to retain existing CAAMHP staff, increase CAAMHP staff, improve links with other mental health services and continue to train YOS staff on child and adolescent mental health intervention. This is in keeping with YOS literature (Key Elements of Effective Practice - Mental Health, Youth Justice Board, 2008; Harrington, et al., 2005; Health Needs Assessment of Young People in London with complex emotional, behavioural and mental health problems who are or may be at risk of committing a serious crime, 2010; Perry, Gilbody, Akers & Light, 2008). The ZMHCPP grew out of mass democratic, anti apartheid and human rights movements in Zululand. Liberatory and social action models were mostly utilized during its inception. It has an action orientated and multi cultural approach which is effective in staff development and community intervention. There has been a shift towards more usage of mental health and organizational models. Practitioners felt that the aim should be to retain focus on culture, the people, community development, illness prevention and health promotion, improve structure and

increase staff. This is in keeping with ZMHCPP literature (Edwards, 2002a, 2000b, 2011) and provides specific recommendations.

South African child and adolescent mental health services and ZMHCPP in particular could learn from the way in which many United Kingdom child and adolescent mental health services and WKYOS are very structured and systemic and the benefits which the mental health and organization models can bring to a service. United Kingdom child and adolescent mental health services and WKYOS in particular could learn from the way in which a number of South African child and adolescent mental health services and ZMHCPP in particular are focused on intervention being more people and community orientated and the benefits of the phenomenological and ecological models.

It was evident how the mental health and organizational models have been relatively more employed in the United Kingdom and WKYOS in particular due to services taking place in an economically developed country. However there is shift towards use of other models such as the phenomenology model. Similarly the liberatory and social action models were used in a number of South African and ZMHCPP community settings during the apartheid era. Since the end of apartheid there has now been an increase in emphasis on other models such as the mental health and organizational model in South Africa owing to improved democracy, constitutional entrenchment of a human rights culture and economical development. New models need to be created and evaluated. They also need to be compared in different contexts, which was one dimension of this thesis. This adds to the work by Edwards (2002a, 2000b) on evaluating models of community psychology: social transformation in South Africa.

### **5.3. Conclusion**

There is a great need for international comparative studies due to endemic and increasing illness, disease, violence and poverty. The United Kingdom and South Africa have strong historical links. Community psychology is undertaken in both countries. A variety of paradigms and model are used in the United Kingdom and South Africa. The mental health and organizational models have been used more to inform intervention in the health system in the United Kingdom. During the apartheid era the liberatory and social action model were utilized in a number of community interventions in South Africa. Children and adolescents are vulnerable groups that can have many complex needs. This study provided a unique opportunity to undertake international comparative research and complete a theory driven comparative case study of WKYOS and ZMHCPP child and adolescent mental health interventions.

The WKYOS clients' emotional and mental health scores improved in comparison to a matched control sample that did not received intervention. The WKYOS staff valued having a WKYOS CAAMHP, joint working, training and enhanced relationships with other mental health services. They felt that the role should be continued to be valued and more YOS CAAMHP staff should be employed. A shift in some use of other models other than the mental health model such as the phenomenological model was evident.

ZMHCPP practitioners felt the programme provided valuable culturally focused community interventions to children and adolescents, helped staff to develop, but that awareness, structure and staffing matters needed attention and that the focus on culture, community and

humanity should not be lost. Evidence of a shift in more use of models such as the mental health and organizational model was evident.

The WKYOS service could learn from the way in which ZMHCPP services are provided to clients so that they own the service and it is community orientated. The ZMHCPP project could learn from the way in which WKYOS services are very structured particular in terms of staffing and practice.

The study highlighted that various models are often used to inform interventions but that some models are focused on more than others depending on context, time and people. It re-emphasized the importance of evaluating existing models, creating new models and comparing models.

#### **5.4. Limitations of the Study**

The original sample of WKYOS experimental group clients who were managed by the WKYOS CAAMHP from July 2008 to August 2009 was 85 but due to incomplete Asset scales data from 44 of these participants could not be used. Previous research has identified incomplete Assets as an area which requires improvement in YOS services and this research supports that literature (Harrington et al., 2005; Mental Health Needs and Provision, Summary, Source, a Report by Manchester University on mental health needs and provision, 2010; Health Needs Assessment of Young People in London with complex emotional, behavioural and mental health problems who are or may be at risk of committing a serious crime, 2010).

