

**BLACK CLINICAL PSYCHOLOGISTS IN
THE WESTERN CAPE:
THEIR PERSPECTIVES ON THEIR WORK.**

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ABSTRACT

Being a Black, African language-speaking trainee clinical psychologist and fluent in different languages can have both its advantages and challenges. Challenges include, among others, working in one's own mother tongue after having been trained in other languages; ethnic and/or cultural differences from trainers and clients; and the burden of what may at times be a misperception that there are similarities between the client and clinician who apparently come from the same background. There are also other difficulties that come with working in a multi-cultural society.

This study examines how four Black clinicians (two interns and two qualified psychologists) in the Western Cape, trained in English, deal or dealt with some of the challenges posed by working with Black, African language-speaking patients and/or clients. Results are based on semi-structured interviews with these clinicians about their experiences mainly with Black clients, and about their experiences of training.

The interviews were taped and transcribed verbatim and the data analysed qualitatively. Results were analysed and discussed according to the following expected themes: clients' demographic data, clinicians' experience of their clients; clients' perceptions of clinicians as well as the process of therapy; clinicians' experience of training as well as being in the professions; and lastly, clinicians' opinions on certain traditional African practices and related phenomena. There were also emergent themes that were

identified and discussed, and these include: witchcraft, psychosis or *amafufunyana* (negative spirit-possession found among Xhosa and Zulu-speaking people); Black patients' interpretation of their condition; effects of the past (or racism) on White people; the question of whether being Black is different from being White; as well as the role of community psychology, particularly in South Africa. The study makes recommendations regarding the training and practices of Black clinical psychologists.

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CHAPTER ONE.
INTRODUCTION.
BACKGROUND TO THE STUDY.

My interest in the study was mainly brought about and influenced by my own experience of being a trainee clinical psychologist at University of Cape Town's Child Guidance Clinic (CGC) where, as part of training, I had an opportunity to work with clients from different backgrounds, including those from the Black community. Among those who were from the Black community was one particular client, who presented a number of challenges for me (in all cases where clients are mentioned in this study, their details have been changed to protect identity). Firstly, she would miss appointments and not call to reschedule or cancel. She would arrive when I was not expecting her, wanting to have a session immediately, which was impossible for me to fit into my tight schedule. I was also advised by my supervisor not to see the client on demand because of the unrealistic expectations this might raise. Secondly, she assumed and at times insisted that as a Black South African, I (the researcher, but therapist at the time) should automatically understand and therefore condone her behaviour towards her grandmother because, as she put it, "...as you know, it was the way we have been brought up...". That, I felt, was problematic and an assumption which I did not hold. Thirdly, this client, after her grandmother was referred to another therapist, insisted on having access to whatever grandmother was saying to her therapist because she, the client, was "the one who made the referral", as she put it. Because of respect for confidentiality and other ethical considerations, I did not agree to provide information regarding the grandmother's therapy to my client.

Other incidents involved working with a Sesotho-speaking family (with whom I did not envisage any problem as Sesotho is my first language!). There the problem was particularly with finding words in the language to communicate with them. Therefore I ended up having to substitute with English ones, which, though that family could understand, might have been difficult for others who do not understand English very well. Many of the technical words in psychology I have learnt in English, and even if I am Sesotho-speaking, I have used English words more than those from my

home language. Such words include the following:- masturbation, sexuality (homo- or hetero-), therapy, diagnosis, etc.

Lastly, towards the end of my first internship year, I also had an opportunity to write a paper with three other Black interns on some of our experiences of training, which further strengthened my interest in this area. The observation I made was that, even though some of the issues were experienced differently by the three of us, they also seem to have experienced Black patients as somewhat different from other patients.

These encounters mentioned above as well as others with Black patients triggered some questions in me. This project will attempt to find some answers or generate more discussion around these questions. Here are some of the research questions:-

- a). Has or can the training in psychology help me (as a Black clinician) work with Black patients, and if so,
- b). What are the issues that need to be considered, for example:-
 - i). Cultural/Ethnic differences
 - ii). Linguistic difficulties/differences
 - iii). Ethical differences (for example, the client demanding access to grandmother's therapy)

As the literature review will show, there is a feeling among many people that there should be more Black psychologists trained in order to meet the growing need and challenges facing the profession in this country. Further of note though is that, from my clinical experience, and from that of my other Black colleagues referred to earlier, just having more Black people in the profession is not the only answer. Having more Black psychologists also poses other challenges, which could be taken for granted. Some of these challenges are captured in the literature review that follows.

LITERATURE REVIEW.

History and Development of Clinical Psychology in South Africa.

In 1914, the University of Stellenbosch established the first Psychology department in South Africa. However, only after the Second World War did clinical psychology become established in South Africa, with some American and British Psychologists setting up practices here (Kleintjes, 1991). In October 1946, the 34th Congress of South African Medical Association accepted proposals for the registration of medical psychologists. This led to the committee for supplementary services of South African Medical and Dental Council (SAMDC) approaching a number of psychologists and psychiatrists to consider registration of medical psychologists. The meeting was held in 1948, and the committee recommended using the term clinical psychologist rather than medical psychologist. Their recommendation was not accepted because the tasks of the clinical psychologist would be professionally equal to that of a medical doctor and would therefore not fit into the category of supplementary service. It was therefore decided not to continue with the registration of clinical psychologists until an association could be established which would represent the interests and feelings of South African psychologists (Nicholas & Cooper, 1990).

The psychologists at the meeting arranged another meeting for the following day to discuss the formation of a psychological association. The South African Psychological Association (SAPA) was therefore officially founded in 1948 in Bloemfontein, with membership of thirty four. (Nicholas & Cooper, 1990). One of its aims was to “establish psychology as a science in South Africa and forming a base from which to lobby for legislation to control the practice and profession” (Kleintjes 1991; p.3). At that time, and constitutionally, the membership was open to all races, though, as Nicholas and Cooper (1990) put it, “it was not until 1962 that the first black psychologist was allowed to become a member of SAPA” (p. 51).

In terms of legislation, in 1955, the Dental and Pharmacy Act of 1928 was amended to include psychologists and only in 1964 did they get a separate register. Later, in 1974, Act no. 56 of South African parliament, gave statutory recognition to psychologists, defining a psychologist as someone

who is registered with the South African Medical and Dental Council (SAMDC), in one of the following categories: clinical, counseling, educational, industrial and research psychology (see Kleintjes, 1991; Kleintjes & Swartz, 1996; Manganyi & Louw, 1986). The SAMDC established a body called The Professional Board for Psychology in order to regulate the practice of psychology in the country. Certain requirements were therefore laid out for registration as a psychologist, which stipulated among other things that, in order for a person to register as a psychologist, s/he must have completed a Masters degree in the appropriate field of specialization plus a year's internship at an institution recognized for the purpose. (Louw, 1992; Manganyi & Louw, 1986).

Psychology and the history of racial divisions.

Between the years 1957 and 1962 there were many debates about the merits and demerits of admitting black psychologists to SAPA. When Blacks were finally admitted, this led to the resignation of some White psychologists, who then formed their Whites-only organization called Psychological Institute for the Republic of South Africa (PIRSA), on the 23rd of June, 1962 (Kleintjes, 1991; Kleintjes & Swartz, 1996; Nicholas & Cooper, 1990).

In keeping with apartheid legislation at the time, all people who were not White were excluded from PIRSA. The literature on race issues in South African psychology has therefore tended to focus on disenfranchised psychologists as a homogenous group. This includes Black (African), Coloured and Asian psychologists. In the available literature, therefore (which focuses on the development of psychology in general), there is very little referring specifically to Black (African) psychologists. Here "Black" refers to all people who speak indigenous African languages other than Afrikaans. Given the scarcity of literature in relation specifically to Black African South African psychologists, this subsection will draw heavily from the work of Kleintjes (1991), Kleintjes and Swartz (1996), Manganyi and Louw (1986) and Nicholas and Cooper (1990). The authors focus mainly on disenfranchised psychologists as a group, though Manganyi (1991) sheds some light on the plight (then) of Black African psychologists/interns, at the time when race played an important role not only on how hospitals were segregated but also in terms of which clinician was permitted to see which patient.

Important to note is that at the time, South Africa was still a racially divided society, with the National Party winning the elections in 1948, further entrenching racial divisions and imbalances. The existence of both SAPA on one hand and PIRSA on the other posed tensions and difficulties to which the Professional Board responded by selecting three members from each to represent psychology. Later in 1982, the two bodies were replaced by one, the Psychological Association of South Africa (PASA), to represent the interests of all psychologists in South Africa, irrespective of their colour.

However, in the 1980s South Africa remained a divided society to a point where professional associations and political positions interacted and this affected both psychologists and psychologists in training. Such realities led to the dissatisfaction on the side of politically progressive mental health and social service workers with what Flisher, Skinner, Lazarus and Louw (1993) referred to as “the relative silence of mainstream organizations and associations about the evils of apartheid” (p. 236). In 1983, the Institute for Family Therapy held its conference in Sun City in Bophuthatswana, to which a group of postgraduate students from University of the Witwatersrand objected. Their objections were based on the fact that it was insensitive to hold a conference of that nature where families were broken through regulations like influx control. Bophuthatswana was one of the so-called “self-governing states” or Homelands, created under apartheid laws to get as many Black people as possible out of South Africa, with “leaders” or heads of such “states” chosen by the South African government. After the conference, that group of students who objected decided to formalize the group which they called OASSSA (Organisation for Appropriate Social Services in South Africa), in Johannesburg in 1983, which later established a branch in Cape Town in 1985 (Flisher, Skinner, Lazarus & Louw, 1993; Vogelmann, 1987).

As put by Vogelmann (1987, p.25)... “in attempting to discover what an appropriate South African psychology is, it is important to make this discovery using three primary principles of analysis. The first is that people’s psychological and physical health are linked to their living and working conditions. These conditions are determined by the position of power that people have. Thus mental health and politics (and in South African situation, Apartheid) cannot be separated”. (Lloyd Vogelmann was OASSSA’s chairperson in 1987).

In January 1994, a new organization called Psychological Society of South Africa, (PsySSA), was formed at a national conference held at the University of the Western Cape (UWC), to replace PASA, and in the same spirit of trying to transform psychology in order to respond to the realities of South Africa. PASA was dissolved at its annual conference in Durban in September 1993. Though open to all races (PsySSA), its membership was largely White. This racial pattern remains in PsySSA but there is a commitment to address historical imbalances through, for example transforming its leadership, aiming for more representation of Black people, and recruiting more Black people into psychology.

Manganyi and Louw's 1986 study of psychology in South Africa documented racial imbalances which needed to be addressed. Visser (1989), in Kleintjes (1991), also found that, at the time, there were no more than 20 Black Clinical Psychologists in the country, 10 Coloured and fewer than 15 being Asian. These statistics should also be understood against the following population estimates:

Mid-year (1989) population estimates: (Central Statistical Services; 1990).

Asians	941 000
Blacks	21 105 000
Coloured	3 168 000
Whites	4 790 000

At the time of the study, the situation had not changed that much, with a lot of underrepresentativeness in especially the previously disadvantaged communities, hence the need to train more psychologists from those communities.

The population estimates, as supplied by the Central Statistical Services confirm that there is, based on the Census, at least in 1995, a population estimate of:

Total number of all South Africans 41 244 000, with	
Africans	31 461 000 (76,3%)
Coloureds	3 508 000 (8,5%)

Asians	1 051 000 (2,5%)
Whites	5 224 000 (12,7%)

Statistics at the time of the study

All the attempts that I made to ascertain the number of Black psychologists registered with the SAMDC proved fruitless, as many people and organisations contacted, including the SAMDC, were unable to assist. However, personal communication with the National Director of Mental Health and Substance Abuse, indicated that the SAMDC does not keep statistics of registered clinicians on racial grounds. The justification for this is that it would replicate categories of the apartheid years. This could be seen as (or even argued by a predominantly White and male SAMDC) as a positive and non racist move. Paradoxically, I argue, not keeping these statistics is in fact, racist. It obscures some of the serious historical and current imbalances. This can have serious implications for training because it will remain unknown how many non-white clinical psychologists are there, making it difficult to argue for training of more people from those backgrounds as there will be no evidence to support the call.

Another issue worth noting is the uneven distribution of not only psychologists but mental health professionals among the provinces, with some provinces like Gauteng and Western Cape enjoying the biggest piece of the pie. As noted by Freeman and Pillay (1997), Mplumalanga has “a population of close to three million people, in the State sector there is one psychiatrist, two psychologists and twelve social workers to service around 80% of the population (2.4 million)” (p. 46). On the other hand, the Western Cape, has 62 psychiatrists and 55 each of psychologists and social workers for a population of about 3.5 million people (Freeman & Pillay, 1997). The question of maldistribution in the mental health services was also raised as one of the areas that need serious attention by the most recent South African Health Review, (Lee & Zwi, 1997).

Training of Clinical Psychologists in South Africa.

As already stated, University of Stellenbosch was the first in the country to have a psychology department, though clinical psychologists got their training some time later, from the University of

Natal. The training (Masters Degree in Clinical Psychology), was offered in collaboration with recognized state hospitals, as far as they (hospitals) could offer practical training or internship. The situation was still the same at the time of the study. In addition, universities like the University of Cape Town also work in collaboration with Non-Governmental Organisations (NGOs), with the likes of The Trauma Centre for the Survivors of Violence and Torture, and the Community Counseling and Training Centre (CCATC) which provide interns with placements and exposure to Community Clinical Psychology.

The Role and Responsibility of Psychology in the world and in South Africa.

