

Obstacles to the utilisation of psychological resources in a South African township community¹

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Attitudes and beliefs regarding the utilisation of psychological resources were explored among a group of black Africans of 18 years and older. Both males and females participated in focus groups that were conducted at Itsoseng Clinic on the Mamelodi Campus of the University of Pretoria. Discussion questions addressed participants' perceptions of psychologists and psychotherapy, barriers to seeking treatment and recommendations for improved service delivery. The focus group responses indicated that reasons for seeking treatment included HIV&AIDS, problems related to the participants' socioeconomic situation, relationship issues and educational problems (learning problems, career guidance and educational stress among tertiary learners). Key barriers to service utilisation included the stigma of mental illness, lack of knowledge, affordability of treatment, lack of trust, impersonal service and lack of cultural sensitivity. Participants discussed the issue of the psychologist's race, as they felt that many white psychologists lack sensitivity toward and knowledge of black communities. Participants further stated that black psychologists were not much better due to the acculturation that occurs during the training of black psychologists. Recommendations for more culturally sensitive services are suggested. The implications of these findings for the practice and profession of psychology are also examined.

Keywords: black communities; focus groups; implications for psychology; multicultural psychology; psychology training; township communities; underutilisation; utilisation of mental health services

According to Neighbors (1990), a consistent finding in the literature is the underutilisation and premature termination of psychological services by African-Americans from culturally diverse backgrounds when services are perceived as culturally inappropriate. Psychological services are currently underutilised by the South African population as a whole, and especially by the black population (Ruane, 2008). In this article I propose that possible reasons why South African black communities may be less receptive to psychological resources include the neglect of specific cultural needs and diverse family dynamics within these communities. According to research conducted in America, a number of factors may have an impact on people's willingness to engage in a psychological therapy process (Thompson, Akbar, & Bazile, 2002; Whitehead, 2003). Examples of factors affecting utilisation of therapy are cultural values, family structure and belief systems, such as a belief in the need to resolve family concerns within the family (Thompson *et al.*, 2002). As Eagle (2005) points out:

South African conversations about inter-racial clinical exchanges are heavily reliant on American research that is not always contextually relevant. For example, minority vs majority relations in terms of populations demographics and the different kinds of political power wielded by American and South African black citizens contribute to a distinct set of dynamics (p. 49).

Whitehead (2003) explains that the underutilisation of psychological services by African Americans may be related to the fact that historically, psychological services and theories of practice were "based on the experiences that were almost exclusively white in orientation" (p. 11). The South African authors, Strous and Eagle (2004), discussed the South African context of how the competing values of racism, humanist-based counselling theory and the ideal of universal human rights are likely to result in ambivalent attitudes when white psychologists deal with racially significant material. The provision of appropriate services to black communities is therefore dependent on psychologists' competencies. Whitehead (2003) suggests that it is imperative that psychologists have specific, culturally responsive competencies to provide appropriate services to culturally different populations,

such as different racial and religious populations. The choice of the word 'culture' is hesitant. Although culture is not used interchangeably with race, racial divides are still present in South Africa to the extent that cultural differences often become synonymous with race. Eagle (2005) tackles the difficult area of working with 'culture' in the training of psychologists in South Africa and aims to "stimulate debates about the 'rules of engagement' in relation to sensitive topics in contexts of old and new power relations" (p. 41).

The suggestion that psychologists have culturally responsive competencies is particularly valid when describing the South African population, which consists of large numbers of people with psychological problems, including those in township areas (Eskell-Blokland, 2001; Lifschitz & Van Niekerk, 1990; Ruane, 2006; Van Niekerk & Prins, 2001). "It place[s] the accent on accessible psychosocial services, re-defining the roles of psychologists, democratising psychological practice, prevention, competencies, empowerment of under-represented groups, collaboration, and inclusive modes of knowledge production" (Seedat, Mackenzie, & Stevens, 2004, p. 595). The limited number of professionally trained psychologists who are able to provide psychosocial assistance to communities further compounds these problems (Ruane, 2006). Research and interventions (specifically in the township of Mamelodi) by South African authors (e.g. Eskell-Blokland, 2001; Lifschitz & Van Niekerk, 1990; Ruane, 2006) address the nature of psychological problems confronted by therapists, but are limited in terms of mental health-seeking behaviour of black Africans within township contexts. There is therefore a need to investigate and understand both the attitudes and beliefs of black² Africans regarding the utilisation of mental health services and the barriers to seeking assistance within South African township communities.