As previously discussed, one of the difficulties of undertaking international comparative studies is coordinating such studies. Although not written up in the thesis aims, original intention was to collect quantitative and qualitative data from WKYOS and ZMHCPP clients. Collecting qualitative feedback from WKYOS clients as well as pre and post test emotional and mental health rating scores for ZMHCPP clients was not feasible due to logistical issues. This is therefore seen as a limitation as the study was not as rigorous as it could have been.

### **5.5. Recommendations**

It is recommended that more international comparative studies are undertaken which focus on a variety of services and cover a number of paradigms and models. It is recommended that new paradigms and models are created and that existing models are continuously evaluated. WKYOS and ZMHCPP should take into account the aspects which each service could learn from the other. YOS Assets should be completed by key workers as incomplete Assets might affect future studies. Key role players from the various ZMHCPP sectors should discuss the recommendations for the service highlighted by the ZMHCPP practitioners. It is recommended that process and outcome quantitative and qualitative data is collected on a regular and more ongoing basis at both the West Kent Youth Offending Service and Zululand Community Psychology Mental Health Programme and that staff regularly provide input and complete appreciative inquiries into the programmes that inform service delivery and programme development.

### **5.6. Résumé**

This chapter covered the discussion and conclusion. The references and appendices follow.

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## **APPENDICES**

### **Appendix A**

#### **Section 8 of Asset: Emotional and Mental Health Subscale**

##### **Pre-test**

- 0 - Client experiencing no difficulties
- 1 - Client experiencing mild difficulties
- 2 - Client experiencing moderate difficulties
- 3 - Client experiencing severe difficulties
- 4 - Client experiencing profound difficulties

##### **Post-test**

- 0 - Client experiencing no difficulties
- 1 - Client experiencing mild difficulties
- 2 - Client experiencing moderate difficulties
- 3 - Client experiencing severe difficulties
- 4 - Client experiencing profound difficulties

## **Appendix B**

### **Staff information letter**

Youth Offending Service

West Kent Area

Croft House, East Street

Tonbridge, Kent, TN9 1HP

Tel: (01732) 362442

Joynes House, New Road

Gravesend, Kent DA11 0AT

Tel: (01474) 328664

davidjohn.edwards@kent.gov.uk

## **A COMPARATIVE EVALUATION OF CHILD AND ADOLESCENT MENTAL HEALTH INTERVENTIONS IN THE UNITED KINGDOM AND SOUTH AFRICA**

Dear participant we are asking you to help evaluate child and adolescent mental health intervention within a youth offending service (YOS). Participation is completely voluntary and participants must be able to provide consent for themselves in order to participate in the study.

You will be asked to complete questions about child and adolescent mental health intervention within a youth offending service.

All participants' information will be kept confidential. Participants are free to withdraw at any stage of the process.

If you have any questions feel free to contact me on either of the above telephone numbers or email address.

Many thanks

David John Edwards

## **Appendix C**

### **Staff consent form**

Youth Offending Service

West Kent Area

Croft House, East Street

Tonbridge, Kent, TN9 1HP

Tel: (01732) 362442

Joynes House, New Road

Gravesend, Kent DA11 0AT

Tel: (01474) 328664

davidjohn.edwards@kent.gov.uk

## **A COMPARATIVE EVALUATION OF CHILD AND ADOLESCENT MENTAL HEALTH INTERVENTIONS IN THE UNITED KINGDOM AND SOUTH AFRICA**

### **CONSENT TO PARTICIPATE IN RESEARCH**

Dear participant, we are asking you to take part in this research so that we can evaluate child and adolescent mental health intervention within a youth offending service (YOS).

This research will be conducted by David John Edwards.

Participants must be able to provide consent for themselves. If you agree to participate in this study you will be asked to complete three qualitative questions.

If you agree to participate you will be increasing the understanding of child and adolescent mental health practitioner intervention within a youth offending service.

Participation is completely confidential. The data may be used for future research, but no names will be kept with the data.