Psychology, with its values, beliefs and practices originating from Western countries, has been seen traditionally as a social science of behaviour and experience. Historically, it was also influenced by positivistic thinking, with its scientific approach to understanding human behaviour. In their scientific endeavour and practical application of knowledge, psychologists' aim was to understand and work with individuals, families and small groups (Lazarus, 1985). In working with individuals, the aim was to help them "cope with their lives and to solve human problems on specific and broad levels" (Atkinson, Atkinson & Hilgard, 1983; Leften, 1982; Moll 1983, summarized by Lazarus, 1983). However, in the last few decades, the focus also shifted to working with or helping communities (Swartz, 1996a).

In South Africa, with the history of oppression and racial discrimination and their effects on people, psychologists realised in the 1980s that they had to redefine their role in terms of relevance and meeting the needs of different people. There had to be radical transformation within the profession, and the move from a more neutral and objective view of "the world out there" which was thought to be "independent of human understanding" (Lazarus, 1985). This is also consistent with arguments raised by authors like Vogelmann (1986, in Perkel, 1988), that Apartheid and mental ill-health were inextricably linked. As noted by Maw (1996, p. 4), in the 1980s, there was "an implicit challenge [which] was faced by those working in the helping professions: if the government's policy of apartheid caused so much suffering to so many was it ethical to remain neutral?". There were also other authors and psychologists questioning psychology's relevance (Lazarus, 1985;

Perkel, 1988), calling for, as put by Dowdall, (1982), cited by Swartz, (1987), “Western therapy to take account of local factors”, and the fact that psychologists cannot continue to be neutral. Choosing of sides was inherently necessary (Dawes, 1985).

The question of relevance was however, not challenged only in South Africa. In countries like the USA for example, as early as the 60’s, there was an already increasing awareness on the side of psychologists, of the impact of social forces on people as well as the inequalities in the distribution of psychological services to communities. As a result, they came together to formulate an alternative approach which would not only address social issues but would also address the question of accessibility of psychological services to communities. This process saw the birth of community psychology which was defined by the American Psychological Association as seeking “to broaden the perspective of applied psychology to improve not only the individual, but also the relationship between the person and his/her social environment and the ecological interaction between settings and systems” (Lazarus, 1985, p. 2). From that time, it became evident that given the realities and challenges that were facing the society in general and psychology in particular, there was a need for relevance and a move from value-neutrality by the profession.

“Relevance”: What does this mean?

The word “relevance” means different things to many people but also triggers a lot of questions to one’s mind, amongst which are: should there be “Black psychology”?, Black clinicians for Black patients and therefore White clinicians for White patients?, Are there things like “Black” problems, “White problems”?, “who can speak for whom”, etc.

In trying to make sense of the confusion and many questions that the word “relevance” raises, my use of it will be restricted to what Maw (1996) understood to be “contextualised South African Psychology”, the aim of which was, inter alia, the upliftment of the society. I take this further by also acknowledging the importance of recognising the history of the country and therefore the differences between people, which need to be understood and respected in psychological work. If clinicians understand and are sensitive to taking context into account, it may be that barriers of race

and culture may not be insurmountable. The issue of linguistic difference, however, remains, and will be discussed later.

The founding of OASSSA that was referred to earlier, as well as the launch of "Psychology in Society" journal in 1983, became significant landmarks for a way of directly linking professional services to the upliftment of society within which they work. These were in response to some of the problems of neutrality and perpetuation of the status quo where, according to a 1986 anonymous article cited by Maw (1996), psychology was seen as serving the needs of the privileged minority, against the backdrop of political reality where such needs were very different from those of the majority. The writer went on to suggest ways of working differently, which included "empowering" and "liberating" the "oppressed" against "capitalism", (p. 6). While such "radical" statements are true about the groupings that existed then, they can also, if not understood correctly, lead us into thinking that the "oppressed" represent a homogenous group, leading us into ignoring the different experiences of "the same oppression" on these people.

A number of contemporary writers have made valuable contributions in terms of the experiences of disenfranchised people in this country, (Kleintjes, 1991; Kleintjes & Swartz, 1996). However, implicit in their definition of "black" as including Black, Coloured and Asian people is the assumption of homogeneity, even though those "black" people experienced apartheid differently. What I am trying to say might be clear in the following example: My experiences of South Africa (as a Black South African originating from the conservative Free State) are different from an Afrikaans-speaking, "Coloured" as defined by apartheid laws, and who lived in the Western Cape, whose experiences are also different from a so-called "Indian", who was not allowed into the Orange Free State, as it was at that time. All of us were oppressed (which was common!) but could also live in certain/ *different* areas and had *different* job opportunities, freedom of movement etc., because of our colour as defined by apartheid laws. This therefore makes it problematic to put all in what Gobodo (1990) referred to as one "illusory melting pot" without acknowledging unique experiences and diversity which will help us learn from each other. This is also consistent with arguments by authors like Kottler (1990, 1996); Swartz (1996a, 1996b, 1998), among others, who

had problems with the then popular “similarities discourse”, and who warned that ignoring differences and overstressing similarities can sometimes be problematic. Hence, I argue, it is not true what Thornton (1988, p.18, in Swartz 1996b, p. 21), wanted us to believe that:

“In the marketplace and workplace, listening to music or watching television, at houses and in churches, people in fact experience the same desires, profess the same religions, follow the same leaders, and eat the same cornflakes, notwithstanding their multicultural condition”.

It might be true that people (**who have TVs!**) watch the same programmes but is also simplistic and a potentially misleading, patronising assumption to think that that can make them the same. People’s experiences of where they watch those televisions for example, are different and should be acknowledged. Therefore such statements, if taken uncritically might render the therapist/counselor susceptible to “not listening” because s/he, by assuming that because both therapist and client are (Black/White) South Africans, therefore they know them fully. This reminds me of an extract I read which cited Martin Luther King Jr., as saying “...you cannot know me unless you know what makes me me”. (This is however, not quoted verbatim).

It is therefore important for us to have more information specifically about the experiences of Black psychologists. One area which is often associated in the literature with Black experience is that of indigenous healing.

Indigenous Healing.

Indigenous healing has been a subject of debates for decades, with different people having different ideas about, among other things its role and therefore future in the mental health field. Some of the debates that I have mentioned in the beginning, were around which word (between “traditional” and “indigenous”) is more appropriate. Spiegel and Boonzier (1988, cited in Korber, 1990), argued that the term “traditional” was used in South Africa to label an entire category of people whose behaviour and thinking are portrayed negatively. They are seen as “conservative”, “backward”,

“irrational” and therefore unable to compete with “modern”, “progressive” or “developed” people (p. 48). There might be other meanings and understanding of “traditional” which are different from the above-mentioned authors’, and which are not understood to have such negative connotations. However, for the purposes of this study, such discussions might not be relevant. Therefore, with the aforementioned issue in mind, I choose to refer to “indigenous” as opposed to “traditional”. The former term is also used by progressive as well as contemporary writers, though for their own reasons, see Bodibe and Sodi (1997), Bührmann (1984), Korber (1990) and Swartz (1996b), to mention but a few.

From what Schweitzer (1980) and Ngubane (1977), cited in Korber (1990) found, indigenous healing covers a wide range of practices including the *inyanga* and *sangoma* among the Zulu, the *molopo* among the Pedi, the *dingaka* among the Sotho and the *igqira* among the Xhosa. In addition, each of these “sub-categories” has their own area or field of expertise and a set of practices, which may, slightly or totally, differ from each other. This categorisation was also identified by Strangard (1985) and Setiloane (1978); cited in Bodibe and Sodi (1997), with each author citing different types or specialisations of such healers.

From the literature mentioned above, it seems, just like other professionals (doctors, psychologists, etc.), indigenous healers also have their areas of specialisation or expertise. This calls into question the view that practitioners can help all people with all their difficulties. Further of note is that calls on the part of some authors for psychologists to accept indigenous healing were made “generally”, without these authors knowing exactly what indigenous healers do. However, there are exceptions of people like Bührmann (1984), and others who got more exposure to indigenous healing than others. It should be noted however, that I am not suggesting that in order to know one has to go through the process yourself or do research similar to Bührmann’s. What is necessary is a critical approach.

Ignorance about what exactly certain healers are doing, can make possibilities of working together with them difficult. This view is supported by what Swartz (1996b) said about research in this area, that authors “are almost uniformly well disposed to indigenous healing, often without any evidence

presented in support of this view” (p. 129). This makes one question some methodologies employed to study this area. Other questions arise: Is it an area so delicate that questioning it would lead to feelings of undermining indigenous practices?. Is it an exclusive area understood and therefore legitimately accounted for only by those who practice it (Hence statements of cultural congruence between healer and community)? If this is true, is it only those who practice it who can talk on its behalf?

Such questions are confusing and might be answered as part of another debate. I therefore think that before we can make any “case for cooperation” (Korber, 1990), “professionalisation” (Chavanduka in Kottler, 1988; cited in Korber 1990), or total rejection (which is unlikely because people are consulting them anyway!), there should be more open research, which will therefore enable other professionals, especially in the mental health field, to make informed suggestions/contributions where patients need to consult indigenous healers as alternative or concurrent treatment. As put by Boonzier (1985), cited in Korber (1990):

“ If white South Africans are treated by homeopaths, acupuncturists and a range of ‘alternative’ practitioners in addition to doctors, why is it considered so strange that blacks also make use of a variety of healing systems? If the explanation lay exclusively in the power differentials between western and alternative medicine, one would expect that the patterns of choice amongst whites would also have attracted some academic interests” (p.

49).

Good research needs to be done in order to enable people to know about all forms of alternative healing. Even at present, one cannot say that only a certain sector of our society consults with indigenous healers. Patterns of use are changing, and long-held stereotypes were probably never true.

Language

Language plays a major role in terms of relationships that develop between people. The same can be said for the clinician/patient relationship in service provision. However, in South Africa, and in mental health in particular most helpers have been White, English or Afrikaans-speaking. There is a serious question about accessibility of such services to the majority of the population, who are mostly Black and African language-speakers. Such issues of accessibility have been tackled by (though not exclusively), universities, and their psychology departments in particular. Firstly, indigenous language-speakers have been recruited into training. Secondly, universities have taken up debates on the question of interpreters, who have until recently been taken from, especially in the hospitals, patients' relatives, friends, other patients or other health professionals (colleagues), most of whom have little or no formal training in interpreting. Such a use of interpreters has had few advantages and many problems, as it hampered or even shattered what Swartz (1996b) termed "the image of a psychiatric interview as an intimate relationship between the distressed patient on one hand, and the caring, empathic psychiatrist [or psychologist] on the other" (p. 26).

This historical problem was also noted by Drennan (1998), in that "under apartheid government, mental health services to non-English or Afrikaans-speakers were either not provided or mediated on an ad-hoc basis by available nurses, cleaners or anyone who was close enough to be roped into interpreting" (p. 2). This was clearly illustrated in an example referred to by Swartz (1998), involving a registrar (psychiatrist in training) who could speak only English and had to interview a Xhosa-speaking patient. The patient, on the other hand, could not speak English. The registrar then called a relative to do translating for them. However, the relative in question did not interpret very well. This therefore created a need for yet another interpreter and that could only be a Xhosa-speaking ward cleaner who was called in to assist, adding the fourth person to a relationship which was initially between two people. As already stated, such situations not only create serious relationship problems but also serious ethical ones as well. As Swartz (1998, p.26) noted "[t]he issue of confidentiality, a value held dear in biomedicine, and mental health services in particular, is raised when relatives and ward cleaners are used as interpreters (at times other patients serve as

interpreters as well)". There have been other problems with such use of interpreters which have been noted by Swartz (1996b). However, these will not be discussed here.

Other difficulties are raised by Drennan (1998). One's inability to speak the patients' language leads to situations where a professional cannot "engage with [such] a patient, to connect with them in a way that feels like meaningful rapport has been established. As such they are avoided [in the hospital system especially] in the allocation of patients" (p. 12). In addition, such difficulties might lead to frustration on the side of the clinicians as they may be left to rely on features like eye contact, objective hallucinations and side effects of medication as "reliable" prognostic indicators. There can easily be, according to Drennan (1998), a loss of opportunity for connectedness.

Towards a solution.

In response to some of the difficulties raised, different institutions adopted different ways of addressing the impasse. However, important to all the suggestions is the willingness on the side of the professionals to learn at least one indigenous language other than Afrikaans, even though it would take them a long time to learn such a language to any degree of competence. In order to help its students in functioning in a multilingual society like ours, the University of Cape Town's Child Guidance Clinic has come up with a policy whereby before entering the MA program, candidates should be able to demonstrate a basic capacity in an indigenous language apart from Afrikaans. The requirement was set to be compulsory from 1998 (Swartz & Maw, 1996). However, they have also noted some of the difficulties like competence in performing certain tasks (psychological assessment, psychotherapy, etc.), in those languages in which candidates might not be fully conversant.

Other steps taken by the Clinic include the Bicultural Workers Project, which was started in 1994, offering training and ultimately part-time employment as interpreters to UCT's undergraduate psychology students. Such students "would be trained in [among others] necessary psychological skills and would then provide an interpreting service in educational programmes in townships, in the counselling of Xhosa-speaking adults and children within clinic and hospital settings" (Swartz

and Maw, 1996, p. 8). Projects like this would also expose most of these Black students to what exactly psychologists are doing, therefore motivating them to study further in psychology.

Other institutions have also attempted to deal with the problem of interpreters. In spite of energy in training them by National Language Project and Language Facilitation Program of the University of Free State (Erasmus and Mathabule, 1996; in Swartz, Drennan and Crawford, 1997), certain problems have been identified. If these problems are solved, they can help alleviate problems in our mental health system. Firstly, there was no agreement between medical professionals as to who should be the interpreter. Secondly, there is no accepted status and place for interpreter and no posts or funding for them, about which Drennan (1998) was also concerned. Thirdly, there were also problems around role and allegiance of interpreters, given, as was raised earlier, the fact that most interpreters (at least hitherto) have been general assistants or cleaners.