The legacy of apartheid, the nature of the demographics of both trainee and registered psychologists, and the context of black communities within South Africa have had a huge impact on black communities' help-seeking behaviours. Apartheid resulted in poverty, limited resources in communities (limited finances, services, and infrastructure, to name but a few), and poor education in the Bantu³ education system. In previous years, university students were predominantly white as universities were seen as elitist and most were reserved for the white population. In addition, entrance requirements were of such a nature as to exclude people with fewer educational opportunities. Subsequently, the training of psychologists was largely undertaken by white psychologists with white students, with the addition of a selected few 'lucky' black students (Ruane, 2008). This meant that the labour market of psychology was predominantly populated by the white elite who could afford university tuition and only a small number of black psychologists entered the profession. This also meant that the psychology curriculum focused on European and American knowledge to the detriment of local knowledge systems (Bakker, Eskell-Blokland, & Ruane, 2007). Local knowledge and indigenous knowledge systems were, and may still be, viewed as inferior and not worthy of postgraduate study (Bakker *et al.*, 2007; Ruane, 2008).

The fact that the vast majority of South African psychologists are white has been a point of criticism and contention for many years (Berger & Lazarus, 1987; Peltzer, 1998). Although the Professional Board of Psychology (1999; 2001; 2002) cites this as an area of concern, practically speaking the situation appears unchanged over time (Ruane, 2008). "Psychology has been accused of being irrelevant, and of advertently or inadvertently bolstering apartheid. Since 1994, much has changed in psychology. However, much has remained the same" (McLoed, 2004, p. 613).

Various researchers (e.g., Eskell-Blokland, 2002; 2005) state that western mental health systems, and subsequently those trained under western mental health systems, may provide inappropriate services to under-served communities due to the nature of the presenting problems. According to Eskell-Blokland (2002; 2005), who has extensive experience of working in a community clinic, as well as other mental health workers in similar settings (e.g. Bodibe, 1990; Henning, 1990; Lifschitz & Van Niekerk, 1990; Rankin, 1999; Wittstock, Rosenthal, Shuda, & Makgatho, 1990), clients present for counselling or help due to complaints of psychosomatic symptoms (Henning, 1990), proclaimed spirit afflictions (Janzen, 1984), vague feelings of dis-ease or social problems. When

treating many of the residents of Mamelodi, these symptoms may need to be considered in a holistic sense, with treatment centred on the person-as-a-whole. As such, the treating profession needs to ask how these symptoms function within the individual's life. Such an investigation would include issues of spirituality, family life and assistance through traditional medicine.

Bakker *et al.* (2007) comment that the literature yields references to psychology as having little impact in Africa, citing Dawes (1986), Eze (1991), Gilbert (1989), Nsemenang (1995), and Peltzer (1998) in this regard, while Seedat (1997) accuses South African psychology of being in a state of disillusionment and disempowerment. It is furthermore seen as taking inappropriate individualist approaches in cultural contexts (Mungazi, 1996; Mwamwenda, 1999; Tembo, 1985). Marsella (1998) exhorts the profession to acknowledge, understand and address the role of cultural variations in behaviour and experience in practice, research and training, while Vogelmann (1986) suggests that acknowledgement of local cultures is essential for effective psychological practice. Whitehead (2003, p. 23) supports critics in arguing "that the majority of traditionally trained counsellors operate from a culturally biased and encapsulated framework", which results in the provision of culturally conflicting and even oppressive counselling treatments (Ponterotto & Benesch, 1988; Sue, 1981). These counsellors, although well-intentioned, often unknowingly impose their white middle-class value system onto culturally different clients who may possess alternative and equally meaningful and justifiable value orientations (Katz, 1985; Ponterotto & Benesch, 1988; Sue, 1981; Whitehead, 2003).

BACKGROUND

The township of Mamelodi, on the outskirts of Pretoria, South Africa, is a highly populated area comprising a community of generally low socioeconomic status. The residents form a cosmopolitan community of Sotho, Zulu, Tswana and other language speaking groups. Members of the population come from different areas in South Africa and neighbouring countries and are in different transitional phases of urbanisation (Ruane, 2006). The Itsoseng Clinic is a community clinic situated in the township. It is my opinion that the clinic may be underutilised by the Mamelodi population and larger feeding area. The clinic is located on the premises of the University of Pretoria's Mamelodi Campus, which was previously known as Vista University (a historically black university). The Itsoseng Clinic draws large numbers of clients from the local township population as well as the students attending lectures on the campus. As such, the client (and student) population may be summarised as underprivileged and disadvantaged, of low socioeconomic status and lacking resources and infrastructure (Ruane, 2006).