If you decide to participate you can withdraw at any stage of the process.

You may ask any questions about the study. David John Edwards can be contacted on the above telephone numbers or email address.

Signing your name means that you agree to participate in this study.

I,.....agree to participate in this study about the child and adolescent mental health practitioner intervention within a youth offending service. I understand that participation is entirely voluntary, confidential, that I can withdrawal at any time and that the nature of the research has been explained to me. If I have any questions I can contact David John Edwards on the above telephone numbers or email address.

.....

Signature of Participant

.....

Date

## **Appendix D**

### **Questionnaire**

Youth Offending Service

West Kent Area

Croft House, East Street

Tonbridge, Kent, TN9 1HP

Tel: (01732) 362442

Joynes House, New Road

Gravesend, Kent DA11 0AT

Tel: (01474) 328664

davidjohn.edwards@kent.gov.uk

## **A COMPARATIVE EVALUATION OF CHILD AND ADOLESCENT MENTAL HEALTH INTERVENTIONS IN THE UNITED KINGDOM AND SOUTH AFRICA**

### **Biographical information**

Age:

Gender:

Ethnic group (e.g. White, Mixed Race, Black African):

Educational level (e.g. year at school or college):

### **Questions**



What is your experience of YOS child and adolescent mental health intervention?

What did you appreciate about YOS child and adolescent mental health intervention?

How can YOS child and adolescent mental health intervention be improved?

## **Appendix E**

### **Client information letter**

Department of Psychology

University of Zululand

P. Bag X1001

KwaDlangezwa

3886

South Africa

(035) 9026602

davidjohn.edwards@kent.gov.uk

### **A COMPARATIVE EVALUATION OF CHILD AND ADOLESCENT MENTAL HEALTH INTERVENTIONS IN THE UNITED KINGDOM AND SOUTH AFRICA**

Dear participant we are asking you to help us evaluate Zululand mental health community psychology programme (ZMHCPP) intervention. This research will be conducted by myself, David John Edwards, with the assistance of ZMHCPP staff. Your participation is completely voluntary, which means you can choose to participate or not participate in the study. You must be able to provide consent for yourself in order to partake in the research.

If you are part of the intervention group your, before and after child and adolescent mental health intervention, rating scores will be utilised in the study. You will also be asked to complete three questions about ZMHCPP intervention. These questions are: What is your

experience of the ZMHCPP intervention? What did you appreciate about the ZMHCPP intervention? How can the ZMHCPP intervention be improved?

If you are part of the control group then you will be asked to rate yourself at the pre- and post-testing time point. Intervention provision will be available for all participants who would like intervention.

You are free to withdraw at any stage of the process. Participation is completely confidential. All your information will be kept confidential. The data may be used for future research, but no names will be kept with the data. If you agree to participate you will be increasing the understanding of Zululand mental health community psychology programme intervention. You may ask any questions about the study. I can be contacted on the above telephone numbers or email address.

Many thanks

David John Edwards

## **Appendix F**

### **Client consent form**

Department of Psychology

University of Zululand

P. Bag X1001

KwaDlangezwa

3886

South Africa

(035) 9026602

davidjohn.edwards@kent.gov.uk

## **A COMPARATIVE EVALUATION OF CHILD AND ADOLESCENT MENTAL HEALTH INTERVENTIONS IN THE UNITED KINGDOM AND SOUTH AFRICA**

I confirm that I have read or had the information sheet read to me. I confirm that

☐

I understand the information sheet and that I have had an opportunity to ask  
questions about the study.

I understand that my information will be kept confidential and presented in an  
anonymous way.

☐

I understand that participation is voluntary and that I can withdraw from the study at any stage.

☐

I give consent to be part of the study.

☐

.....  
Signature of Participant

.....  
Date

## **Appendix G**

### **Staff information letter**

Department of Psychology

University of Zululand

P. Bag X1001

KwaDlangezwa

3886

South Africa

(035) 9026602

davidjohn.edwards@kent.gov.uk

## **A COMPARATIVE EVALUATION OF CHILD AND ADOLESCENT MENTAL HEALTH INTERVENTIONS IN THE UNITED KINGDOM AND SOUTH AFRICA**

Dear participant we are asking you to partake in an evaluation of Zululand mental health community psychology programme (ZMHCPP) intervention. Participation is completely voluntary and participants must be able to provide consent for themselves in order to participate in the study.

