COGNITIVE BEHAVIOURAL THERAPY IN SOUTH AFRICA: COUNSELLORS' EXPERIENCES FOLLOWING A TRAINING PROGRAMME

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ABSTRACT

Many South African communities experience high levels of violence and other phenomena that potentially provoke symptoms of traumatic stress among residents. Cognitive behaviour therapy (CBT) has been demonstrated to be an effective psychological intervention to ameliorate symptoms of trauma, but is seldom practised in South African community mental health settings. In order to determine the barriers to implementing CBT, 12 credentialed community counsellors participated in a two-day training workshop focused on CBT. Counsellors were asked to implement CBT with their clients who presented with symptoms of PTSD. The counsellors were then asked to complete a questionnaire six-months after the training workshop in order to identify the barriers they experienced in implementing the treatment model. The chief barriers that counsellors identified included high workload and limited time, unsuitable clients, client drop out, and an inappropriate match between the counsellor's theoretical paradigm and the CBT model. These results are considered in the context of community mental health care in post-apartheid South Africa.

INTRODUCTION

Post-apartheid South African society is characterized by high levels of community violence (Bowley *et al.*, 2002), rape (Jewkes & Abrahams, 2002), motor vehicle accidents and a history of human rights violations (Kagee, 2004). Such traumatic stressors invariably result in high rates of symptoms of post-traumatic stress (Carey, Stein, Zungu-Dirwayi, & Seedat, 2003). Various psychological interventions have been demonstrated to be effective in Western countries in reducing symptoms of post-traumatic stress, such as avoidant behaviour, intrusive thoughts and physiological hyperarousal. Among these interventions is cognitive behaviour therapy (CBT), which has enjoyed considerable acclaim as an empirically validated treatment for a variety of disorders, including post-traumatic stress disorder. Cognitive behaviour therapy is based on an underlying theoretical rationale that an individual's affect and behaviour are largely determined by his or her cognitive appraisal of the world (Beck, 1976). This approach assumes that cognitions are based on attitudes or assumptions, also called schemas, which are founded on previous experiences. The cognitive model of treatment of psychopathology was originally developed for the treatment of depression (Rush & Beck, 1978), but has also been demonstrated to be successful in the treatment of generalised anxiety disorder, obsessive-compulsive disorder, PTSD and others.

Cognitive behaviour therapy is not widely taught in South Africa and, as such, few credentialed clinicians are proficient in service delivery using this approach (Möller & Van Tonder, 1999). The dearth of training opportunities in CBT means that many clinicians have not had the opportunity to

use this therapeutic modality and as such have not had the opportunity to reflect on its potential in addressing psychosocial problems facing communities. This paper describes an investigation into the barriers facing trained clinicians in implementing CBT principles in their practice with victims of trauma in South African communities.

METHOD

Participants

Participants were 12 professionally certified counsellors with at least a Master's degree in their respective fields, who were invited to participate in a weekend CBT training workshop. Eight of the counsellors were qualified social workers, three were registered psychologists and one was a labour lawyer with advanced training and certification in counselling. None of the counsellors reported that they had had any training in the conduct of CBT. Nine participants (75%) were female, and 6 (50%) were from historically disadvantaged communities. Of the 12 counsellors who participated in the study, 8 completed a follow-up questionnaire aimed at assessing their experiences in applying CBT in community settings. Counsellors had an average of 7.8 years of experience in their profession.

Materials

The research team produced a training manual that outlined a CBT programme directed at ameliorating symptoms of trauma. The manual was based on the work of Foa, Hembree and Dancu (1999), and Foa and Riggs (2001). A CBT treatment programme originally developed and validated by Foa and her colleagues was adapted to accommodate participants' clinical practice needs. This adaptation involved reducing the number of sessions required for a treatment course, while simultaneously ensuring the inclusion of the essential components of the treatment modality. The modified treatment programme consisted of six weekly sessions of 60 minutes each. The programme included training in the administration of specific procedures aimed at ameliorating post-trauma reactions among survivors. These included psychoeducation about common reactions to trauma, calm breathing training, recounting the trauma memories (imaginal exposure), approaching safe situations (in vivo exposure), and cognitive restructuring. Handouts based on the CBT model were also provided.

Design and Procedure

Community counselling agencies in Cape Town and surrounding areas were identified and letters were sent to directors inviting interested credentialed professional counsellors to attend the training workshop. We selected only professional counsellors who possessed a graduate degree to participate in the workshop. All 12 counsellors who were invited to participate were present for the whole of the two-day workshop. After participating in the workshop, counsellors were asked to implement CBT with their clients who presented with post-traumatic stress symptoms. Counsellors were further asked to adhere to the treatment manual to the extent that their work permitted in order to ensure fidelity to the CBT treatment model.