In the study I aim to investigate the attitudes and beliefs of the clients at one community service clinic (Itsoseng Clinic, Mamelodi) and of the student population on the University of Pretoria's Mamelodi Campus. The methodology used was duplicated from a study by Thompson *et al.* (2002). The sample selected from the Mamelodi township community and student population comprises black Africans who are underprivileged, previously disadvantaged and from a low socioeconomic background.

METHOD

Recruitment

Participants were volunteers recruited via posted announcements displayed in and around Itsoseng Clinic. The posters invited all who were interested to participate by sharing their views on three key issues, namely:

- black Africans' perceptions of psychologists and psychotherapy,
- barriers to treatment seeking, and
- recommendations for improved service delivery.

The invitation was written in English, Sotho, Zulu and Tswana (as the four most widely understood of the 11 official languages of South Africa). It was posed in such a way as to invite students, members of the Mamelodi community, clients and family members to join the researcher in a process

of co-creation of some of the perceptions of the local community, without assuming any position of expertise.

The participants, clients, family members and university students who were approached were in a unique insider position to answer the research questions with respects to this community clinic and to contribute to a discussion concerning the mental health-seeking behaviours of black people living in a township context. The participants were selected due to their involvement with the Itsoseng clinic as clients, volunteers or university students seeking psychological assistance. Therefore, these findings cannot be generalised to other black township communities. However, the findings have implications for the management of the Itsoseng Clinic as well as for institutions that train psychologists to work with diverse client groups.

Participants

A total of 12 black Africans (eight females and four males) participated in the focus group. Ages ranged from 18 to 46 years. The average education level was Grade 10, with six participants currently enrolled at the university. The participants comprised clinic clients ($n = 1$), members of the Mamelodi community ($n = 3$), family members ($n = 2$) and undergraduate students ($n = 6$: four from psychology and two from other faculties). Therefore, half of the recruited sample were members of the Mamelodi community without university education. The sample is therefore not representative of the Mamelodi population as a whole and therefore the findings cannot be generalised. The findings do, however, provide a look into the situation regarding the use of psychological resources in Mamelodi from the perspective of the participants. It could be said that these participants' views are tainted because they are close to psychology and psychological services, because of their being present within the clinic. However, it could also be hypothesized that this fact makes the stated findings more relevant in that participants with knowledge of psychology have expressed them.

Focus group as method

The focus group was conducted by the researcher, a white psychologist with eight years' experience working in the township of Mamelodi and Itsoseng Clinic. A black third-year Sotho-speaking psychology student assisted with necessary translations. However, the members of the focus group chose to speak English.

According to Gibbs (1997), the main purpose of focus group research is to draw upon participants' attitudes, feelings, beliefs and experiences in a way that would not be feasible by other methods, such as observation, one-to-one interviewing, and questionnaire surveys. Terre Blanche, Durrheim, and Painter (2006) elaborate this point by saying that a focus group is comprised of a group of people who share similar experiences, but that the group is "not naturally constituted as an existing social group" (p. 304). Focus groups are particularly useful when there are power differences between the participants and the professionals, and when the everyday use of language and culture of particular groups is of interest (Morgan & Kreuger 1993). For these reasons, this method of investigation was considered suitable for this investigation. Focus groups are a qualitative research strategy that uses a semi-structured discussion format (Morgan, 1988). As the group facilitator/author, the researcher began the process and moved the discussion along with the aid of discussion questions. The research questions were proposed by Thompson *et al.* (2002) because the questions were related to counselling culturally diverse groups (see questions later). However, the specific content and order of content were driven by participants' responses (Stewart & Shamdasani, 1990). The findings cannot be generalised to the entire Mamelodi population or other black township communities, but they provide a glimpse into a situation that needs further investigation.