You will be asked to complete questions about Zululand mental health community psychology programme intervention.

All participants' information will be kept confidential. Participants are free to withdraw at any stage of the process.

If you have any questions feel free to contact me on the above telephone number or email address.

Many thanks

David John Edwards

## **Appendix H**

### **Staff consent form**

Department of Psychology

University of Zululand

P. Bag X1001

KwaDlangezwa

3886

South Africa

(035) 9026602

davidjohn.edwards@kent.gov.uk

## **A COMPARATIVE EVALUATION OF CHILD AND ADOLESCENT MENTAL HEALTH INTERVENTIONS IN THE UNITED KINGDOM AND SOUTH AFRICA**

### **CONSENT TO PARTICIPATE IN RESEARCH**

Dear participant, we are asking you to take part in this research so we can evaluate Zululand mental health community psychology programme (ZMHCPP) intervention.

This research will be conducted by David John Edwards.



Participants must be able provide consent for themselves. If you agree to participate in this study you will be asked to complete three qualitative questions.

If you agree to participate you will be increasing the understanding of Zululand mental health community psychology programme intervention.

Participation is completely confidential. The data may be used for future research, but no names will be kept with the data.

If you decide to participate you can withdraw at any stage of the process.

You may ask any questions about the study. David John Edwards can be contacted on the above telephone number or email address.

Signing your name means that you agree to participate in this study.

I,.....agree to participate in this study on Zululand mental health community psychology programme (ZMHCPP) intervention. I understand that participation is entirely voluntary, confidential, that I can withdrawal at any time and that the nature of the research has been explained to me. If I have any questions I can contact David John Edwards on the above telephone number or email address.

.....

Signature of Participant

.....

Date

## **Appendix I**

### **Questionnaire**

Department of Psychology

University of Zululand

P. Bag X1001

KwaDlangezwa

3886

South Africa

(035) 9026602

davidjohn.edwards@kent.gov.uk

## **A COMPARATIVE EVALUATION OF CHILD AND ADOLESCENT MENTAL HEALTH INTERVENTIONS IN THE UNITED KINGDOM AND SOUTH AFRICA**

### **Biographical information**

Age:

Gender:

Population group (e.g. Black, White):

Educational level (e.g. year at school):

### **Questions**

What is your experience of the ZMHCPP intervention?

What did you appreciate about the ZMHCPP intervention?

How can the ZMHCPP intervention be improved?

## **Appendix J**

### **Confidential Psychological Report**

#### **Identifying data**

Name:	Julia (pseudoname)
Gender:	Female
Age:	18
Date of birth:	1991
Date of report:	
Home language:	isiZulu
Referral reason:	Psychological difficulties
Nature of assessment:	Therapy
Dates of therapy:	26/08, 2/09, 27/9
Referral source:	Self-referral

#### **Referral reason**

Julia referred herself for therapeutic intervention due to her psychological distress of not coping in her life emotionally since the passing away of her grandfather. She was presenting with depressive symptoms, feelings of chronic emptiness and experienced suicidal ideations.

#### **Relevant background information**

Julia is a first year nursing student at the University of Zululand. She lives with her aunt, uncle and their three children, who have been diagnosed with childhood autism. Previously to starting university she lived with her mother, grandmother and grandfather. Since the passing

away of her grandfather in 2008 she has experienced extreme psychological distress. Julia reported that she had a very special relationship with her grandfather, she viewed him as her only father figure, her mentor, her confident and her best friend. She has not dealt with his death and she blames herself for him passing away. She reports feelings of a constantly depressed mood, due to the emptiness of missing her grandfather. She reports that she has had many very brief romantic relationships in an attempt to fill her emotional void, but she has been emotionally abused and cheated on. Her academic performance has declined considerably since the loss and she reports lack of motivation to improve. Julia expressed that she feels negative and hopeless about the future and often thinks about ending her life. She is a high risk case in that she has suicidal ideations and she has a plan but has not carried it out. She reported that she was about to ingest pills a month ago, but thinking about what her grandfather would think and her Christian belief stopped her. Julia has poor relationships with all her family members and friends, and thus does not have a good social support network.