Instruments

A questionnaire assessing experiences with CBT was mailed to each counsellor. The questionnaire inquired about the number of clients that each counsellor worked with since attending the workshop, clients' most common presenting problems, the specific CBT techniques that were used, counsellors' opinions about the cultural appropriateness of CBT, and their opinions of what

would make CBT more applicable in the South African context. The questionnaire was then mailed to each counsellor six months after the workshop in order to assess their experiences in conducting CBT and to ascertain the barriers they faced in its implementation.

Results

Of the 12 counsellors who originally participated in the training workshop, 8 returned questionnaires. Upon inquiry we learned that one person had left the country and the others had subsequently resigned from their organizations. The eight counsellors who returned questionnaires indicated that in combination they had worked with a total of 516 different clients, of whom 186 (36%) presented with a trauma-related problem. Of these clients, 17 received cognitive behavioural therapy. Five of the counsellors who participated in the training workshop indicated that they implemented the full CBT model with at least one client, two stated that they implemented some elements of the model, and one indicated that he did not use CBT at all. Counsellors provided the following reasons for not integrating CBT into their clinical practice.

High work load and limited time: respondents indicated that a high case load in many instances prohibited using the CBT model as it required a time commitment of at least one hour per week and a minimum of six sessions.

> *"We have a really high caseload. We do group work and attend seminars and workshops. I'm also an intake worker. This is mainly the reason why most cases that qualify for CBT are referred to more specialized services."*

> *"Because of work load and the limited time our organization is not specializing in intensive therapy."*

Unsuitable clients: respondents stated that their client base, in some cases consisting only of children, were not suited for the adult-focused CBT programme.

> *"My main clients are children and I know that CBT is not suited for children. Within the organization that I work we refer to psychologists at the hospital."*

Client drop out: respondents stated that many of their clients reported being unable to attend six counselling sessions because of problems in getting time off work, transport problems, or not having child care. In some cases clients reported improvement in their psychological status and indicated that they did not require further treatment.

> *"I started with a few, but they unfortunately were unable to attend all sessions. They either could not get off from work or they said they were better and did not need any further counselling."*

> *"Mostly it was because clients come for only approximately 3 sessions. Also many did not have avoidance symptoms prominently."*

Presentation with multiple problems: Respondents reported that clients often presented with a multitude of problems, of which symptoms related to a traumatic event was only one. Thus they felt that the clinical imperative was to address all of the problems with which clients presented, rather than focus only on symptoms of trauma. This made manual-based intervention difficult to conduct.

> *"Clients normally present with more than one problem. If they present with trauma they often express a need to work with other underlying issues once they have been debriefed. This makes it difficult to work according to the manual."*

Inappropriate match between the agency and the CBT model.

> *" I do mostly critical incident debriefing and short-term strategy implementation."*

There was general consensus among the respondents that CBT, when applied, was very beneficial to their clients. The following reasons were given to illustrate in what way benefits would accrue to clients:

> *"Clients would benefit (from CBT if they received it). It would be an opportunity to speak to someone when needed. However, clients are reluctant because of its being 6 sessions."*
>
> *"Yes, I think they do benefit, especially by recounting the trauma. They feel acknowledged. It helps to lessen the impact, etc. Psycho education is also beneficial. It helps to normalize their responses. Calm breathing is a very useful coping skill."*
>
> *"Yes, the techniques are useful, although it is difficult to present in a manualised way."*
>
> *"If one is specializing in this method, it will be beneficial. However, if you have a heavy workload it will not benefit the client because of a time constraint."*
>
> *"Yes, very definitely. All techniques are relevant".*
>
> *"Yes, clients can identify with CBT techniques. It is well structured."*
>
> *"Yes, but not as rigidly as set out in the training. Clients differ and so does their situation and the tempo at which clients master certain activities."*
>
> *"Yes, but not in an organization such as ours. We have an open-door policy and a high caseload and a lack of manpower and limited time and resources."*

The main problems that participants identified in implementing the CBT model with survivors of traumatic events included:

- The fact that six sessions were too many and that many clients do not return for follow-up appointments;
- Completing the assessment forms, which were seen as too long and too time consuming;
- Having to recount the traumatic event several times;
- Difficulty in applying the technique of approaching safe situations, as few of these exist in communities in which most clients reside;
- Adhering to the manual was a challenge as this was not customary practice in community mental health settings. "*It is difficult for the counsellor to stick to what is in the manual. We often end up talking about other issues*";
- Insufficient time to apply the model in the context of a heavy case load;
- Lack of suitability with the clients who are served by the agency;
- The model was not appropriate for all therapists such as those that are not technique oriented, but instead were oriented towards client-centred or narrative therapy.

