FINDING A FIT: AN AUTOETHNOGRAPHIC INQUIRY INTO THE CHALLENGES OF APPLYING THERAPEUTIC PSYCHOLOGY IN A TOWNSHIP CONTEXT

by

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DECLARATION

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

ABSTRACT

The broad aim of this study is to contribute to Itsoseng clinic's ability to respond effectively to the psychological needs of the Mamelodi community. The specific objectives of the current study in this context are to document the researcher's challenging experiences of applying therapeutic psychological services at Itsoseng clinic over the past three years, to contrast these experiences with existing research, and to make recommendations accordingly. The study employs an autoethnographic method of qualitative inquiry to analyse the researcher's personal experience in order to understand its sociocultural significance. The study is conceived from an ecosystemic postmodern social constructionist perspective. The findings suggest that the central challenges experienced by the researcher relate to difficulties with psychology itself, the broader contextual demands of the township context, specific challenges at Itsoseng clinic, a challenging sociocultural context and norms, and language difficulties. The findings provide valuable information and recommendations on how to potentially apply therapeutic psychology in a township context and for the enhancement of Itsoseng clinic's ability to respond effectively to the psychological needs of the Mamelodi community.

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CHAPTER 1

I stand on the threshold,

I am the gate keeper.

The holder of mystical tools,

and answers to fill the hands of desperation.

I am on a pedestal, ready to falter,

in the face of longing eyes, broken hearts and emotions that find no shelter.

(Poem by researcher; 2015)

OVERVIEW

Introduction

One of the legacies of the apartheid era in South Africa are large densely populated and severely under-resourced township communities on the outskirts of most urban living areas. One of these communities is Mamelodi, in the east of Pretoria, Gauteng. People in township communities have limited access to healthcare and are dependent on state hospitals and clinics. Access to mental health care in these contexts is particularly limited. This study focuses specifically on the Itsoseng psychology clinic in Mamelodi and my experiences in this context over the past three years.

Research context

Itsoseng clinic in Mamelodi Pretoria offers a range of psychological services, to this under-resourced township community, including assessment and psychotherapy. This service provision is complicated by the widely recognised challenges to psychological practice in

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township contexts (Ruane, 2006). Little research into the Mamelodi context or trainee psychologists' experiences in a township context has been documented.

Area of inquiry and rationale for a focus on "challenges"

The current study focuses on the researcher's own challenging experiences of applying therapeutic psychological practices in the Mamelodi context over a period of three years. This is not to suggest that there were only challenging experiences in this context, but rather that the challenges and responses to these are of clinical significance and warrant further inquiry. Furthermore this does not suggest that we problematize Itsoseng clinic or the Mamelodi context, the source of these challenges are recognised to have contributions from all participants involved.

Scope of the study

The scope of this study is limited to exploring the unique personal experiences of the researcher in a specific context, contrasting and comparing these experiences with those documented in the same and other community contexts. The focus on challenges experienced in the application of therapeutic psychology is consistent with the delineated scope of a mini dissertation. Follow up studies in this context could potentially focus on other areas of experience. A similar study has not been conducted in the Itsoseng context to date.

Justification, aims, and objectives

Mamelodi is an economically disadvantaged community and as such faces a variety of social difficulties and challenges. Most people in the community rely on free healthcare services, which places a tremendous strain on these service providers. As one of these health care providers and the only fully psychological service provider to over a million people, Itsoseng clinic needs to be able to respond effectively to the needs of the community (Blokland, 2014).

The broad aim of this study is thus to contribute to Itsoseng clinic's ability to respond effectively to the psychological needs of the Mamelodi community.

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The specific objective of the current study in this context is thus to document the researcher's challenging experiences of applying therapeutic psychological services at Itsoseng clinic over the past three years, to contrast these experiences with existing research and to make recommendations accordingly.