The focus group examined mental health attitudes and views of psychotherapy and therapists. The group met on four occasions, with discussions lasting between 2 hours 18 minutes and 3 hours 45 minutes. The following discussion probes suggested by Thompson *et al.* (2002) were used to address mental health attitudes:

1. What types of problems require psychotherapy?
2. Describe your image of a psychologist. Describe your image of a counsellor. Who would you prefer to see?
3. Does race/gender/ethnicity matter in the selection of a therapist?
4. What characteristics would you look for in the mental health facility you attended? What characteristics would you look for in the therapist you saw?
5. What goals would you set for therapy? What would you want to accomplish in therapy?
6. What do you think of people who seek therapy? How would you feel if others knew you were seeking therapy?
7. What are the barriers to your seeking/not seeking professional psychological assistance?

These discussion probes were used to initiate and encourage discussion. The specific content and order of the discussions were driven by the participants' responses (Stewart & Shamdasani, 1990). The discussions were audiotaped and transcribed by the author and the translator. Thereafter, the participants were invited to comment on the transcription to consolidate their impressions during a feedback session. The data were interpreted by breaking them down into categories from which the themes were derived.

Procedure

The focus groups were conducted in June 2007. The first one commenced with a brief introduction to describe the purpose of the group. The researcher commented on the fact that she was a white psychologist seeking answers about the mental health-seeking behaviours of black people living in Mamelodi. A discussion was opened around this and the participants stated that they felt comfortable discussing the topic openly and honestly with the researcher as they knew she had worked in Mamelodi for many years. Even though the participants stated that they felt comfortable, it was important for the researcher (as social constructionist) to acknowledge her role within the research process. This acknowledgement emphasised her position, not as an expert, but rather as one who was curious about the perceptions of the Mamelodi community. The researcher needed the community members to help her answer questions that she could not answer without their assistance. The participants were invited to speak in Sotho, Zulu or Xhosa as a translator was available. Themes organically emerged through the focus group discussions and these themes were 'checked' with the members of the focus group before noting them as findings. During this reflexive feedback process, the participants were invited to add to the themes and to comment on the resulting themes.

RESULTS AND DISCUSSION

As social constructionist research, this study shifts away from the perception that research uncovers pre-existing realities, towards the co-creation of realities. In this process, context is acknowledged as a co-creator of reality (Du Preez, 2004). Social constructionism as research epistemology holds a view of reality that states that values, knowledge, social institutions and theory are products of social interaction and are not entities separate from human existence (Gergen, 1985). This approach recognises people's own sense of reality and how it changes as their interpretations of their lives change (Denzin & Lincoln, 2000; Miller & Fox, 1999). Thus, human nature and the social order are products of conversation and interaction (Viljoen, 2001). The social construction discourse informs life, research narratives and therapeutic practice, and is influenced by the intellectual and cultural background of postmodernism against which it developed (Freedman & Combs, 1996). The fundamental premises of social constructionism include a critical approach to taken-for-granted knowledge, an emphasis on the historical and cultural *situatedness* of our worldviews and of our subject fields, and the notion that knowledge is created and maintained by social interactions (Burr, 2003). Therefore, social constructionist research accepts the notion that specific and local knowledge is a valid construction of meaning. This is also the nature of the findings of this study.

Participants noted the primary reasons for seeking therapy as being HIV&AIDS-related

counselling, socioeconomic problems and learning problems. Alcohol abuse, rape, child sexual abuse and domestic violence were cited as major life events or traumas requiring additional therapeutic intervention. Grief, largely associated with HIV&AIDS, and attempts to cope with life stressors (i.e. relationships, finances, discrimination, etc.) were identified as appropriate reasons for seeking professional mental health services. Many of these themes overlapped with the findings of Thompson *et al.* (2002). However, differences in responses were related to comments regarding HIV&AIDS, disclosure of HIV&AIDS status and serious instances of domestic violence. Various sub-themes are presented under the five main themes, which together create the participant's construct reality of the situation regarding the use of psychological services at the Itsoseng Clinic. The participants' constructions⁴ are indicated in inverted commas. Their responses are integrated into the discussion and not presented separately. This was necessary because of overlapping and similar responses from several participants.

Barriers to seeking psychological services

Cultural beliefs are a major barrier to seeking psychological services. These include beliefs such as the need to resolve family concerns within the family, as well as the expectation that black men adopt a position of power and authority within the family and community. These findings are similar to those of Thompson *et al.* (2002). Among many of the participants who had no tertiary education and so arguably have not been exposed to *sophisticated* views of mental illness, there was no acknowledgment that therapy was required to address certain issues. In the researcher's opinion, this could be ascribed to the African worldview in which black communities deal with both spiritual and personal problems within the community context and do not seek assistance from outsiders.