SOME MODES OF PRESENTATION BY BLACK PATIENTS.

This section will examine some of the ways in which Black patients in particular, present their difficulties. They may communicate linguistically as well as somatically, and use different idioms of distress, as well as metaphors.

As already noted in some of the literature referred to above, language plays an important role, not only in being the vehicle through which relationships develop, but also in its enabling of clinicians to understand their patients' difficulties. This understanding further enables those clinicians to make an informed diagnosis and therefore treatment and/or referral. It is further worth noting that patients' conditions may be misdiagnosed if the professional does not understand ways in which such difficulties are communicated or experienced.

Communication through the body

Modes of presentations by patients have differed across cultures but there have also been some similarities. Somatization, for example, or what Swartz (1998) refers to as "speaking through the

body” is one of the phenomena or conditions that have been identified as existing cross-culturally. Drawing on the work of Kleinman, (1986), Swartz (1998) argues that “...there is evidence [throughout the world] that using the body to speak of and experience distress is in fact more common than experiencing distress and anxiety purely in psychological terms” (p. 125).

Somatization has also been referred to in the Diagnostic and Statistical Manual of Mental Disorders or DSM-IV (APA, 1994), (though as a psychiatric disorder known as somatization disorder), referring to “ a pattern of recurring, multiple, clinically significant somatic complaints [causing] significant impairment in social, occupational or other important areas of functioning” (p. 446).

However, as already stated, there have also been some differences across cultures in terms of the meanings attached to such symptoms which, if not understood within a client’s particular cultural viewpoint, might lead to an incorrect diagnosis and treatment. For example, Gobodo (1990) referred to a case of a Xhosa-speaking, female patient whom she was seeing, who had what she termed “persistent vaginal irritation” (p. 94). That condition, in terms of the Xhosa tradition, was as a result of her sexual involvement with a man who was not circumcised. Her condition, if taken out of context, presents a perfect example of somatization disorder.

This kind of somatization, I argue, should be understood and therefore treated in a different way. Swartz (1998) also refers to a classical culturally appropriate case of somatization as a result of a patient (purposely or not) not having participated in certain rituals that are expected of him. Swartz therefore concludes that among other things, somatization of this kind or speaking through one’s body “...is not necessarily a feature of illness at all, but also a way of expressing and engaging with the world” (p. 129). This underscores Gobodo’s (1990) view that “therapists should be cognizant [and sensitive] to the background of their patients” (p. 94).

Use of language.

There are other important things to note that can also come in the way for the therapist to understand the patient. Among those are the way in which the language is used. Black patients, like

any other patients from other backgrounds, also tend to use idioms or even metaphors to express how they feel. One example could be in a Zulu expression of “abantwana banjani?” which literally means “how are the children?”. This can idiomatically also mean “how are you?”. The expression can be used even if the person has no children. Another example comes from one of my colleagues who is also a Black therapist. She worked with a client whose husband had died in her arms and instead of communicating that directly to the therapist she kept on using the Xhosa expression, “ndiyagodola”, literally meaning that “I am cold”. At first the therapist took the expression literally. She later thought that the client was wanting physical contact with her, and only when she later explored further, did she learn the client was referring to bereavement. Walaza (1997), also referred to a particular client (Black woman), who came to her for help, who, at first “bombarded me with metaphoric explanations of her victimhood and how she understood it....I did not know how to use her symbolic communication to understand her suffering, but after a while I realised that all I could do was provide her with a space to articulate her pain in a way she herself understood it.....that experience provided me with a window into how metaphoric or symbolic communication - particularly [albeit not exclusively] by women - establishes a context for healing to take place” (p. 27). These and other similar situations might be difficult for the therapist to understand if s/he is not in tune with what is meant.

The clinicians may therefore find it hard to work with people who present their difficulties in such a way. However, such difficulties are not experienced only by White, English or Afrikaans-speaking therapists, hence I argued earlier that just training more Black professionals is not the only solution to the problems experienced as a result of multi cultural nature of this country. Of further importance will be some of the good old principles of honesty and openness if one does not understand, and clarifying with the patient if what we understand is what they mean.

This issue of language or words that patients use was also dealt with in a study conducted by Lund and Swartz (1998). They were looking at how Xhosa-speaking patients experience their condition, looking particularly at psychosis and *amafufunyana* (a state of negative spirit possession found among mainly Xhosa and Zulu-speaking people). They found that patients make use of certain words or concepts mainly as what they termed “explanatory models, describing a range of

symptoms.....as a way of explaining why the condition has arisen, and therefore [being] as much an etiological explanation as it is a diagnostic label” (p. 67). Here they were referring to the use of words like “*amafufunyana*” and “nerves”. Results of this study also highlighted the importance of understanding what patients mean by certain words without jumping to conclusions about their conditions.

The above literature has highlighted a lot of important issues, debates as well as challenges related to working with Black patients. In the following chapter entitled “methodology”, effort will be made to look at the best possible methodology to employ in studying some of these issues in the context of the work of Black clinicians. Current debates on different methodological approaches will also be highlighted, mainly in support of the one chosen.

CHAPTER TWO: METHODOLOGY.

STUDY DESIGN.

Given the fact that there are few Black clinicians in the Western Cape, as well as the unprecedented nature of the study, I chose an exploratory, descriptive and essentially qualitative research approach, with the individual clinicians (that is, psychologists and intern psychologists), being the unit of analysis. This kind of research has its history in the workings and contributions, as early as 1781, of Emmanuel Kant, a philosopher who broke sharply from Cartesian objectivism (Hamilton, 1994). Kant argued that human knowledge "is ultimately based on understanding, an intellectual state that is more than just a consequence of experience [and] human claims about nature cannot be independent of inside-the-head processes of the knowing subject" (p. 63). It is evident from his argument that it was important for researchers to acknowledge the role of participants not just as "subjects" of research but as agents in the production of knowledge. Investigators could no longer be like what Descartes (1637, cited in Hamilton, 1994) thought of as objective in the search for the truth, but "should stand back from those elements of the world that might corrupt their analytic powers" (p. 62).

Morse (1994), argued that "the laboratory of qualitative researcher is everyday life and cannot be contained in the test tube, started, stopped, manipulated, or washed down the sink" (p. 1).

Using such a methodology would therefore enable participants, in their natural settings, to verbalize and explore their experiences.

There are a number of approaches within the qualitative paradigm and the specific one employed in this study falls within what Blummer (1969) and Denzin (1978), cited by Marshall & Rossman (1989) called "symbolic interactionism", which looks at the meaning respondents make and take in their interaction with others.

Marshall and Rossman (1989) further argue that research of this nature values “participants’ perspectives on their worlds and seeks to discover those perspectives.....and is primarily descriptive and relies on people’s words as the primary data” (p. 11). The choice of this method is also supported by Allan (1991), in Allan & Skinner (1991), and Crabtree & Miller (1992) who further argue that the decision or choice of research style is shaped by the following: i) the way the research problem is formulated and research agenda specified, ii) analysis objectives, as well as iii) determination and articulation of research aim. Therefore, the way the research question and objectives have been formulated, have also led to choice of this particular approach or made it appropriate.

POPULATION AND SAMPLING.

As already stated, the focus of the study is on Black clinicians, particularly those who have done and/or are still doing some clinical work, particularly with Black patients.

The inclusion of the criterion (“**those currently involved in some kind of clinical work with Black patients**”), was necessary in excluding those psychologists not doing clinical work at the time of the study.

In order to get a broad, and fairly representative picture of events and to preclude any bias in selecting them, it was planned that participants would be selected in terms of two qualified and two training psychologists, taking one in each group coming from a Historically Black and a Historically White Institution.

It is worth noting that in the Western Cape alone (which is where the research was focused), there are altogether three qualified, Xhosa-speaking clinical psychologists. Of the three only two are still in the health care environment. Although they are in senior and more managerial positions, they are also doing clinical supervision of psychologists. The third one is working for an insurance company in the personnel department. The two interviewed were both trained at Historically White Universities but one has experience of studying and teaching at a Historically Black University. In

terms of the intern clinical psychologists, there were five apart from me. Of that five, one was from a historically Black institution and currently in the final year of practical training and was in a good position to comment on training at a Historically Black University, so he was a good candidate to include in the study. I selected one from the three that are from a Historically White university. The other two, who are close to me, I used to brainstorm the questions, but they did not form part of the study.

The participants, all of whom were firstly contacted telephonically and given information on the broad aim and content of the study, were therefore selected on the basis of their availability and willingness to participate. Two of the four interviews were conducted at participants' work places, one at one participant's home and the other one at the researcher's home. All interviews were audio-taped.

This method and a spread in selecting the sample, as argued by Marshall and Rossman (1989), provides a rich mix of many of the processes, people, programs, interactions, and/or structures that may be needed for this kind of research.

All participants have worked and still work with Black patients and all but one, grew up and got their undergraduate training in South Africa. The fourth participant was born in South Africa, went into exile as a child and came back to South Africa to do her post-graduate degrees.

The interns were both completing their final (internship) year of training. There were three female and one male participant, all but one with their first languages being African. The other one, because of having gone to exile at a very young age, speaks English as a first language. However, both her parents speak indigenous African languages and the participant is fluent in an indigenous African language. All interviews were done in English, because this felt most convenient. This issue will be discussed later.

DATA COLLECTION.

Semi-structured interviews (given in Appendix) were used. These were designed to provide the researcher with an opportunity to motivate participants to give relatively complete responses and to probe for more answers. This also assisted in providing "the researcher room for active intervention" (Potter & Wetnerell, 1987, p. 163), to probe further based on non-verbal cues, follow-up questions and explore responses, (see Huysamen, 1995; Lemmis, 1987, cited in Allan & Skinner, 1991, and Mitchelle & Jolley, 1992).

Semi-structured interviews are also helpful in their flexibility and therefore suitable for the kind of research approach used, that is, qualitative, with the structure of the schedule helping to focus on themes targeted or expected.

DEVELOPMENT OF THE INTERVIEW SCHEDULE.

The structure of the interview schedule was informed by personal involvement as well as drawing from some literature, for example, Bührmann (1984); Crabtree & Miller (1992); Kleintjes (1991); Marshall & Rossman (1989); Roper (1994); and Wolcott (1990), whose work gave some understanding about interviewing as one of the tools of qualitative research. I also got some input from some of my colleagues who were not participants in the study. From the first draft, which helped the researcher "in making some tentative or working hypotheses" (Huysamen, 1995), came some provisional questions to investigate, which were expanded upon until the final schedule was developed. However, even though I referred to the "final" schedule, it was a flexible one with one interview informing the next. This is one of the elements of qualitative research which, unlike quantitative approaches, does not have "prescriptive procedures, so that often individual investigators tend to adopt techniques, rather than adhere to recommended protocols" (Morse, 1994, p. 3).

CONSTRUCTION OF THE INTERVIEW SCHEDULE.

The final schedule included both closed, and (mostly), open-ended questions. For example:-

- a). Question 15: Was there enough vocabulary in the African language that you use(d) to communicate or elicit enough information from them?
- b). Question 5: How do you think your Black patients perceive(d) you?,

Most of the questions are aimed at exploring respondents' views on certain aspects of their experiences in relation to their Black patients. The questions were also compiled drawing from the work of Ahrends (1995); Bührmann (1984); Kleintjes (1991); Kottler (1996); Mange (1994); Mkhize (1981); Ngcobo (1981) and Roper (1994).

DATA GATHERING.

The schedule also included some identifying information, (gender, social class, race, etc.), as well as main, expected themes. As already stated, the participants were interviewed at different places and days, with data gathered by means of audio-taping the interviews. The interviews ranged in length between an hour and an hour and a half, which was influenced by, *inter alia*, the extent of the detail participants went into, and that was, in turn, influenced by their experience or length of being in the field. As far as possible, the recorded material was transcribed verbatim, yielding forty pages of written text.

Participants were also assured of confidentiality in an event of reporting the findings, to further ensure and maximize trust and honesty in their responses. They were also numbered, for reference sake, in the order in which they were interviewed. It is worth noting that confidentiality becomes problematic and even impossible when one is working with representatives of as small a group as Black clinical psychologists in the Western Cape because they might be identified. However, because they are the only ones available, it is impossible to overcome that problem. In what I present I have tried to be sensitive and not to report material which might be personally

embarrassing to participants. This ethical requirement does of course limit what I am able to discuss.

ANALYSIS AND INTERPRETATION.

This process was conducted in three phases. The first phase, which also provided the researcher with relative familiarity with material (Levett, 1988), was covered through personally performing the interviews, transcribing tapes and reading through the transcripts. Also see Hammersley & Atkinson, (1983); Parker (1992); Potter & Wetherell (1987). This process is also supported by Ely et al., (1991), cited in Mange (1994), because of its helpfulness in providing “assistance in recalling the experience, expanding details and often provided [providing] a fresh perspective” (p.21).

In the second stage, the transcribed material was categorized in terms of themes or patterns covered in the interview schedule, particularly the ones identified as the “targeted ones”. Then, a small proportion of unhelpful ones were discarded (Van Maanen, 1993), also for “data reduction” (Wolcott, 1990), as well as maintaining the focus.

Following that, was the third stage, where data were scrutinized and examined more carefully for exposing, among other things, “coherence and contradictions in values, emotions, goals and choices one would not otherwise discover in all their complexities” (Essed, 1994 p. 101, in Bhavnani & Phoenix, 1994). This approach is also shared by Potter & Wetherell (1987).

RELIABILITY AND VALIDITY IN QUALITATIVE RESEARCH.