Given that the current study is based on the researcher's own experiences it is also legitimate to offer a personal justification for the study. Over the past three years the researcher has faced numerous challenges in interfacing his therapeutic psychological training with the needs of the Mamelodi community and in doing so has acquired relevant knowledge and experience to share. These experiences offer both academic worth, as well as clinical value for informing the practice of therapeutic psychology in South African township contexts.

Ethical considerations

The study does not include any human participants and takes the form of a personal autoethnography. The data used in the study thus comes from the researcher's own experiences at Itsoseng clinic and published research. At no point is any personal information or identifying information on clients from Itsoseng clinic used in the study, nor is there risk of harm to clients. Clients are only referred to by way of pseudonyms or generic terms, for example "a middle aged male client". Dissemination of results takes the form of a dissertation submitted electronically to the University of Pretoria's library and a scientific journal article submitted to an accredited journal. The results are thus also available to Itsoseng clinic. Permission for the study has been obtained in writing from the clinic director Dr Linda Eskell-Blokland.

Chapter layout

Chapter 1 offers an overview of the aims and objectives of this study. Furthermore it provides an initial indication of the research design and methodology employed.

Chapter 2 offers a review of relevant local and international research in order to provide a background and context for the study.

Chapter 3 discusses the research design in detail, including a description of the epistemological and ontological framework of the study. Data type, collection and analysis are also discussed in the context of an autoethnographic study.

Chapter 4 includes the research data selection process and audit trail.

Chapter 5 includes a presentation of the data in terms of autoethnographic accounts, identification of various subthemes and data patterns. Links between these and current research are made.

Chapter 6 discusses the results and reflects on the implications of the findings. Recommendations are made for dealing with the challenges of using therapeutic psychology at Itsoseng clinic, and suggestions for further research in the Mamelodi context are provided.

Chapter 7 contains the references used in this study

Conclusion

This chapter provided an overview and description of the context for the current study, with reference to the central research question and aims. Justification for the research was discussed and the research design briefly outlined. Finally an overview of the study's layout was provided.

CHAPTER 2

LITERATURE REVIEW

Introduction

In order to situate the current study within broader and more specific contexts it is necessary to consider relevant research relating to the area of inquiry. Accordingly an outline of psychology in a South African context is provided, with further emphasis on documented challenges of applying therapeutic psychology in township contexts. Finally a review of documented mental health care practitioner's experiences in township contexts is also provided.

Psychology in a South African context

Psychology in South Africa is still by and large a product of the western world, based on its constructs, theories, epistemologies and lived experience (Baloyi, 2009; Eskell-Blokland, 2005; Macleod, 2004; Mkhize, 2004; Vermeulen, 2011). For example; western psychology promotes a separated self with an emphasis on individuality, which is at odds with the collective emphasis in most indigenous cultures (Pedersen, 2013). Conceptions of self and identity are also still bound up in the post-apartheid context in South Africa. People still view themselves in terms of the racial categories and ordering of the apartheid system (Seekings, 2008). It is worth noting that the father of the apartheid system Hendrik Verwoerd was a psychologist. This is significant as it was the context of the apartheid system; with its institutionalised racism, which gave rise to the development of townships in South Africa. Psychologists along with other helping professionals are now challenged with addressing the long-term effects of apartheid. The salience of race as an issue continues with people in large under resourced township communities still struggling to find access to basic living needs. Thus after more than twenty years of democracy, questions about psychology's role and relevance are still ever present and difficult to address (Kagee, 2014; Long, 2013). However, some researchers question the psychology relevance debate's socio-political value in the current South African social milieu (Long, 2013). This broader social context in turn informs

attempts to use and find a fit for therapeutic psychology in specific contexts such as Itsoseng clinic in Mamelodi.

There is however another side to the coin in the psychology relevance debate. In the past decade and a half the world has rapidly experienced a shift through globalisation and rapid acculturation towards a global village and culture (Eskell-Blokland, 2005; Foster, 2004; Marsella, 2012; Mkhize, 2004). This largely Eurocentric way of living and cultural values brings with it the healing modalities of the west, including therapeutic psychology. The indigenous population of South Africa thus find themselves in a mixed cultural context and somewhere on the continuum of acculturation (Chapman, 2014; Mkhize, 2004). In this context there may accordingly be a growing fit and demand for western therapeutic psychology.