Overcoming the obstacles

Respondents volunteered several suggestions to overcome the barriers to implementing CBT in their work. These included having fewer sessions, eliminating assessment questionnaires and

motivating clients to come for 6 sessions. A further comment mentioned was that specialised training was needed in the field and that more practice was needed to increase the skill level of counsellors than could be offered in a two-day workshop.

Cultural applicability of CBT

Most respondents stated that that they thought that CBT was applicable in the South African context and that South African clients would benefit from it if it were offered. One respondent made an important observation that persons living in dangerous areas, characteristic of most of the poor in South Africa, do not experience some events as traumatic because they are so common. Another stated that CBT may work well with white and "coloured" clients, but she was unsure of its benefit to Xhosa-speaking clients. A further respondent expressed the reservation that persons living in South African communities are not familiar with counselling and the process of having to speak about one's feelings.

Benefit to respondents' clinical work

Respondents reported several benefits after participating in the training workshop and implementing cognitive behavioural therapy in their clinical work. These included learning and practising new techniques such as conducting a structured interview, assigning homework, in vivo and imaginal exposure, breathing retraining and cognitive restructuring. One respondent stated that she had gained a better understanding of the theory informing cognitive behaviour therapy, while another valued a deeper understanding of PTSD. Finally, one respondent stated that she was more open to the cognitive model as a result of the training. A full analysis of the impact of the training workshop on the attitudes of counsellors towards CBT is reported elsewhere (Kagee, Suh & Naidoo, 2004).

DISCUSSION

In post-apartheid South Africa, which is characterised by high levels of community violence and large numbers of people affected by violence, there is a need for services directed at the systematic treatment of psychological trauma. However, the availability of empirically supported treatments for psychological disorders is of limited value unless they are utilised by mental health practitioners to benefit their clients. Over the last 15 years there has been significant progress in terms of the development and validation of effective psychological treatments for PTSD, such as CBT exposure treatment programmes. Most research of this nature has been conducted in the United States and Europe. The goal of our study was to disseminate effective CBT treatment for PTSD among practitioners working in South African communities and to identify the barriers that confront clinicians in implementing such treatment in their practice. The identification of such barriers is a necessary step towards ensuring the availability of empirically supported treatments for South African clients.

The counsellors who participated in the CBT training workshop reported substantial increase in their knowledge of CBT techniques, positive changes in their attitudes towards CBT, and strong motivation to implement CBT treatment programmes with their clients. More than half of the counsellors who responded to our 6-month follow-up questionnaires reported that they implemented the full CBT treatment programme with at least one client. A quarter indicated that they had implemented at least some elements of the CBT treatment programme. The counsellors reported a number of benefits to their clinical work such as learning and practising new techniques and gaining knowledge of CBT theory and PTSD as a diagnostic entity.

Among the lessons learned from this pilot study is the importance of providing closer on-going supervision to counsellors. However, although supervision by the trainers of the CBT treatment programme was offered to the counsellors via telephone and email, it was difficult to remain in contact with the counsellors after their training because of their heavy caseloads and the fact that the counsellors worked in different locations throughout the Western Cape region of South Africa. When disseminating empirically supported treatments to clinicians in different cultural settings, ongoing supervision is a necessity, as is subsequent training of new counsellors by local supervisors who have already been intensively trained. Nonetheless, for South African clients to benefit from empirically supported treatments, it is necessary to adapt such treatments to the local context, to provide ongoing supervision and opportunities for trouble-shooting, and to evaluate clients' progress during and after treatment constantly. For empirically supported treatments to be effectively dispensed in South African community mental health agencies, key decision-makers such as programme directors and administrators also need to be supportive of clinicians, for example, by ensuring adequate caseloads and time available for in-service training and ongoing supervision.

Despite the benefits that may accrue from the implementation of empirically supported treatments, these remain unacknowledged in community mental health settings in many parts of the world, including South Africa. Such psychological interventions form part of a broader movement in evidence-based health care, whose aim is providing maximum benefit for consumers of health care in a manner that is time and cost effective. Thus, for community psychology and social work to thrive in South Africa, further attention to the use of empirically supported treatments such as CBT remains an imperative.

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