Reliability refers to replicability of research findings. Kirk and Miller (1986), referred to it as “the extent to which a measurement procedure yields the same answer however and whenever it is carried out” (p. 19). This may take different forms, such as test-retest reliability or inter-rater reliability. Qualitative research focuses on the particular, and tends not to focus on reliability as generally understood. Validity refers to “the extent to which it [the measurement] gives the correct

answer” (Kirk & Miller, 1986, p. 19). Another important aspect of validity (external validity), refers to generalizability of the findings. This is also difficult in a study of this nature because firstly; the study, by definition, is exploratory/qualitative, which looks at the subjective feelings and responses of participants and which can differ from time to time or situation to situation. Secondly the small size of this sample does not in any way suggest that results can be generalizable. However, the hope is that this study will trigger or contribute to already ongoing debates in the area of mental health service provision to people of different backgrounds.

Further of note are other current debates and comparisons between qualitative and quantitative methodologies, especially with regard to what constitutes good interpretation in qualitative research (Hammersley, 1992, cited in Denzin & Lincoln, 1994). The authors identified four basic positions on the issue. The first position is held by those who argue for the application of the same criteria to qualitative research as are employed in quantitative inquiry. Here the argument is that there should be one set of criteria applied to all forms of research, including among others: internal validity, external validity, reliability and objectivity (Denzin & Lincoln, 1994), which, the authors argued are consistent with what they label positivist research. The second position identified is the postpositivist, which argues for the development of evaluative criteria unique to qualitative research, because “it represents an alternative paradigm to quantitative social research (Hammersley, 1992, p. 57; cited in Denzin & Lincoln, 1994). The third position, postmodernism, contends that the “character of qualitative research implies that there can be no criteria for judging its products” (Hammersley, 1992, p. 58; cited in Denzin & Lincoln, 1994). According to this position, the very idea of assessing qualitative research is antithetical to the nature of this research and the world it attempts to study. Fourthly, the poststructuralism position, contends that “an entirely new set of criteria, divorced from positivist and postpositivist traditions, needs to be constructed...such criteria would flow from the qualitative project, stressing subjectivity, feeling, and other antifoundational factors” (Ellis & Flaherty, 1992, p. 5-6; Richardson, 1991; Seidman, 1991; cited in Denzin & Lincoln, 1994, p. 480). In this dissertation, I choose to adopt and therefore argue in favour of the second position, more so because it advocates for the development of unique evaluative criteria for qualitative research because it is different from quantitative research.

Leininger's (1994) arguments, which could be located within the second position, contend that "it is important to use qualitative criteria to assess qualitative methods within qualitative paradigms [furthermore], qualitative researchers should not rely on quantitative criteria such as reliability and validity to explain or justify their findings...such dependence reflects a lack of knowledge of the different purposes, goals and philosophical assumptions of the two paradigms" (p. 96). Also see Morse (1994), who further argues that dependence on such criteria "reflects a lack of knowledge of the different purposes, goals, and philosophical assumptions of the two paradigms...which are radically different" (p. 96).

Leininger (1994), proposes, among other things, six major evaluation criteria for qualitative research. Briefly, these are:

- a). **Credibility**, which refers to the "truth", value or "believability" of findings
- b). **Confirmability**, referring to the repeated direct participatory and documented evidence observed or obtained from primary informant sources
- c). **Meaning-in-context**, which refers to data that has become understandable within holistic contexts or with special referent meanings to the informants or people studied in different or similar environmental contexts.
- d). **Recurrent patterning**, which refers to repeated instances, sequence of events, experiences, or lifeways that tend to be patterned and recur over time in designated ways and in different or similar contexts.
- e). **Saturation**, which refers to the full "taking in of occurrences" or the full immersion into phenomena in order to know it as fully, comprehensively, and thoroughly as possible.
- f). **Transferability**, which refers to whether the particular findings from a qualitative study can be transferred to another similar context or situation and still preserve the particularized meanings, interpretations, and inferences from the completed study.

This may not be an all-inclusive list of issues to bear in mind in evaluating qualitative studies, but it certainly does trigger a certain process in terms of some of the criteria (like validity and reliability), that may be problematic in terms of social research. Evaluation of this study (and other qualitatively

influenced ones) aligns itself with the tradition of not using quantitative criteria to evaluate qualitative studies, (Denzin & Lincoln, 1994), further embracing Morse's (1994) argument and Leininger's (1994) albeit not all inclusive, six evaluative criteria suggested.

It is important to note the current debates around issues of reliability and validity of the methodology used. From this chapter it seemed however, that the chosen, (qualitative) methodology will help in the study of this nature although one will also bear in mind some debates for and against it. In the chapter that follows, which is entitled "Results and Discussion", effort will be made to follow up on themes outlined in the first chapter as well as issues and phenomena raised, particularly in the literature review, with the hope that the methodological approach chosen will be helpful in finding out about those phenomena.

CHAPTER THREE:

RESULTS AND DISCUSSION

Many themes emerged from the study. However, because of the restrictions of the study of this nature, the analysis and discussion will be limited to those themes that are specific to the focus of the study. The emergent ones will also be briefly highlighted, discussed and incorporated into the recommendations. However, they might also form part of another study.

The findings and the discussions will be presented as follows:-

Clients' Demographic Data.

Firstly, information will be presented on whom the clinicians have been working with, in terms of their predominant race, gender, age and social class as well as the clinicians' feelings about that particular group or the variety. It should be noted that the question of a certain gender and age of people who come out and present their emotional difficulties might be universal. However, one's status and age may have a different meaning for Black clients than for White clients, hence the inclusion of age and gender categories.

Clinicians' experiences of their Black clients

This will be covered according to the following:-

- i). the clients'/patients' perception of the clinician and the process;
- ii). the assumptions, (if any) that they bring into the relationship (especially based on the clinician's colour);
- iii). vocabulary and/or linguistic difficulties and/or differences experienced;
- iv) potential differences in the treatment they offer those clients/patients, as opposed to the ones they offer(ed) clients from other backgrounds.

Clinicians' perceptions of the profession

Furthermore, the participants' experience of training, (both academic and social), feelings about being in the profession, their perceptions about traditional healers, ancestors, rituals and other related phenomena, will be presented and discussed.

The chapter will be concluded by a general discussion of preceding themes as well as the "unexpected" or emergent ones. At the end, questions raised by the study will be highlighted and some recommendations made. Throughout the chapter, reference will also be made to relevant literature.

CLIENTELE

Predominant Race:

All the participants have worked with a range of clients, particularly during their internship years. However, within that variety of people they saw, the predominant race was Black, (for all participants), as all did their internships in state hospitals and/or public institutions and having been the only African language-speakers in their teams. Participants felt that they saw more of the patients who could not speak any other language but an African language.

Participants 3 and 4 are already qualified psychologists, with the former having worked and still working in an organization which helps predominantly Black people, while the latter practised privately in a township, seeing only Black patients, although it was not her choice. For Participant 3, she also saw "a fair amount of other races as well", as she said. As for Participant 4, who also worked with White patients in her internship year, she mentioned that there had to be prior arrangement or negotiation between her supervisor and the potential patient (mainly students at a historically White university), to check out if they would be comfortable with seeing a Black clinician, which was not the case for Participants 1 and 3. The difference from Participant 4 is noteworthy especially for Participant 3, as the two trained around the same period, being among the first Black interns in the country given racial inequalities at that time.

Participants 1 and 2 are still completing their internship, with Participant 1 having seen a variety of patients. However, within that variety, she worked mainly with Black people although she also worked with others from other backgrounds. She attributed the fact that she worked mainly with Black patients to her race and language, especially as she was able to understand patients' African languages. Participant 2, who worked in a predominantly black institution (with his definition of black including "Coloured" and "Indian" patients), mainly worked with African-language speaking patients, which he also attributed to the referral system (with only those patients referred to the hospital), and the language that patients spoke. He was the only team member who fully understood the African language spoken.

It appears from the participants' responses that, even though they have had an opportunity to work with a variety of patients, they have worked and still continue to work predominantly with Black patients, which is dependent largely on where they work and/or do their internships. In those cases where they had to work with Black people only, this was usually because they happened to have been the only African language speakers among the team members. This was also to the patients' advantage because they could then express themselves in their own language without having to try to use a second or third language or even talk through interpreters.

Gender:

All participants have worked with more female than male patients, whom they felt, unlike their male counterparts, are more open and ready to come out and ask for help with problems of emotional kind. As Participant 2 put it:

"I think it's got something to do with the fact that, males might look at it as unmanly to talk about their problems, or to even accept that they do have a problem, or to seek help".

Participant 3: ... "I would assume that perhaps maybe I have seen more females than I have seen men, because women will be the ones that present with various complaints that men would usually sit

with for years..."

Participant 4:... "My patients were predominantly female, I saw males as well but the majority of students I saw was predominantly female... I think that, particularly in African culture women are more likely to seek help for, for, eh, problems of an emotional kind than men are..."

However, as already indicated, participants also saw a few male patients, some of whom referred themselves, while the others were referred by other people or came "indirectly", as Participant 2 put it.

"... and the rest [of the men he saw] had to come because they were initially part of the problem, so they had to be part of the solution, so they came indirectly, not directly to seek help for themselves", he said.

Even though all of the participants predominantly saw more females than male patients, not all attributed that to reluctance on the side of men. As Participant 1 put it:

"I think it's been a coincidence, in the hospital system, it was a coincidence".

It appears from what participants are saying that, whether men are reluctant to come or seeing more females is just a coincidence, the trend seems to be, as far as they are concerned, that more females present with emotional problems than males do.

Social/ Class Background:

For all the participants, especially while working full time or as interns in more "public" institutions, (that is, universities, hospitals and Non-Governmental Organizations or NGO's), they worked mainly with poor people and/or working class people who could not afford financially, to

be seen privately. This also includes the ones who could be seen as “middle class”, but whose financial circumstances (medical aids, etc.), could not allow them to be seen privately anymore.

In addition, especially for Participants 3 and 4, who also worked privately, they worked with Black middle class patients who could afford these services. However, Participant 4 also felt that the reasons why people from lower socio-economic groups are unlikely to approach especially private psychologists, could be many, including their cultural/belief systems, as well as their notion that psychological services could be more expensive than traditional healers. She reported however, that she in fact charged on a sliding scale, at rates lower than that of traditional healers.

As she put it: “...I think also because, eh, people from lower socio-economic groups wouldn't think of coming to a psychologist, they would ra..they would probably eh, opt for, you know a diviner, more kind of traditional forms of healing...”

She continues: “...there's a myriad reasons why people of lower socio-economic groups do not go to a psychologist, and many of those reasons have got nothing to do with the fact that psychological intervention is expensive, in many cases, because, in fact in many cases you find that many people go to traditional healers, they might end up paying more, much more than they would to a psychologist...”

Participant 2, who, unlike the rest, worked only with poor, working class and/or unemployed people, felt that middle class people are financially resourced and can afford private treatment. For the poor people, they had no choice but to approach public institutions, therefore risking the stigma that is attached to being seen at what he called a “mental hospital”,

“...in so much as they do have those fears of social alienation of having been seen at those mental hospitals but they still come...”, he said

It appears that, especially from what Participant 2 said, people might benefit a lot from hospital systems and other mental health institutions but get prevented or their treatment gets hampered by stereotypes and stigmatization that communities hold of such institutions. This view is also consistent with what Bührmann (1984), said about the meanings that people attach to certain places:

“...the venue can also have meaning, e.g., being seen in a room at a mental institution, a general hospital or at private consulting rooms can be interpreted by patients [and other people] in terms of his life situation and the nature of his problem.” (p. 33).

From participants' perspectives, it could be hypothesized that it is of absolute necessity for the public to be educated about emotional problems and mental illness as the mentally ill still have to go back into communities and deal with what Participant 2 termed “social alienation”, which is likely to precipitate and/or perpetuate the cycle of relapses or promoting what is sometimes informally called a “revolving door syndrome”, that is, the coming in and out of the hospital like a revolving door.

Age:

All participants worked with a variety of age groups, from children to young adults and also a few patients who were in their sixties, mainly because of the requirements of institutions and/or units where they worked.

Participant 1: “...I think also, because, eh, especially in the hospital, there were more older people, and people suffering from psychological disorders.....at the Strawberry Clinic (pseudonym) because they are seeing children, I would say, yah, there I saw more children...”

Participant 3: "...when I was at Strawberry Clinic, I saw lots of children, and when I was at Castle Hospital I saw more of young adults, because of the Neuro Clinic, when I was in the psychiatric ward I saw a variety of people, in the Peoples Centre (pseudonym) I saw a range from children to teenagers and adults..."

From what participants said, neither the clinicians nor the patients had much of a choice, but were rather working together because of where the clinicians happened to be working, and where patients, voluntarily or not, went to for help.

BLACK PATIENTS IN THERAPY.

Their perceptions.

There was a general feeling among the participants (1, 2 and 3) that very few patients knew what to expect of the process or even what role the clinicians were to play. This was because many people, especially in hospitals, are used to being attended to by doctors, nurses and social workers. So they would first think of clinicians as one of those professionals. For the interns, what made it more complicated and challenging was their status as well as being seen as young, or "students", as Participant 1 got introduced to her would-be-patients at the hospitals, which made her work doubly hard, almost to convince her patients that she is as competent as everybody else, which can take time and a lot of work.

Participant 1 "...initially it's difficult for clients to take me seriously, also because I'm young and Black and most people associate the work with white doctors...however, as relationship develops, after I've demonstrated competence, they get more receptive and trusting....but I assert myself, exercise competence, use boundaries to let them know that this is my job....."

However, participants also felt that some of the above-mentioned difficulties and perceptions of both the therapist and the process could also have been purely on the basis of lack of knowledge about psychologists and what they do, on the side of Black patients in particular.

Participant 3 "...the majority are not sure whether I'm a social worker

doctor, or nurse...mostly doctor, because they medicalise their suffering...but get disappointed when you do not give medication..."