Participants who were students at the university stated that they lacked sufficient knowledge of the signs and symptoms of mental illness according to how the discipline of psychology viewed mental illness. "*We don't know enough about the signs of mental illness*", and "*I don't know what someone like this will look like*", were some of the responses. This led to discussion on African views on mental illness and culturally-specific disorders. According to the literature, the African worldview incorporates religious and magical beliefs (Lund & Swartz, 1998) together with folktales (Matshakayile-Ndlovu, 1994). The majority of the participants felt that this was not something that fell under the training and expertise of psychologists. "*They do not know our culture. They cannot understand.*"

Participants from the community responded by saying that they had no information on the psychological resources and services that were available to them. This problem was further compounded by the fact that psychological services in Mamelodi are very scarce. In fact, there are only two places where psychological services are offered, namely, the Agape Healing Community (Lifschitz & Van Nierkerk, 1990) and the Itsoseng Clinic (Ruane, 2006). The Itsoseng clinic is the only formal psychological service provider in Mamelodi, which has a population of approximately one million people.

The stigma of mental illness is a significant barrier to mental health services. The participants noted the "*embarrassment and shame*" experienced by those who received services whether or not they personally had used such services. In addition, the cost was noted as a significant barrier to seeking mental health treatment. This perception seems to be a significant driver of the utilisation of mental health services, with the participants from the community commenting that "*services are seldom sought out due to the [perceived] costs involved*". Both the Agape Healing Community and the Itsoseng Clinic have been operating in Mamelodi for a number of years, and offer free services to the community. One participant called these clinics a "*useable*" resource. The discourse on useability of resources proved relevant: the fact that a resource, such as a service or infrastructure, existed in Mamelodi did not mean that the community would utilise it. The service would first need to be constructed as useable, of value, by the community before they would make use of it.

Perception of psychologists

Psychologists were described as "*old white men*", who were "*racist, unsympathetic, uncaring and*

unavailable to communities". Participants who had sought therapy noted the difficulty in locating black therapists. Furthermore, white psychologists were described as elitist and "*too far removed from the community to be of assistance to black people*".

The participants in this study appeared to share the views of the critics as discussed earlier. They stated that white therapists were "*showing what they could do*" and emphasised the need for white psychologists to "*take the time to develop a relationship with the client*". Participants reported a belief that psychologists, unlike social workers and counsellors (referred to here as lay counsellors or advice-givers within the community without any formal training), fail to facilitate a relationship, participate in community education, prevention and outreach. Notably, the participants distinguished between psychologists and counsellors, and did not have as negative a view of counsellors. This perception begs the question: what role have psychologists themselves played in perpetrating the myths around psychology to the extent that the communities view psychologists much more negatively than lay counsellors? The researcher was curious as to why the participants referred to psychologists consistently as being white. One participant responded: "*The black ones, once they receive their papers, do not come back to their homes and work; only you white ones do*". This reflects the perception that most newly qualified black psychologists do not return to their communities to work. This is most likely because many black psychologists are highly sought after in institutions due to the limited number of qualified black psychologists in South Africa (Ruane, 2008).

The participants' reference to the predominance of white psychologists working in black communities is a cause for concern, as many white psychologists may lack the skills and knowledge embedded in local cultural discourse and practice to assist these communities holistically (Blokland, Bakker, Louw, Ruane, & Viljoen, 2005; Eskill-Blokland, 2005; Ruane, 2006). According to Ruane (2006), psychologists trained in mainstream psychology have little knowledge of traditional healing systems, issues related to African religion and spiritual connectedness or indigenous knowledge, and are therefore seldom aware of how vital a role these factors play in the African worldview.

Over and above traditional African worldviews, limited financial and physical resources mean that the community seeks help from traditional mental health systems such as traditional healers, as opposed to western psychological systems such as formal psychological interventions. The black population of South Africa is in a state of transition from a traditional way of life towards an amalgam of traditional and western worldviews. According to one participant, this position "*dominates that the blacks seek traditional healing for some ailments while seeking westernised healing for others*". When asked to explain this further, the participant stated that psychology did not always invite people who rely on traditional practices to seek its assistance. The participant stated that the traditional healer or *sangoma* is still regarded as "*the healer that possesses the skills needed for the healing of afflictions resulting from emotional and psychological turmoil*". The student participant elaborated that psychology as a discipline, and psychologists in general, need to be "*rooted within the black communities*". "*They need to identify with the people ... we need to see the same faces every year.*" Another strong view that was expressed stated that "*We are not a community service location. This is where we live*". Therefore, according to the participants, there needs to be an integration of traditional and western perceptions (Hopa, Simbayi, & Du Toit, 1998) and practice of psychology.