Challenges to provision of psychological services in township contexts

Psychological difficulties in their various forms are widely recognised as being merely one part of a person's life and are related to the broader challenges faced by their community (Maslach & Jackson, 2013; Petersen, Bhana, & Swartz, 2012). While there has been an improvement in the socio-political situation for township dwellers, since the inception of democracy some 20 years ago the situation remains far from satisfactory (Blokland, 2014; Darkey & Visagie, 2013; Macleod, 2004). Factors such as on-going service delivery failures, xenophobia, poor health care in general, poor schooling and rampant unemployment confound attempts to provide mental health services, which only represent one part of the issue (Barbarin & Richter, 2013; Darkey & Visagie, 2013).

A related international and local problem is the neglect of mental health by the public health care system; despite evidence that mental health has a significant impact on medical health and vice versa (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009; Fleischhacker et al., 2008; Hert et al., 2011; Lawrence & Kisely, 2010). The emphasis on medical health in practical terms means that township dwellers have far greater access to healthcare for physical conditions and yet have very limited access to psychological services, even for serious mental health problems such as schizophrenia, bi-polar mood disorder, personality

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disorders and depression, to name but a few (Williams et al., 2008). Studies on this phenomenon reveal that the poorest countries spend the lowest amount of their overall budgets for public healthcare on mental health (Saxena, Thornicroft, Knapp, & Whiteford, 2007). People with the lowest socioeconomic status, who have the greatest need for mental health services, have the least access to it.

Beyond the pragmatics of psychological service provision is also the problematic understanding, attitude and beliefs about psychology in township contexts (Sorsdahl, Stein, & Flisher, 2010; Theron & Donald, 2013). Problems relate to the stigma of mental illness, lack of knowledge, unrealistic client expectations, costs of treatment, concerns about trust, a sense of impersonal service and a lack of cultural sensitivity (Kakuma et al., 2010; Petersen & Lund, 2011; Ruane, 2010). Ruane (2010) also found that many people in Mamelodi perceive white psychologists as lacking sensitivity toward and knowledge about black communities. Participants in the same study indicated that black psychologists reflected similar difficulties due to the acculturation process of the formal psychology training they had received.

A further difficulty relating to the aforementioned understanding of what psychology represents in township contexts is evident both in the study by Ruane (2010) and in a study by Phala (2009). In both these studies presenting problems at Itsoseng psychology clinic included; HIV & AIDS, socioeconomic problems, relationship difficulties and educational problems. These problems are typically addressed by counsellors, social workers and counselling and educational psychologists to name but a few. The scope of practice of the student clinical psychologist with its distinct focus on psychiatric disorders seems then on the surface not to be applicable. Yet, the aforementioned may be blanket terms for describing problems, used by the community, which encompass clinical psychological concerns. For example: academic difficulties are often a sign of an underlying psychological problem, such as depression (Dyrbye, Thomas, & Shanafelt, 2006; Owens, Stevenson, Hadwin, & Norgate, 2012).

Mental health care practitioners experiences in township contexts

Mental health care practitioners are frequently left with a sense of hopelessness when confronted with the overwhelming social problems of their clients in township contexts (Blokland, 2014). Practitioners are under pressure to see large volumes of clients who by and

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large are inexperienced in terms of therapeutic psychology and seldom see their problems as having psychological components (Mkhize & Kometsi, 2008). This places practitioners in a position of needing to filter through a wide range of problems that would not typically be presented to mental health care practitioners in more westernised contexts (Schierenbeck, Johansson, Andersson, & Rooyen, 2013). For example: problems usually are framed in the form of psychosomatic symptoms, spirit afflictions and general discomfort, often accompanied by social stigma. All of these challenges are further complicated by language barriers, which can compound cultural barriers to addressing clients' problems (Deumert, 2010; Ruane, 2010).