Participants therefore found themselves having to give some kind of education about their role which helps people change their perceptions and those expectations like to be given medication. Others like Participant 3, at times even challenge the role of psychology and its place in the African society, particularly given the problems of dire material need that some patients present with, which they could not help them with beyond a certain point. However, on the other hand, it has also helped participants look at and evaluate other modes of intervention in that context.

This is consistent with Swartz (1996a), expanding on Julian Rappaport's concept of a community psychologist whom he saw as a "boundary spanner", who can be creative, "engaged in the world in such a way that the usual trappings of professional psychology, and especially the rarefied version of professional psychology as value-neutral and separate from the world, are abandoned...trying out new roles, breaking rules, finding out things we would never find out in the confines of the consulting room" (p.6-7).

However, for Participant 3 (particularly while working privately), there were no such problems, because she only worked with those Black patients who knew who they were coming to see and for what reasons. That made it easier for her to carry on with her work. Furthermore, and even though they had a prior knowledge, there was a feeling that apart from being seen and respected as a professional, there were other people who also gave her a status of a healer in relation to their emotional problems. With respect, confidentiality and acceptance, clients began to trust the process.

She also echoed what other participants said about the place where clients are seen, though, in terms of how they then respect you.... "the physical setting says something to the patients", she added.

Treatment Methods.

The participants use different treatment methods depending on the nature of the problem presented. Common amongst them though, was the way of understanding or formulating the situation, which is informed by systems and psychodynamic theories. As for intervention methods chosen, they are dependant upon things like the nature of the problem and, most importantly, the place where clinicians work. For example, according to Participant 1, the length of time patients were able to spend at the hospital constrained her planning and therefore the treatment.

The qualified Participants in particular, (that is, 3 and 4) most of whose Black patients do not stay long in therapy because they cannot afford to, are at times compelled to do brief-term work, crisis intervention and give more practical assistance. Participant 3 also mentioned that Black patients leave earlier than the clinician would recommend because of what she termed “ the feeling of being healed”- short term immediate relief of distress and symptoms.

Other intervention methods that are being used include systems work, which Participant 2 felt enables him to help and empower families in terms of how to deal with and understand each other.

Evidence from what participants said suggests that, irrespective of the person’s background, it is important for clinicians to thoroughly assess in order to understand the dynamics of the patients’ problems and, based on that, make an informed treatment choice. In addition to that, and particularly in working privately, the person’s financial circumstances are crucial. In the hospital settings, the length of the patient’s stay determines the treatment method to be used. Such factors, it seems, dictate time frames within which goals can realistically be met.

Some responses, notably those from clinicians who have worked in hospitals, spoke of an experience of reduced effectiveness as professionals arising from an unspoken institutional imperative to somehow make people feel better as soon as possible. Clinicians described feeling

that they were required to “get patients healed and ready” in order that they may return to unchanged external environments which, in many cases, had served as precipitants of the illness.

These and other difficulties facing mental health professionals, and psychologists in particular, in the South African context, are consistent with arguments raised by contemporary writers in the field (see Dawes, 1985; Kottler, 1996; Perkel, 1988; Swartz, 1996a, b; 1998 and Vogelmann, 1986).

In addition, it is also worth noting how, especially Participant 3, worked with patients from other backgrounds, particularly White patients. The emergence of such “unexpected” themes was made possible by the nature of the research instrument used (the interview schedule), which enabled the researcher to probe for more responses. This participant reports that when she works with patients from different backgrounds, she brings to the work her sensitivity to socio-political, cultural and other variables that could be influencing the situation.

As she said:

“...so the working differently was not about giving the service that is watered down but rather a service that is taking into account consideration of the socio-political, cultural variables that people come from and not negating that as a factor in a therapeutic process, so that whatever the hurdles that I come across I understand it within that context...”

This way of working is also consistent with how other participants also (even in working with Black patients), adapt their therapeutic interventions to the context with all the constraints referred to earlier.

Long-Term Therapy with Black patients: Does it work?

This subsection is aimed at exploring respondents’ views on what Long-term therapy means for both clinicians and their Black patients, and if it’s a viable option at all, especially given all the problems that have been raised in terms of how long patients stay and why. All felt that long term therapy can work, though it gets constrained by factors like money and the patients’ need to “feel

better soon”, in order to carry on with life’s other challenges, and not using the process as a better understanding of themselves (Participants 1,2 &3).

Participant 1:

“...but I think that what does come into play is that often people from lower socio-economic background do not have money to be sitting in therapy for a long period, so you work with that, and focus on certain things, but acknowledge that you are not going to be able to work on all of their problems but focus on some of their difficulties..”

Participant 2:

“...but with the vast majority of our people, who cannot afford the luxury of paying for that service and secondly, who cannot really understand to what extent will coming to talk about your problems would be of help rather than dealing with them head-on...”

Participant 3:

“...many don’t stay for a long time...the fact that sometimes constraints mean that people can’t stay in this process for a long time, so they’ll try very hard to get better soon...the whole notion of using psychology as a crutch hasn’t been the culture of Black people, which I think other cultures have developed, not out of necessity but I think out of need”.

In addition, Participant 3 also felt that with the history of Apartheid, violations and brutalities against them, Black people developed a sense of resilience, which enabled them to cope with extremely stressful circumstances.

Participant 4 worked mostly with Black middle class people, who were more informed about the process. The similarity with other participants is that her patients did also not stay very long, with the longest being eight months, once a week sessions.

“...it really varied on the type of problem...some problems are like transient, you know people who, someone who is suffering a loss for example, or someone who is going through a difficult patch, ...and some of the problems are more longer-term problems like, you know, long-lasting emotional challenges that people face...”

Do patients make assumptions based on clinician's colour?

All participants have experienced that all patients, and not only Black patients, do make assumptions based on the clinician's colour. Both Participants 1 and 2 experienced it more with Black patients, while Participant 3, to her surprise, it was mostly with White patients. Participant 4, although she did experience it, felt differently from others about it.

Participant 1 felt that some of her Black patients did expect that, because she was Black, she should understand certain things about them, even though she did not, which became a slight problem for patients in that it was like she was distancing herself from them. She did however, make it clear to them that she might understand certain things, but that does not mean she shared similar beliefs and/or experiences. For Participant 2, even though he could see that Black patients “identified” with him and trusted him because of his colour, patients (and particularly one who was concerned that he was being researched), made it clear to him that for as long as he is in that particular setting and thinking like “those White doctors”, would never feel fully understood. This, Participant 2 felt, was educational for him in that he could understand the patient in his context and also accommodated

his belief in other forms of healing. Furthermore, he could therefore understand when they insist on being treated at other places as well, or by traditional healers.

Participant 2: "...I do understand that I was a clinician and I am not the only person who's working in, and if it does not suit my patient, he can go and seek help elsewhere..."

Even though Participant 3 had similar experiences, hers were mainly with White patients. This happened especially with the ones who felt let down by what she termed "the White world" and looked to her as "the greatest person ever", therefore expecting her to fulfill that role:

"...assumptions are usually based on what has hurt us out there, who we think can save us...in actual fact it's interesting that I had more White clients thinking that I would help them more than White people, because they've been disappointed by the White world and they feel they've been failed..."

In addition, she also felt that assumptions like these are influenced by the patients' perceived or real helplessness,

"...I also think when you are in a position of helplessness it's natural to think that the person who makes things feel much more clear to you is probably good and saving..." she said.

For her what seems important is not necessarily to challenge such people but rather to be with them where they are, be realistic and not let them down by confronting in a negative way and setting them up for other failures. It depends on their situation.

Participant 4, although she did experience some patients having assumptions about her, she did not think that it had anything to do with colour. She felt that it is tied with the people's choice of therapist. This choice therefore (of either Black/White/male or female therapist), is based on

patients' experiences. In addition, she felt therefore that a male patient might choose to work with a male therapist because of his feelings that he might understand his situation more than a female therapist, especially in situations where they feel that their emotional difficulties stem from their relationship with their female partners.

“...I struggle with that question, because even a White person going to a White therapist has certain assumptions; assumptions about therapy is not a problem for Black people only...for example, when a White man goes to a male therapist and they've been emotionally ravaged by their partner's infidelity for example, there's certain assumptions that he has, he expects that this man should understand what deception means, ...so it's not a unique feature of Black therapy to have expectations...”

From the participants' perspectives, it appears that assumptions and expectations about the process do exist. However, they also felt that those assumptions can be from anyone, (Black or White, male or female) and are therefore influenced by different processes, especially the clients' life experiences and/or experiences of other therapists. Participants also highlighted the sensitivity on their part, to what the clients feel might be good for them.

“Respect” of patient by therapist based on age or gender.

Participants 1, 2 and 3 experienced some uncertainty in working with older patients, particularly in the beginning of the process. This was especially when it came to asking about or mentioning certain words which, especially in the African culture, young ones are not expected to ask older people. These participants however, dealt with the situations differently.

Participant 1 dealt with it by “putting across a kind of frame, boundaries, and, just explaining, the work that you are there to do, and almost working, with those difficulties”, she said.

She continues...issues like sexuality, menarche, etc., especially in the History-taking interview

I struggle to, and I have done it but always find that when I do ask those things, I ask almost with an apology”.

Participant 2, when faced with such difficulties, dealt with them through assuring patients of confidentiality and giving some information about the type of questions that he is going to ask, :

“...What helped me was to actually start by informing the patient that whatever we do was confidential and it won't go out and which I think, made them to be more relaxed and also informing them that there are going to be a lot of questions that I would be asking them, some of them are weird questions but they help me unpack and understand where the problem lie”, he said.

Participant 3 experienced more difficulties when she was in training in terms of asking certain questions to certain patients. However, even though it was difficult, she talked about it in supervision, and also showed respect in other ways including the way she received patients, which made them more aware that she understands them. She also made patients aware and used their coded ways of talking or referring to certain things, which also helped a lot.

“...Initially when I started, those were very difficult, those were blind spots, and I tried to evade them and not in a way that I wouldn't talk about them in supervision... I think it also depends on how you say things to people you can still show respect not in terms of what you say but in your being and it takes a lot of practice, and respect goes a long way in terms of the way you receive the person and the sense that you are there for them, not a young person who does not know what they are doing but as an experienced human being....and I think also it's having knowledge of how to, because some people say Black people don't talk about sex, but there's

a coded way of talking about these things and if you can acknowledge that these coded ways are the right ways...They might be giving you that coded message "I'm smoking the green thing" not wanting to say "dagga" but if you name it for them what they know,... [is that] you understand them..."

In addition, especially in relation to Black patients who are older than her (say in their 60's), she found it appropriate to address them as adults.

"...Like for instance in contact with an older man in their 60's, you just can't say "Mr. so and so", people refer to them as "Tata" (Father)...I think we can explain as to why we do that...it's trying to make a situation as familiar to people as possible", she said.

Participant 4, because of working mostly with people who understood the process, did not have much problems around naming certain things. However, her only concern came when and after going through the process of divorce. She felt that she was going to forfeit the respect that she got from the community because of her new status. However, that did not seem to happen, especially with her patients. They still came to ask for help, and to her surprise, with marital and other relationships problems. Through showing respect to people in similar ways that have been mentioned by Participant 3, her relationship with patients was still fine.

Participant 4.. "...I think it's delivering, the way you project yourself, you know, there are so many things that you have to think about to maintain a certain, to project a certain image about yourself, particularly when you deal with Africans, precisely because we know all those things are important...", she said.

It appears that, even though all participants dealt with it differently, respect can be an issue when working with Black patients, making it difficult to say certain words at certain stages of the process.

However, what seemed to contain both patients and therapist was also different with different people: “boundaries and frame” (Participant 1); “confidentiality and explanation about questions to be asked” (Participant 2); being human and using patients’ language “coded” (Participant 3) and “the image that you project” (Participant 4). This also raises the issue of working in a relatively close-knit community where you may be known personally.

Linguistic Difficulties/Differences.

Participants 1, 2 and 3 reported to, at times, struggle with the use of certain words, especially the ones that might not exist or are not easily translatable from English to Xhosa, or any African language. Participant 1 struggled particularly with getting clients to reflect on their feelings, which made her ask them in a form of a story or an analogy:

“...but I think that, sometimes, when trying to reflect... upon feelings and really trying to draw out a kinda feeling, that, I found quite difficult, because the words are kinda literal...it’s a bit difficult sometimes to get people to get to certain things, whereas it’s easier to do that in English... I would either use English or, at least try and use an analogy, to describe it, try to find a story..., she said.

Participants 2 and 3 struggled with words like “masturbation”, which Participant 2 skipped completely and never asked. However, for Participant 3, and with experience, she developed ways of asking them, which include the use of phrases and proverbs available in Xhosa language. She, like Participant 1, also used analogies, though it took longer.

“..I never skipped things, I always found ways of communicating, but sometimes it would take me, when I want to translate directly, it would take me twice the time...the word you used “masturbation” is probably the difficult one to grapple with, but in the

last while I found proverbs and symbolism and ordinary sayings that are used..."

Participant 4, though she indicated that she did not struggle with particular words, mostly used analogies and "the patients' language", to get to certain feelings

"...therapy is about being where the patient is, really it's not a problem if you stick to that..

However, she was concerned about the meaning that gets lost when people try to translate directly from English to Xhosa, especially when people make use of interpreters who are either "not bothered", as she put it, or do not understand certain words used. She gave an example of a situation where...

" the patient, during the visit we had to the outside clinic, with one psychiatrist at Khulumani Hospital (psuedonym) where I was doing my internship. The psychiatrist was reviewing this patient and so she had been working through a nurse who was interpreting, and so all the way driving back to Queenstown, we were talking about this patient and she said she was happy with the progress, the only thing she was concerned about, was that the patient said that his blood was running, and she thought that, you know for her that was a clear sign of pathology, the patient said blood running, you know in Xhosa, if you say... "hayi ndiphilile igazi lam liyabhaleka" and the nurse say "oh I'm well, my blood is running" and the doctor of course thinks "oh my goodness this person is mad", only to find that the person was saying "I'm as fit as a fiddle."