Epistemological differences

Participants stated a reluctance to trust professionals not active in black communities and activities directed towards community well-being: "*They are not here, they do not know*". The participants stated that psychologists not working in a specific community were not familiar with the subtle nuances of that community, including how certain issues are resolved and whom to include in the resolution of problems, such as consulting with a *sangoma* or traditional healer. Participants also stated the lack of knowledge that psychologists have about traditional African healing systems and the African worldview.

Reluctance to trust professionals

Participants reported that while psychotherapy may be beneficial, most psychologists lacked adequate knowledge of black African life and the struggles many black Africans experience. Such knowledge is required to accept or understand black communities. Participants felt that there were many stereotypes of black Africans in the larger society and doubted the ability of psychologists to remain free of the attitudes and the beliefs of this society. When asked their views on black therapists, the participants were hesitant to comment whether black therapists were "*better than the white ones*". One participant explained that black therapists received training at white institutions, and were therefore largely "*exposed to the way whites do things*". It was felt that the often inappropriate interventions and individualist approach taught at traditionally white higher educational institutions were inadequate in equipping a psychologist of any colour to deal with the problems of black clients. This situation may reflect an example of what Eskell-Blokland (2005) refers to as *successful colonisation*. She says that successful colonisation results in the colonised forsaking their own culture in the process (Bakker *et al.*, 2007).

Psychotherapy

Psychotherapy was described as an invasive and impersonal strategy. According to one participant, the strategy "*appears intimidating, for the rich and reinforcing of the dominant white culture of the South African society*". Psychotherapy was described by another as a "*costly luxury*". Participants reported that they were irritated by the inability of therapists to explain clearly "*the goals of therapy, how it would help, and to provide reasonable time limits to reach goals*". They compared this to a traditional approach, where "*the sangoma gives steps to follow to heal*". Participants also reported a preference for therapists who focus on providing tools, skills and strategies that promote successful coping rather than using an insight-oriented approach. In the African worldview where assistance is sought from traditional healers, counsellors and so on, the client expects a resolution to the problem once they have followed the healer's advice and instructions. These insights into the perceptions of psychotherapy assist in constructing the need for a culturally sensitive therapeutic process when working in such settings.

Cultural sensitivity

As stated earlier, South Africa's mental health challenges are situated within the context of an apartheid legacy, including issues of poverty, poor quality education, unemployment, inadequate housing and power imbalances (Blokland, 1992). South Africa's history has contributed to the development of psychological problems and stressors, especially in disadvantaged communities. For example, the adverse socioeconomic situation of disadvantaged communities has led to a larger divide between those who are able to afford psychological services and those who are not (Ruane, 2006). Culture is sometimes used as the code word for class exploitation "*in the sense of township culture and working class culture*" (Eagle, 2005, p. 51). It is on this level that the issue of cultural sensitivity is discussed, and not the level of race.

Most of the participants reported that they would prefer consulting with a black therapist, but, as one participant stated, "*I don't know any working in Mamelodi*". When asked to expand on this, the participants responded, "*Whether black or white, if the psychologist does not live or work in Mamelodi they cannot know our problems and fears*". This view seems to derive from the perceived lack of cultural sensitivity to African issues and experiences that disadvantaged black people have historically confronted. The participants believed that white therapists were influenced by frequently encountered stereotypes of black people. However, they also noted that black psychologists could also be too far removed from indigenous culture and were therefore as insensitive as non-black therapists. Some participants reported a belief that "*few, if any, of the therapies in use were developed with black treatment in mind*". They reiterated their view that psychologists, both black and white, are trained in the same way, with the same client population in mind, namely, people who are "*rich*"

and live in comfortable safe environments and would not suffer what black communities suffer with on a daily basis". Therefore, the perception is that any therapists trained within this framework will fail to serve the majority of the population of South Africa.