### **Behaviour during therapy sessions**

During the therapy sessions Julia presented as a polite, friendly and co-operative individual. She was well groomed and was orientated to time, place and person. Her speech was fast and fluent and her thoughts seemed to race at times. Her affect was appropriate in respect to her emotional situation, and she cried often. She exhibited average insight.

### **Diagnostic impression**

Axis I: Major Depressive Disorder, Recurrent, Moderate without psychotic features  
Axis II: nil  
Axis III: nil

Axis IV:        Poor primary support group

Axis V:        51-60

### **Theoretical formulation**

Carl Rogers (1902-1987) was the pioneer who developed person-centered therapy (PCT). To provide Julia with the emotional support that she required, PCT was an appropriate therapeutic stance to use. This therapeutic approach may be understood as a *way of being* and as a *shared journey* in which the therapist and the client expose their humanness and participate in a growth experience (Corey, 2009). On this journey, the therapist guides the client, and through this process healing is possible. PCT is a non-directive therapy, where the therapist focuses on reflecting and clarifying the client's verbal and non-verbal communications with the goal of assisting clients to become aware and to gain insight into their feelings. In view of this stance, Julia was able to understand the passing away of her grandfather as part of life's journey. Through reflecting on the decisions she has made in her life thus far, many of which were impulsive and irrational in terms of interpersonal relationships, she was able to gain valuable insight into herself and what she was feeling.

The fundamental principles of PCT guided the counselling process. The first premise of PCT, is that the therapist should employ a stance of *congruence* or *genuineness* towards the client. This implies that during the therapy sessions the therapist is real, genuine and authentic towards the client. This was ensured during Julia's therapy sessions, and in a way it encouraged her to self-disclose and feel comfortable about sharing her painful story during therapy. The second principle of PCT that was followed during Julia's therapy was that of the therapist adopting an attitude of *unconditional positive regard* and *acceptance* towards the client. During the therapy sessions, the therapist showed Julia that she cared and respected

her, while the therapist was also non-judgemental toward her. The third premise of PCT that the therapist followed, was that of *accurate empathetic understanding*. Through genuine empathy, Julia was able to value her life experiences, and especially treasure the special time she spent with her grandfather before his death. She was also able to modify her perceptions about herself, others and the world, and increase her confidence in her decision making, specifically in terms making mature choices when selecting romantic relationships. An important aspect within PCT is *listening* to the client, and just '*being*' with the client as she tells her story. The therapist ensured that she was an active listener towards Julia, and it was evident that Julia appreciated her therapist just '*being*' there with her and sharing her experiences.

An additional therapeutic approach that was incorporated into Julia's counselling sessions was that of an Existential approach. Existential therapy is guided by the assumption that as human beings, we are essentially free and therefore responsible for our choices and actions in our lives (Corey, 2009). The therapist helped Julia become aware of this perspective, and this gave her insight into understanding that she is responsible for her decisions, and she is accountable for making future choices that will benefit her. Julia was able to realise that she was responsible to herself to heal from her passed loss, and that she needs to decide to move on in her life, and to work towards a future that will make her happy. Julia owed herself a favour to make responsible future choices in terms of becoming involved in appropriate friendships and relationships. Existential therapy encourages clients to find meaning in their life experiences (logotherapy), as well as to find meaning in pain and suffering. For Julia, this was particularly important. Through the medium of therapy, Julia realised that she could find meaning within her pain of losing her grandfather, and that her loss has let her grow as a young woman and become a stronger individual in the process.

Cognitive behaviour therapy (CBT) is a modality that is based on scientific research, thus it has empirical value in terms of a therapeutic modality. Some of the basic principles of CBT were incorporated into Julia's therapy sessions. One of the basic principles of CBT is that psychological distress is largely a function of disturbances in cognitive processes (Corey, 2009). Hence through therapy, Julia was taught to focus on changing her cognitions in order to produce desired changes in her affect and her behaviour. She gained insight into being able to understand that if she changed her negative thinking patterns, she will be able to in effect experience positive changes in terms of her affect and behaviour. Psycho-education is an important part of CBT, while homework and responsibility of the client to assume an active role in one's change both in and outside of therapy is important (Corey, 2009). In view of this, Julia was given homework, and she understood that it was her responsibility to ignite change in her life, and practise her new adaptive thoughts and behaviour beyond the therapy session.