The participants' responses indicate that they have struggled and might still be struggling with certain words that are easier to say in English than they are in African languages. Most of them dealt with the situations differently, amongst which was either to skip them, use analogies or

patients language, proverbs available, or just to be where clients are at. It was also worth noting, especially from experiences of Participant 4, the limitations that accompany direct translation, especially when someone who is not trained in a particular field (or not taking the welfare of the patient seriously) is involved.

BEING BLACK-IN-TRAINING: PARTICIPANTS' EXPERIENCES AND EXPECTATIONS.

Academic.

All participants had different experiences and expectations of professional training. Furthermore, it should be noted that not all trained at the same place and time. Both participants 1 and 2 were still interns at the time of the study, with Participant 1 studying at a historically White university while Participant 2 was at a historically Black university. Participants 3 and 4 qualified in the late 1980's. Both however, studied at historically White universities; Participant 3 in the Western Cape, and 4 in the Eastern Cape.

For Participant 1, training was an unexpectedly positive experience. However, the positive side of it was as a result of her putting a lot of effort in order to avoid being undermined. She needed to prove, to herself and those that would underestimate her abilities, that she deserved the place in the course and did not just get there because of the colour of her skin.

“...It's been quite positive...I actually expected to struggle more I expected to be kinda undermined, a bit put down, and needing to struggle more...I think there's always that thing there, ehm, you don't want to be perceived as a good Black...instead it makes you to have more of a drive to work harder...people see that you are competent you did not get there because you are Black”, she said.

For Participant 2, it was a mixture of both “good and odd” experiences, as he put it. It was good in a sense that for the first time, all the theories that he learned in his undergraduate and Honours years

began to make practical sense. He could understand the problems that people presented with within theoretical frameworks. However, the “odd” part of it was the dominance of European theories, needing to hear more of others, with the likes of Fanon (1969), and others, who he feels have made valuable contributions towards the understanding of human development.

Another aspect of the “oddness” was as a result of his own academic background which he felt did not prepare him enough for the challenges he faced at university level:

“...I felt disadvantaged by my educational background, which, I think didn’t really prepare me for the kind of work to do, and I felt dragged along”, he added.

Participants 3 and 4 experienced the course to be a bit difficult, even though Participant 4 reported to have had a lot of support from the department. The difficulty was mainly due to not having had prior access and exposure to relevant material. In addition, Participant 3 also felt that as a first generation Black student she did not have support (academic) from family members, friends, etc., with theories and paradigms, which her White counterparts possibly had. Those inequalities then put a lot of pressure on Black trainees to work much harder and for longer hours than others from more advantaged backgrounds.

Participant 3:

“...I would say it was difficult but I think I probably as a Black student took twice the effort to try and master some of the things that were quite available to White students because of the circles they moved in, because of the theory they were exposed to, because of the books they read...

Another factor that participants referred to was that of language. Black students study in English (which is not their mother-tongue). They therefore have to read for a number of times before understanding. After this they have to go work with Black clients, and translate what they have learnt into their own languages. This was a long process which they felt students from other backgrounds did not have to go through.

Participant 3 continued:

“...so as a Black student I have to acquire the book first of all, you’ve got to read the book and understand some of the things and sometimes your family members and people that you’ll go to and ask for help don’t know anything so you were totally alone in terms of information and understanding for yourself...It was also complicated by the fact that you were not only, you work within you language, translating things from English.....so you’re doubly disadvantaged”, she said.

Participant 4 referred to it more as a challenge than a difficulty, and, like both participants 1 and 3, she had to put a lot of effort.

“...there’s no question about that, you know, I think I had to work longer hours...I had to really push myself, so to speak...I took that as a challenge, a challenge to be confronted and to work on, and I did, that’s how I really worked and I survived...I wouldn’t say that there were difficulties, I really believe that a lot of challenges that Black students face in these institutions are as a result of lack of support, and I had support...

From what the participants said, all experienced their courses differently, with both the good and not-so-good experiences. What was common among their responses though, was the need (or unspoken pressure) to work harder to prove that they deserved their respective places in the course, amidst all the difficulties like unavailability of resources, lack of role models or academic support from significant others and language, as indicated by Participant 3.

Kleintjes (1991) also found that, though some black interns felt that they were accepted into the course on the basis of merit, others felt “not good enough”. She further indicated that “some [black] interns have found it useful to discuss the issue with an empathic, direct and objective supervisor...In respect of working with this issue after formal training period is over, interns who have already qualified stated that working as psychologists and seeing satisfactory and satisfying results of their efforts with their clients is an important part of coming to accept and regard themselves as competent practitioners” (p. 23).

Social Experiences/ Interactions in Class.

Every participant experienced their social interactions differently, and unique to their respective classes. However, all experienced, directly and/or indirectly some racism in relation to their White classmates. Participant 1, who did not experience racism directly, reported to have overheard some negative and patronizing comments aimed at undermining Black students:

“...I don't think of sort of experience being undermined or anything, although I've sort of heard, other people, things that are sad, at placements or whatever, upsetting psychologists...remember, there's some patronizing remarks, about, the country being in a state of transition and things like that...”, she remarked.

According to the participant, there were some derogatory remarks at some of the placements where people were implying that Black students do not really qualify to be in the course (Masters), and were rather tokens because the university was moving with the changes that are happening in the country. So it was more of a move from the university to accommodate them, because of the political situation in the country.

Participant 2, who was the only Black student in his class, also experienced what he called “subtle racism”.

“...in as much as we have moved a lot politically, but in terms of our interaction, there’s still a lot of subtle and at times outright racism or prejudice, and it did manifest in our interaction...”

He also referred to what he said was happening a lot in their class. In cases where they as interns had to work in groups, White students always grouped themselves together, Coloured ones together and he was most of the time caught between the groups and not knowing where to fit in. It was also the case when people organized social events like parties, and depending on whose party it was, only certain people (or the ones from a specific group) will attend, leaving him mostly on his own.

For Participant 3, problems of racism she experienced when they (a few Black students) were selected into the Honours class at a historically White university. This became worse when 3 out of 5 Black candidates who applied for the Masters course were selected for the program. In those instances, there were rumors of some White students (more so the ones who did not get in), who were saying that the University (and the Clinic in particular), was trying to get Black students into the program at their expense.

“...we had a difficult time because when we were selected to the Masters class there was an unfortunate thing that happened in our Honours class. In the whole university [there] were two Xhosa-speaking students from third year to Honours, within a predominantly White class ...also applying for Masters and being selected for that there was an issue, there was a feeling in class because three of us who applied got through there was a dynamic where the students...they felt that the clinic was trying to get Black students. Therefore the White students who did not get through, didn’t because the university was trying to create space for us which was quite an unfortunate event and caused quite a lot of tensions...”

Participant 4 also came into contact with some racism, though she said she was fortunate to work under the then Director and the supervisor of their Masters course. That Director, having worked at an Historically Black University, was aware of the possibility of racial tensions and therefore helped in creating good environment for everyone in class.

“...I was actually very fortunate, the department of psychology was headed by David Smith (not real name) who had been at an Historically Black University and who, I think, was conscious, I was the first Black student in the department...there was an attempt to make sure that the environment was understanding...”.

In addition to that, the class was also open to debating and talking about their prior experiences and contact with people of other racial backgrounds, which was a good experience in terms of learning about each other.

One incident involved a fellow White male student, who, throughout his life, has been a farmer and the only contact that he had with Blacks was with his workers. According to the participant, he could not deal with the fact that they were in the same class.

“...I was a woman, I was Black, I mean those are two, very difficult dynamics for a White man, in a situation, or in most situations. Black women are either, you know, they are either prostitutes or they are maids, or, you know, all those kinds of loaded stereotypes about women, and now he had to deal with me as an equal in his own class and he really couldn't relate to me, he used to, play with me, he used to play hide-and-seek with me, and I used to think “my goodness, this is”..., remember it was also an eye-opener for me, and a period of growth, for me as well, and in reflecting on what it means to be a White South African,now this man used to play these games like peeping through my door “Hello Jane (pseudonym)”, and peeping again, he couldn't just walk into my door and say “hello, how are you?”

he had to play these peeping games and peeping back like he would do to his little girl...”.

Supervision.

Participants 1, 3 and 4 experienced their supervisors, particularly during their training years, as sensitive and helpful when it came to problems that their Black patients presented with, which were somewhat unique to them. Those supervisors, who were mostly White, understood the complexities of the situations, were able to learn from them and were generally supportive. However, as Participant 1 said, that did not mean that Black patients' problems were dealt with differently or were given special attention, there was just openness and room to accommodate them.

Participant 1:

“...I do not know that they [Black patients' problems] were given special attention, but I think in supervision, my supervisor will give me assistance on how to work with that...”

Participant 3:

“...but I think in terms of knowledge of some of the dynamics, that I felt that in most cases I was the one who enlightened the supervisor in terms of saying that this does not work in this context, and fortunately I had people who were quite open...I haven't worked with a supervisor that wasn't quite understanding...”

However, she also heard of other fellow Black interns' supervisors, who were not sensitive to their Black patients' situations and context, which was a problem as far as she was concerned.

Participant 4 also did not experience any difficulties in that regard. She got a lot of support from her supervisors as well as other people she was referred to by those supervisors, especially with her projects, most of which explored issues of culture and psychology, with reference to Black people.

For Participant 2, it was different. His particular difficulties with, especially White supervisors, were around the supervisors' emphasis on what he called "internal locus of control", whereby individuals were seen as blamed and pathologised without looking at their context.

As he put it:

"...One of the greatest contentions with the supervisor was the emphasis that my supervisor placed on the internal locus of control. I think that was a problem because I would understand how that person identifies himself. He was not an individual, he was part of a group and whatever he was doing it was not only for himself but family, wife and children and the suffering did have ramifications on those people. In other cases there were times which I thought 'no, this is appropriate, I would have reacted in that way, there's nothing pathological about this', and some of my supervisors would see pathology, which I thought was rather odd".

It seems from what participants are saying that there were differences with regard to how supervisors dealt with problems, particularly those affecting Black patients. However, it also seems that most of the supervisors were quite sensitive and supportive of their supervisees, also eager to learn from them about some aspects of their culture, which were not similar to theirs. However, there were also other supervisors who were not very supportive and accommodative of such issues, making it difficult for the supervisee to learn from that experience, as was the case with Participant 2.

PARTICIPANTS' FEELINGS ABOUT BEING IN THE PROFESSION.

All participants are happy about being in the profession and do not wish to be anything else but psychologists. Participants 1, 3 and 4 would like to work with more than one individual at a time, thereby being more accessible and reaching many people. Participant 4 also felt that such approaches can help people especially with their practical needs.

As she put it:

“..I really think it’s important for people to learn group-counselling skills, particularly among African people, you find that psychology in its clinical orientation, does not yield anything much, really in terms of the practical needs of people...”.

In addition, she also felt that, as far as African married women are concerned psychology can play a role in “freeing women [them] from cultural bondage” because some men, even in “modern times”, would still want to define their marriages and relate to their wives in traditional, oppressive ways.

Participant 2, even though he was happy about being in the profession, is sometimes rather unsure about the effectiveness of his work, needing some reassurance from ex-patients. Coming back and acknowledging the effect of the help given is valued by him:

“...I think it’s very fulfilling and I think I’m doing a lot of contribution in many souls, troubled souls, however, the way in which I do it at times as I said earlier on, it really makes me feel odd because I’m unable to reap the fruits of the work that I’m doing, when the patient leaves the room, I don’t know what is going to happen...so there’s a lot of uncertainties within me about what I’m doing is it really effective?, is it really helping my patients?, especially when they do not really come and say “thank you very much it was very helpful...”.

Participant 3 also acknowledged that even though she is happy about what she is doing, it is also hard and challenging work, though she hopes that it does make a difference to many people's lives.

The participants' responses showed that they are positive about their careers, even though there are a lot of challenges especially about certain realities that people are faced with. Some were also cautious about the application of psychology in its value-neutral, traditional, individual-oriented way, which is not accessible to many people and not redressing certain aspects of the past.

PARTICIPANTS' OPINIONS OF AFRICAN TRADITION.

Ancestors and rituals.

Participants 1, 2 and 3 believe that ancestors do exist. However, for Participant 1, even though she believed in their existence, she was not exactly sure about their role in her day to day life. In addition, she also believes in observation of the rituals related to one's traditions.

“...I think ancestors are there but I don't know what kind of role they play in our everyday life, but like at some things that you do, visiting the graveyard and after that we wash our hands, the slaughtering goat... but I think the rituals are important, because they keep the family connection”, she said.

Participant 2, who also shared similar beliefs, also felt that the ancestors need to be respected and worshipped. He also indicated that [Black] people do worship and observe rituals irrespective of the developments that have taken place, in a form of urbanization and industrialization.

“...I think ancestors should be respected through worshipping and rituals, I think in as much as there has been industrialization and urbanization, our people still continue preaching African religion in various ways”, he added.

Participant 3 felt the same as the above two participants. She also mentioned that she has even recently been participating in rituals herself. She has also been doing her work in a way that is compatible with certain rituals, depending on who she was working with. As she put it:-

“...They do [i.e., ancestors do exist]....and I've come to a point where I'm starting to feel it's important for me to go and participate in a ritual, and I think I've done a few debriefing sessions where I have gone through a ritualistic process with people and it's proven to be much more powerful than sitting and talking”.