IMPLICATIONS FOR THE PROFESSION OF PSYCHOLOGY

Social constructionism recommends a process of reflection and an acknowledgement of alternative realities. Upon reflection, the findings of this study have implications for the profession of psychology. If available mental health services are to be fully utilised by black South Africans, the professional psychologists who work in community settings should possess sufficient knowledge of the mental health-seeking behaviour of black Africans, as well as the necessary culture-specific knowledge. Considering that the boundaries between traditional and westernised ways of living have blurred due to the urbanisation and empowerment of black South Africans, professional psychologists need to move towards being equipped with multicultural counselling skills and to receive training in multicultural issues, such as the African worldview, traditional healing systems and alternative therapies to which clients can be referred. Furthermore, knowledge of issues of culture and race needs to be understood in the context of factors such as socioeconomic status, history and politics. In addition, black Africans from rural areas who are less westernised than those living in urban settings such as Mamelodi, may require even greater cultural sensitivity from the (urban) psychologists whose help they seek. The constructions/findings also suggest that training in cultural sensitivity is equally important for both black and white psychologists, given that black psychologists seem to be as likely to use a western approach in their work as their white colleagues. Thus, it is necessary to address our notions of 'training in cultural sensitivity'. Many universities touch on this superficially or in a single once-off type lecture that, based on literature, can be seen as reinforcing the notion that cultural sensitivity is something 'separate' from 'real' psychology. The participants complain that it is the entire epistemology underlying psychology that is too western. Giving classes in cultural sensitivity from a western point of view, or courses based on western assumptions, will do nothing to change the fundamental problem of applying western solutions to African problems. The problem lies at a deeper level of paradigm and epistemology, not just a lack of knowledge. This is why the participants also distrust black psychologists. Although black therapists have knowledge (of language, culture, etc.), they no longer subscribe to the same epistemological assumptions, which is what alienates them from their 'own' people.

Further research into engaging with a deeper and more challenging critique of the role of psychology in addressing the particular challenges and problems of contemporary South African society is vital. It is also acknowledged that alternative possible constructions can be drawn from these data.

CONCLUSION

Although psychotherapists working in disadvantaged communities agree on the need to develop multicultural competency, many struggle with the question of how to provide the diverse South African population with culturally responsive services. This research provides some answers based on the perceptions of the psychology of people in these communities. It seems that psychology, specifically in South Africa, needs to increase its efforts in black communities. This includes fostering more accurate perceptions of psychology and psychologists in order to encourage communities to consider psychologists as a source of assistance for emotional and interpersonal difficulties. Increased cultural competency amongst psychotherapists may facilitate the type of positive experiences necessary to improve psychologists' image in black communities. This may be done by including multicultural content in undergraduate and postgraduate training courses. Specific attention to multicultural training is needed at a Masters' level in all the categories of registration that include psychotherapy in their scope of practice.

Therapists in black community settings should aim to provide clients with clear therapeutic goals, benefits and timeframes for treatment. However, there seems to be a need for both insight-

oriented therapy and direct interventions for the communities, because ignoring the provision of insight-oriented therapy could perpetuate an exclusionary racist discourse of which psychology has been guilty in the past.

The above discussion focuses on the issues raised by the participants; it fails, however, to extend the conversation beyond culturally responsive services and cultural competency. This may be an important avenue of further research. A limitation of the study is the relatively small size of the sample of participants that raises questions of reliability and validity. However, the participants construct a reality which, despite their small number, adds to the larger picture of how and why black Africans may or may not use community psychological resources.

NOTES

1. An earlier version of this article was presented at the 5th African Conference in Psychotherapy, Polokwane, South Africa, 18-20 June 2008.
2. The term black Africans/people is used to describe the residents of the Mamelodi community. The community is comprised solely of black African language speakers, both indigenous to South Africa as well as immigrants, legal and illegal, from beyond the South African borders. The Mamelodi community refer to themselves as being black people. The term has a history of negative connotations and was often used in a degrading and dismissive manner when speaking of black Africans during the apartheid regime. However, the term is used here in a non-pejorative sense.
3. The Bantu education system was historically an inferior education system provided by the apartheid South African government in black schools. The curriculum differed from that which was offered in white schooling systems.
4. The participants' responses are included verbatim and as such may have grammatical errors as well as display references to 'blacks', which is not meant in a derogatory manner as the responses are the participants' actual words used in the focus groups.

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