## **Process of sessions**

### **First session**

In the first therapy session, therapeutic contracting was addressed, and rapport was established between Julia and the therapist. The presenting problem was identified and the goals of therapy were discussed. Julia shared the story of the loss of her grandfather and her life since his death, and the therapist applied the basic principles of PCT during the session. During this session Julia self-disclosed about her suicidal ideations and her plan about ingesting medication to do so. To deal with this the therapist used the principles of existential therapy and CBT. Existential therapy helped Julia gain insight into the meaning of her life, and how ending her life would mean a loss of her unique contribution to society. She understood that ending her life would go against her Christian belief, and most importantly it



would be something that her grandfather would deeply disapprove of. Through CBT Julia was encouraged to elicit change in her destructive thinking patterns, and through doing this she may experience change within her affect and behaviour. By the end of the session it seemed as if Julia had shifted her attitude concerning her suicidal ideations. The therapist also gave Julia her cellular telephone number in case of an emergency.

### **Second session**

In the second therapy session, the therapist gave Julia a suicidal safety contract, but it seemed as if Julia felt relief and had recovered from her initial suicidal ideations. Julia was also given psycho-education concerning her depressive symptoms and was made aware of the benefits that anti-depressant medication would provide. Furthermore in terms of CBT, Julia was given homework of writing a letter to her grandfather, telling him everything she wished to say to him and bidding him a final good-bye. This letter would help with closure in terms of dealing with her grandfather's death. PCT was used in this session, as the therapist encouraged Julia to talk about her special memories of her grandfather, and talk about her faith in relation to her grandfather's death. Existential therapy was incorporated into this aspect in that she was able to find meaning in the pain of his death. CBT was further used to help Julia change her attitude and dysfunctional thinking patterns concerning the fact that she blamed herself for her grandfather's death. Through the medium of CBT, Julia was able to realise that she was not to blame for his death. Termination of therapy was also discussed.

### **Third session**

In the third session, psycho-education was given regarding the stages of grief and how to move forward in terms of healing. In this session it was important to address the issue of her excessive interpersonal relationships, and how Julia needs to love herself first, and try to

discontinue her dysfunctional pattern of using short-term boyfriends to fill the void that her grandfather has left in her life. Julia needed to correct her distorted cognitions towards herself, in order for her to produce adaptive affects and behaviour. Julia was also encouraged to extend her social networks, so that she may establish a good support system for herself. Julia provided feedback on her experience of therapy, and reported that it had been a positive experience that had assisted her greatly.

## **Discussion**

During Julia's therapy sessions, the therapist employed PCT, CBT and existential therapy as a means to assist her in dealing with her psychological distress. She co-operated well throughout the therapy sessions, and was motivated in terms of wanting to achieve extended change in her life. Julia reported positive outcomes from her therapy, and that she felt confident in being able to cope better in her life emotionally.

## **Conclusion and recommendations**

Based on the therapy sessions, through the modalities of PCT, CBT and existential therapy, Julia revealed optimistic outcomes in being able to cope more effectively, and experiencing meaning within herself and from experiencing the death of her grandfather.

The following is recommended for Julia:

1. Julia may benefit from continued individual therapy, aimed at developing further insight and understanding of her cognitions.
2. Long-term therapy in order to address underlying dynamics from her previous relationships and the impact they may be having on her current relationships.
3. A friends and family network is needed to provide social support and encouragement for Julia.

4. A referral for Julia to see a psychiatrist to assess her depressive symptoms, in case she needs to be put on a dose of anti-depressant medication.

5. Psycho-education to assist Julia in the continuation of her grieving and the promotion of her healing.

Julia is an engaging individual who should be encouraged to be positive and to know that with persistence and determination she will experience a continued ability to cope psychologically.