Participant 4 felt slightly differently from the others, although she at the end said that she does respect the people who died as well as the places at which they used to live. The difference was in her conception of ancestors. She did not think of them [particularly her parents when they die] as, as she put it “hovering somewhere in the air, you know, or in my house...”,

..but I will, they will certainly have a place in my heart,
and I will respect my home, in so far as it is a place where
they died, and I will respect a place where they rest...”.

However, like other participants, she also felt that she would take part in remembrance ceremonies, even though she stressed that she does not believe that they (ancestors) “control” her life. As far as her patients and their beliefs in ancestors and rituals are concerned, she was open to accommodate them, as she sees herself as proceeding “from a point of view that what the patient’s frame of mind is, [and] what the patient’s world view is...I always steered away from judging”.

From what, especially Participants 1, 2 and 3 are saying, they believe in the existence of ancestors, even though they did not specify their role (2 and 3), or they did not know their role (1). For Participant 4 the difference was that she could not believe that they are “alive in spirit”, or “hovering around” as she put it, even though she would respect people who have passed away. What was common among them though is that, all had no problem with patients believing in and even practising rituals. In addition, especially for Participants 1, 3 and 4, they have taken part in and

would also take part in observing rituals either with their families, or as was Participant 3's experience, as part of her job as a psychologist, as long as it would benefit patients. Even though Participant 2 did not explicitly say that he has observed or will observe rituals, he strongly supported the idea of people doing so.

Traditional Healers and the role their role in mental health.

All participants felt that traditional healers do have a role to play, even though they also had concerns about certain things pertaining to them and/or the way they work.

Participant 1:

“..I think traditional healing does work to some extent. Because, I mean, the methods that they use are the methods that have been used before we had modern medicine, so I believe in their herbal remedies, but what I think is that those things don't work for everything and I think the traditional healers have to realize that and there has to be a responsibility from them, on those things that don't work, to send them to hospitals, in the same breath I think if certain things don't work with us and we believe that a person is so entrenched, I believe that a traditional healer has a role to play”.

Participant 2 also acknowledged the work that traditional healers have continued to do. However, he was concerned with some of them who might not be practising correctly, hence a need for some regulation into what they are doing.

“ ..I believe that those people have managed for a number of years and for many centuries to bring communities and families together...I think they should be encouraged to continue working and practising in as much as much as we find some

“bongas”, traditional healers who end up making that field a mess or a questionable field so maybe some regulation needs to take place”, he said.

Participant 3 also thought that traditional healers have been helpful to societies. However, she also had some reservations concerning others who have abused their positions and have been implicated in murderous activities because they were said to be wanting muti. Such incidents have therefore made it increasingly difficult to even refer people to them, which she felt would be irresponsible on her side. However, she also said that she would not object to anybody (particularly patients) wanting to consult with traditional healers too.

“..The problem has been in the past that sometimes traditional healers have also been linked to some of the killings of people because people want “muti”, so it’s been quite difficult and I think that although I’ve always advocated working with traditional healers, I couldn’t be irresponsible and just refer to them..”

In addition, she indicated that both parties (traditional healers on one hand and doctors/psychologists on the other), have been sceptical to refer to one another. She also said that psychologists and doctors in particular, can learn a lot from traditional healing, which, like psychiatry, “works with medication and counseling at the same time”, she said.

Participant 4 agreed with the other respondents regarding traditional healers’ role in restoration of patients’ emotional stability, containment of psychological problems and providing definition and meaning for what cannot be explained. However, she noted two things as problem areas with regard to their work and therefore possibilities of working with them.

Firstly, she has a problem in the way they say they “point at a person who is responsible for some psychological problem or problems, which may not necessarily be psychological problems in a home...you know they kind of identify that the problem is with so and so”. Secondly, especially

with regard to possible referrals she felt that the two systems (how psychologists and traditional healers work) are very different. She felt that as far as traditional healing was concerned, the patient has to be “shown” in their dreams or through going to another healer, as to who will be the most appropriate one to help them.

As she put it:-

“... the system of traditional healers does not work with referrals, that’s a totally different system, referrals belong to the Western world, ...traditional healing works on a totally different...it’s a bodily thing...it’s more perceptive, you know, intuitive kind of function which also uses physical symbols as well. A traditional healer will feel a pain here as the patient walks in, and they immediately, they have an interpretation, that means such and such, so if you were to refer to a traditional healer, I think it would interfere with the whole approach of traditional healing...”

She continues: “first of all, when people go to a traditional healer they are shown, so to speak. A certain traditional healer, either through a dream or through advice by someone who has gone to a traditional healer...”

All participants seem to agree that traditional healers have been and can continue to be helpful to people who consult them. In addition, participants 1, 2 and 3 also agree that both psychology/medicine and traditional healing might offer each other alternatives or support, though with some kind of regulation, in the light of existing abuse of the system by some traditional healers.

Participant 4 however, felt that the two systems are different, and can therefore not even begin to refer to each other. She felt that referrals within those systems happen at a different level, with

traditional healing focusing on things like dreams (in terms of referrals), while psychology works totally differently.

EMERGENT THEMES.

The emergence of these themes was made possible by the research tool used (the interview schedule), which allowed the researcher to probe and make follow-up questions depending on participants' responses, non-verbal cues and so on. In addition, all participants raised different issues which brought about different and "individual" emergent themes. However, there were some which were common among at least two participants. Those categories are: Witchcraft, Black patients' interpretation of their condition - psychosis or *amafufunyana*, effects of racism on White people, is being Black being different?, as well as the role of community psychology.

Witchcraft.

Participant 1 was ambivalent about the phenomenon of witchcraft, though she could not say that it does not exist. Her ambivalence was because on the one hand she had not come into direct contact with it, whereas on the other hand she believes that there are certain things that happen and that we do not understand, hence the difficulty to discard it outright.

“...It’s difficult to say because I myself haven’t had contact with it, but it’s a trick, I’m ambivalent but I can’t say I don’t [believe that it exists]. I think there might be something like that, I think there are things that happen which we don’t understand, so I don’t know, I can’t throw it out completely, I’m ambivalent about it, but I believe in spiritual forces”.

Participant 2 did believe that it exists, though as something “practical and evil”, which he didn’t think is worth believing in as a way of life.

“...It’s something that’s done by evil, there’s no magic in it, you do an evil deed...I don’t look at it as a mystery I don’t look at it as something spiritual, I look at it as something that is concrete and practical...”

Psychosis or *Amafufunyana*?: Black patients’ interpretation of their condition.

Participant 3 also worked with patients who presented with what could be termed psychotic symptoms, though some of the patients understood it to be *amafufunyana* (a state of negative spirit-possession found mainly among Xhosa and Zulu-speaking people). In response, she acknowledged their definition of their illnesses and respected that, although she also felt that psychological psychiatric understanding could also provide assistance.

“...when a person comes to me and say “this is what I have” okay...if we were to believe that sometimes *amafufunyana* is the way that African people define it, it’s an explanatory model for a psychotic breakdown sometimes, what I need is that something is going wrong to the point where this person is not functioning, that’s one level of understanding so I have to understand that for myself but I don’t ever think it’s my role and it’s fair to say ‘look you don’t have *amafufunyana*’ because that could be very devastating to the patient”

She further indicated that she even accepts it if they feel that they should also (or instead), consult with a traditional healer if they think that that will help them.

She continues “...I believe we should help in a way that we can help and say okay fine, you’ve got *amafufunyana* and people who have come to me with *amafufunyana* I have given this kind of treatment, let’s see if it can help you, but if it doesn’t help maybe something else could”.

In addition, she felt the same about patients who are said to be going through the process of *ukuthwasa* (a call to become a healer). However, she also pointed out that from her experience, most people who should go through *ukuthwasa* never landed in psychiatric hospitals. For those who did come to the hospital, initially went home but later came back after realizing that their diagnosis or understanding of their illnesses might not have been correct.

“...the majority of people that I’ve seen who are going through the process of *ukuthwasa* and are clearly psychotic they should be coming back anyway and after a while they realise that it wasn’t that, but it takes time to get to that conclusion and not for me to force the diagnosis on them”.

Effects of the past (or racism) on White people.

Participant 4 also challenged some of the beliefs that are held, especially the ones that only Black people have been negatively affected by Apartheid or racism.

“...we forget that Whites themselves have been affected, you know, by the past and many people miss that...what racism has done to Whites, what Apartheid has done to Whites... I had an opportunity to observe how White people have been affected by Apartheid, ...now the blessing that I had, was that many people in my department were open to examining this, to interrogating these issues within themselves, and that even with this guy [**referred to under “social experiences/ interactions in class-Participant 4’s experience**], this gentleman who was the only man in class, after I raised, you know, the concern about the way he was relating to me, you know in a very calm and containing manner, he was ready to listen”.

From the participant's perspectives, it appears that because of the history of Apartheid and discrimination against Black people in South Africa, people still continue to think that because Black people are the obvious victims, they are the ones who were negatively affected by that past. In addition, it also seems that, which is also what seemed to work for them in their situation, was to be open about each others' experiences and perceptions about one another which were as a result of socialization or "being on the other side". Facing and therefore talking about these issues also made her realise that she might not have been the only one affected but rather even her White counterparts were affected, although processes that were involved might have been different.

Is being Black being different?

Both participants 1 and 2 spoke about different perceptions that exist about being Black, as to whether it is different from being White. Participant 1 did not believe that the difference is necessarily with Blackness, but rather the context because Black people from different backgrounds are different.

“...I think it's not being Black that is different, different cultural contexts, and you can be Black but come from a different cultural context that does not necessarily believe in some or even all of the traditional or “African” practices”.

Participant 2 emphasized both the Blackness and the context. In that way he felt that being Black is different. He referred to the pre-1994 era which led Black people to live as a “collective” to fight the Apartheid government. In addition, the difference, according to him, is also in the Black people's way of life: believing in the spirits, traditional healers and other related phenomena. The Blackness and therefore the difference could be compromised through, among other things, “practising psychology outright [with them]”, and not acknowledging and incorporating those experiences.

As he put it:-

“...Yes, it's different...because of the experiences we had as Black people and because of the collective engagement

we had, with the oppressive systems....Moving out of that collective may be quite alienating and maybe not believing in ancestral spirits and not believing in traditional healers and practising psychology outright is actually compromising that Blackness”.

Community psychology: What is it?

Participant 3 also raised one of the problems they had during their time of training, which was around the time when Universities (particularly the one she trained at), were adopting the notion of community psychology and therefore introducing it into their curricula. There were problems that particularly Black students had with the way it was defined. Firstly, they felt that Community psychology was perceived as psychology of Black people. Secondly, was the fact that they, as Black students, were the ones expected to “go out there into the community” and do community psychology. Their fears and suspicions about the staff’s motives were further exacerbated by some rumours they heard about the possibilities of the university employing a Black lecturer, possibly to be responsible for that course.

“...[There were problems] with the whole notion of community psychology and how we were expected to go into the community, the two of us, me and Shirley Scot (pseudonym)..at the time the university could not quite explain to us what they meant by community psychology. There were statements made about employing a Black lecturer, we wondered whether community psychology was about being Black...or whether it was a situation that was going to try and deal with Black problems, whether it was a psychology of the underprivileged and therefore different, so the definition of community psychology was problematic...”

She continues:

“..and also there was a feeling from us that we’ll be carrying these kinds of “different briefcases” with “different tools” going

to these “different people” doing “different things” and we didn’t want to be part of that...”

Other concerns that they as Black students had were that they were given all Black patients who came to the Clinic and none of their White counterparts were allocated Black patients. They felt that White students were “protected from the reality of dealing with Black clients”. However, that seemed to have changed after the two of them demonstrated their dissatisfaction and the participant also indicated that she was happy that measures were taken to rectify the situation. One of those include the initiative that was taken by University of Cape Town in particular, with regard to the introduction of its Bicultural Workers Program, as has been discussed previously. This program not only offers White interns access to Black patients through trained translators and interpreters but also Black undergraduate psychology student exposure and therefore an opportunity to pursue psychology as a career, which was not the case a few years ago (see Swartz & Maw, 1996).

As Participant 3 said:

“...I’m glad now that the University is using Bicultural Workers and getting White students to see Black people because the only way that White students are going to learn about realities of this country, and some of the problems that have been caused by Apartheid, is that they should be working with Black people...”

SOME CASE ILLUSTRATIONS/EXAMPLES.

PARTICIPANT 2.

African Tradition, Psychology and Religion.

This participant had a female client whose son was killed by his girlfriend. However, there was also a rumour in the community that he had committed suicide. In his interaction with the family, Participant 2 noticed their level of traumatisation and their complicated bereavement, with the

exception of the client herself. She was trying to be strong and supportive to everyone, with father also having broken down and cried in front of the family for the first time.

As another way of getting helped, this mother also consulted with a traditional healer, who gave her a brown powder which she had to sprinkle over the grave as a way of saying good bye to the son, also saying how she missed him. She brought that powder along to therapy to show Participant 2. He did not have a problem with this. A few weeks later, possibly after also having performed what she was told to perform by the traditional healer, she came back “a different person”. He reports that she was talking openly about her son, problems and everything that she could not face before. This even her family was surprised to see her doing.

Later in the process, she had to go to the traditional healer again. This time he indicated that ancestors were expecting her to slaughter a goat and perform what is called “umbuyisa”. This was the ceremony to “bring her son’s soul back from the wilderness”, which will also help her come into terms with the loss. However, her situation was made difficult by the fact that she was then a born-again Christian and that process was against her religion, but she wanted to go ahead with it. She did go ahead and with the support she got from therapy, she managed to cope.

Striking issues for Participant.

- a). The support of what he termed a “well grounded social system” which he said made his role easier
- b). The conflicts that the therapy process helped her deal with, particularly in “having to transcend religious beliefs to keep herself intact”, in terms of doing what’s expected according to the tradition, which is in conflict with her religious beliefs
- c). A realisation that he came to in terms of working with African people “who attach their own meaning to things and which we need to respect”
- d). Being caught up in a situation of being unsure as to whether to be involved in some of the processes (especially going with client to the grave and making suggestions in her saying good-bye) “and will it be regarded as a good thing?”, he asked.

e). Having to be in a room with the family where mother is trying to be strong but the father breaks down and cries and later on having to try and work with the family through stereotypes like the one that the father is not expected to show feelings of hurt. In addition, struggling to get the father to accept help in a form of therapy for himself, which he refused possibly because of embarrassment.

PARTICIPANT 1

Experience with an African client.

Participant 1 relates the following:

It was my experience when working with a particular African client that cultural issues relating to age were highlighted.

Initially before the trust had developed in the relationship and the client was making her own assessment of me as her therapist, although I had told her my name she viewed me as a child in her eyes.

She was forty and although she did not know my precise age she was aware that I was younger than her and for the first two sessions she called me “nono” (little girl). Initially this made me uncomfortable as this is like a pet name and I was not sure why she was using this name. I did not challenge her for this for two reasons. Firstly because I was also aware of offending her and being disrespectful, but also because I wanted to look at it more closely at the situation.

Having assessed the situation it turned out that after she began to trust me as a professional she stopped calling me “nono”. She also became more open and was able to discuss sexual issues that one culturally would not discuss with a child or someone younger than themselves.

Although she stopped calling me “nono” an interesting dynamic developed in the therapy where she began to perceive me as the daughter she never had. She would then invite me to her house or bring me fruit occasionally. These gestures were to show gratitude but could also be understood within the therapeutic context of what she was experiencing and her transference response to me. Interestingly as the therapeutic relationship developed she had pride in the fact that I was African. She also felt able to discuss particular things with me

as the result that she felt other people (Europeans) would not understand, for example traditional healing rites that she had gone through.

It seems from this chapter that not only the expected themes came out but also a lot of unexpected or emergent ones were also important to note. It also seemed that some issues were a bit more complicated than one expected, and also that there were differences amongst participants, irrespective of that they are all Black. Similarly, their Black clientele also formed a diverse group, which is an important factor in terms of clinical practice. This suggests that certain assumptions that we hold of people (either of their similarity or difference), are not necessarily true.

In the following chapter, which is the conclusion, a summary of some of the themes will be done. This will be followed by some of the limitations of this study, challenges in this area as well as the implications of the study of this nature, on clinical practice, training and future research. The chapter will be concluded by my own impressions/experiences of conducting the study which will attempt to take the reader back to the comments I made (about my personal experiences) in the beginning of the first chapter.

CHAPTER FOUR

CONCLUSIONS AND RECOMMENDATIONS.

SUMMARY OF MAIN POINTS

The following will be briefly summarised as the main points from the study:

treatment, assumptions, language, alternative forms of healing, public education on mental health issues as well as need for psychoeducation in the process of therapy.

It seemed from the study that the treatment that participants offer to Black patients is not radically different from the treatment they would offer to any client. However, the only difference is in the importance of taking into account cultural, and socio-political factors, because issues like poverty and discrimination, for example, dictate of them to do more than just therapy. This issue was also highlighted earlier, borrowing from the work of Swartz (1996 b), who indicated that therapists in such situations need to be creative, "break the rules" and go beyond the confines of the consulting room or even our theories, which do not always take our context adequately into account. Of further importance is to make a thorough assessment of all issues (which they will do for any client). All participants' understanding of the clients' difficulties is informed by systems and psychodynamic theories, which also inform their treatment methods. This may be a function of where Participants trained.

As for assumptions that patients bring into the relationship, Participants differed, with 1, 2 & 3 thinking that Black patients do have assumptions based on clinicians' colour, assuming that they both (client and patient) share the same beliefs and experiences.

Important for clinicians is to respect that but also to make it clear to patients that they might not necessarily share some beliefs and experiences with them. Trust and respect seemed important because clients do come to the realisation of differences in background. Participant 4 agreed that assumptions about differences are there, though not primarily based on colour but patients' experiences of the world. This occurs not only with Black patients but also with other patients from other backgrounds as well, so for Participant 4 it's got nothing to do with one's colour. In addition, it is worth noting the multifaceted nature of people's identities (gender, class, race, educational background, political ideology etc.), which could also influence people's choice of healer/therapist and those can also form the bases for their assumptions of others.

Language also seemed to be an important issue which, according to participants is a powerful tool, not only in its literal form but also in terms of the clinician to understand the meaning or nuances, "coded language" as put by Participant 3. Of further importance is for the clinician to even name certain things for patients if such coded language is unclear or precipitates anxiety on the clients' side. This may help clarify for both parties to ensure that they are having a common understanding. Furthermore, it can also help clinicians to learn from patients. This also raises an important issue that, especially in working with Black patients, Black therapists might be at an advantage in terms of language. However, it is also important for psychologists in South Africa to be exposed to different people in order to understand their culture, language etc., so that not only Black clinicians work with Black patients and White clinicians with White patients.

Participants also felt that having worked in public institutions has been helpful in terms of assisting patients who might have had to work with interpreters. As the literature shows, working with interpreters presents difficulties.

Participants acknowledged that alternative forms of healing also need to be explored, especially given that patients do make use of them, but also in acknowledging that psychology might not offer all answers to all patients' difficulties. However, it was also clear that there has to be some care around this because, according to Participant 3, some of the people who call themselves healers have been and still continue to be implicated in certain killings of people in the name of performing rituals or healing them. This also makes it further important to make good research in terms of those forms of healing in order to know, if possible, exactly how they work and what their specialities are.

Public education and awareness of mental illness also seemed to be an important aspect which will help prevent the cycles of relapses, as the public still has negative perceptions and stigmatises people who have been helped in mental health institutions. Participants cited examples of patients being stigmatised or patronised. This is not unique to Black patients or to South Africa, as many international accounts in books and films show.

There was also evidence, from the study, of the need to, during or in the beginning of the process of therapy with Black patients, educate them about what the process of

therapy is. It seemed from the participants' responses that they were still perceived as nurses doctors or even social workers.

LIMITATIONS OF THE STUDY.

Firstly is the sample of the study, which was not only small but also poses challenges in terms of confidentiality, because participants can easily be identified by either their former and current clients or their colleagues/other professionals who might have worked closely with them. However, it is also worth noting that this study was aimed at contributing to the current knowledge and debates around cross-cultural issues in treatment and not to identify as to which clinicians worked with whom and what their difficulties were. The author therefore wishes to apologise for unintentional exposure or inconvenience that could result from this particular study. Effort has been made to be respectful to participants.

Secondly is the issue of language used. All interviews were done in English, which was not even discussed with participants, though one of the aims of the study was to look at how to work in African languages. However, English seemed to be the easiest language through which to conduct the study, as I (and one of the participants) am not a first language Xhosa speaker. The fact that we, without thinking, discussed the material in English underlines the dominance of English in psychology (and other) training.

Furthermore, there were also a lot of themes (expected and emergent) which were not fully covered (especially in the literature review). However, because of the small nature of the study, one could not do otherwise.

Lastly, not much has been written in this area, so there was a limitation in terms of literature available to draw from, which might also be the reason for some themes not to be as well covered as others.

IMPLICATIONS OF THE STUDY FOR CLINICAL PRACTICE.

Three issues seem to be important for practice. Firstly, clinicians must take our South African context into account. Walaza (1997), in her working with traumatised African patients, referred to some challenges she was faced with in unpacking (and adapting) “the psychological jargon in a way that did not lose meaning, but at the same time, retains its relevance in African culture” (p. 27). The effect that the past had on people, in terms of their socio-economic and cultural factors which therefore means that we have to adapt our theoretical practices to fit in with all of that. Secondly is the fact that if clinicians make a good assessment of the difficulties and all the dynamics involved, there might not be difficulties with offering a good treatment. Thirdly is the importance of understanding the clients' language, not just literally but also the meaning behind the use of certain words which might, if misunderstood lead to pathologising rather than helping the patients. Words like “*amafufunyana*”, “nerves” and other somatic complaints might mean different things to patients and therefore

exploring their meaning with the patients seemed to be very important to make an informed diagnosis and therefore treatment.

IMPLICATIONS FOR TRAINING.

It seemed from both the study and the literature reviewed that there is a need to train more indigenous language speaking clinicians in order to redress the imbalances that exist. However, it also seemed that this might not only be the only solution because it might not necessarily be true that only Black clinicians can understand all Black patients (or even that all Black patients would want to be seen only by Black therapists). Of further importance was the question of sensitivity and respect of differences, which can also be demonstrated by clinicians from other backgrounds.

However, an important factor that could help in addressing those imbalances referred to is the need for more transparency from the controlling bodies (like SAMDC), to keep and provide statistics in terms of races because if not, no one will be sure as to how many registered psychologists are from which background, which will further make it difficult to keep track of training of more people from a certain background.

IMPLICATIONS FOR RESEARCH.

From this study one realises that there is a need to do more research into this area, and possibly a much bigger study (to incorporate other regions or even compare the trends

between them) which would contribute to the understanding of how, especially Black people can benefit more from the work done by psychologists. It might also be interesting to ask some of these questions to clinicians and patients from other backgrounds to look specifically at, among other things, assumptions, their experience of therapy, etc., which might not be as different as we may think. In such a study, it might also be important to also look at the effects of apartheid and racism on, especially White people because (as one participant pointed out), there is a belief that because Black people were oppressed, they are the only ones who can claim victimhood, whereas White people (and people from other backgrounds) also have been affected, albeit possibly differently, by these. So it would be interesting to find out how.

There also seems to have been some inconsistency (and even hesitancy) on the side of the participants to speak for or against indigenous healing. This possibly points at the need to do more research (and maybe not just "documentaries") about those forms of healing, which would put clinicians in a better position to argue for or against co-operation with such forms of healing. However, of further importance is for indigenous healers to also be explicit about what they do so that clinicians and patients can make informed and responsible decisions about consulting or cross-referring with and to them.

CONCLUDING COMMENTS

In conclusion, as mentioned at the outset this thesis came out of my personal experiences while training to become a psychologist. In the process of doing it I also realised that I was not alone in terms of struggling with certain issues that came from working with Black clients in particular. Another thing that also came out for me was that many issues were also far more complicated than one expected. Clearly, if this study were repeated in a few years' time issues would be different because we are in a changing environment. This dissertation is a signpost on the road of change.

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APPENDIX

Questions

A. IDENTIFYING INFORMATION (CLIENTS).

1. What is or has been the predominant race of your clients/patients?
 - 1.2 Why do you think that was the reason?
2. Their gender?
 - 2.1 Why?
3. What is/was their social background?
 - 3.1 If only one group, why do you think was the reason?
4. Their age group?
 - 4.1 Why?

ABOUT YOUR BLACK PATIENTS/CLIENTS...

5. How, do you think, your Black patients/clients perceive(d) you?
 - 5.1 Did/does that affect the way you perceive yourself?
6. For how long did/do they stay in therapy with you?
 - 6.1 Can you say why they stay that long?
7. Do you offer them a particular kind of treatment, (e.g. CBT instead of Psychoanalytic Therapy)?
 - 7.1 Is that/are they suitable intervention methods/strategies?
 - 7.1.1 Why do you think so?
8. Do you or did you work with clients/patients from other backgrounds in the same way or differently?
9. Why/why not?
10. Can you comment on whether or not you think long term psychotherapy is a viable option for Black people?

ABOUT YOURSELF.....

A1 In training....

11.1 How was your academic experience of being-Black-in training?

11.2 Did expect anything different?

12.1 Socially?

12.2 Your expectation(s)?

13. How was your experience of supervision, especially with issues that were affecting only your Black patients/clients?

14. Was race ever an issue in or for supervision?

14.1 If "yes", was it addressed adequately?

A2. With Clients.....

15. Was there or is there enough vocabulary in the African language that you use(d) to communicate

or elicit enough information from them?

15.1 How have you dealt with instances where there were not?

15.2 Did you convey the same meaning/message to them?

16. How did you deal with issues of "respect", with those who would not talk about certain matters because you were young/older/male/female/married or unmarried?

17. Do you always understand or even believe clients/patients who present with Psychosis or Somatisation, but insist that they have been bewitched/have "amafufunyana" or "ukuthwasa"?

17.1 Can you say why/why not?

A3 ABOUT THE PROFESSION...

18. How do you feel about being a Psychologist or working in this field?

18.1 If given another choice, would you still want to do this work?

PATIENTS' ATTITUDES OR ASSUMPTIONS...

19. Are there any assumptions that they come with, that you think are based on that because you are also Black and so you can understand or agree with them?

19.1 Can you give an example

19.2 How did you respond to that?

19.3 Did confronting/or not confronting such assumptions affect you relationship?

20. Do you think that your Black patients/clients understand the process of therapy?

20.1 If not, how do you get them to understand it?

21. Do you sometimes have to do more than therapy with them, e.g. even advocacy work for those who are in desperate situations?

BELIEFS...

Can you share some of your opinions on the following:-

22. Ancestors, whether you think they exist or not..

23. Rituals like slaughtering aimed at appeasing ancestors...

24. Witchcraft, particularly "amafufunyana"?

25. Traditional Healers, and if they can offer an alternative or concurrent treatment to Psychotherapy?

25.1 If you think they can, do you ever discuss that with your patients/clients?

15.2 Would you ever refer somebody to a Traditional Healer?

26. What do you think about "Ukuthwasa" or "call" to become a Sangoma/Traditional Healer?

27. Do you think being Black is different?

27.1 Why/why not?

28. Do you think Psychology can respond differently to the needs of Black people, if they have any special needs at all?

29. Has this always been how you felt about these issues even before you studied Psychology?

30. Have I asked you everything, and may I contact you again?

THANK YOU FOR YOUR PARTICIPATION IN THE STUDY.