The issue of language affects all psychology practitioners in township contexts and relates to the diversity of people who present for problems, many of whom do not fluently speak one of South Africa's eleven official languages (Ruane, 2010). In some instances the use of translators is required, which in of itself is challenging, because while the discussions' content may be conveyed, there is often a loss of context, meaning and intention (Hagan et al., 2013). This situation is frustrating for the practitioners and their clients who are not appropriately or accurately heard and may be misunderstood (Kilian, Swartz, Dowling, Dlali, & Chiliza, 2014). According to these same authors it is also a situation that has consequences for both practitioner and client when mistakes are made in, for example, a diagnosis. Language barriers as a result create stressful, ambiguous and uncertainty-laden interactions for psychology practitioners who work in township contexts.

Many mental health care practitioners are also confronted with being unwitting representatives of their cultural and ethnic group (Graham & Langa, 2015). In the context of a post-apartheid South Africa this continues to play out in stereotyping, misunderstandings and perceived insensitivity to cultural norms to all involved (Ruane, 2010).

It is clear from the aforementioned context that using therapeutic psychology in townships has the potential to be perturbing and may result in challenging experiences for mental health care professionals.

Conclusion

The provision of psychological services to township communities is clearly challenging in the context of broader sociocultural factors in South Africa. In this chapter I have argued that part of the challenge is to view people in their contexts and develop responses to these challenges that are thus contextually sensitive and contextually located. The current study reflects such an approach and attempts to describe the profile of language used in the Mamelodi by student clinical psychologists and clients to describe psychological concerns.

CHAPTER 3

RESEARCH DESIGN

Introduction

In this chapter the epistemological, ontological and theoretical perspective employed in the current study is described and justified. This is followed by an outline of the research methodology and specific research design.

Meta-epistemological perspective

The current study is conceived from a postmodern social constructionist perspective. From this perspective, language is seen as the focus of investigation. According to Becvar and Becvar (2006):

> *...language is not a reporting device for our experience, or representationalism. Rather it is a defining framework. Thus, a change in language equals a change in the experience, for reality can only be experienced, and the "reality" experienced is inseparable from the pre-packaged thoughts of society...* (p. 91).

The focus is thus on how we co-evolve shared understandings and meaning through language. Language is seen as a context within which we narrate or story reality. The current study thus focuses on the researcher's own autobiographical narratives.

In line with this Durrheim, Kelly, and Terre Blanche (2006) argue that:

> *Constructionism...holds that the human life-world is fundamentally constituted in language and that language itself should therefore be the object of study* (p. 278).

Durrheim et al. (2006) argue that social constructionism has an explicitly critical element: this is of value when pointing out failings by approaches such as positivism which claim to be value neutral. Durrheim et al. (2006) do however argue that social constructionists can be idealistic, and may at times reduce everything to language and over emphasise relativism. At this point all descriptions of reality can simply "become" constructions.

Epistemological and ontological framework

The current study is conducted specifically from an ecosystemic second-order cybernetic perspective. The ecosystemic perspective is conceived within postmodern social constructionism and functions as an epistemological and ontological framework for the study. Ontology viewed from such an approach has particular tenets, according to Becvar and Becvar (2006):

> *(1) A reality may exist independently of us, but we cannot know reality. (2) The reality that exists for us and the reality we can observe is relative to the theory we use as a metaphor for that reality. (3) What we can observe is a function of the means we use to measure the phenomena of interest and our theories, which suggest what might be "out there". (4) Reality is a dynamic, evolving, changing entity. (5) To observe a phenomenon is to change the nature of the phenomenon observed. (6) Phenomena observed take on the characteristics of the theory or model used to guide and systematise the observations. (7) The appropriate unit of analysis is not elementary parts but relationships, which should be the basis of all definitions* (p. 345).

Rationale for using the ecosystemic framework

It is possible to use social constructionism alone as a framework for researching lived experience as a context, however when it comes to the present study, it is necessary to account for the interaction of the various interdependent contexts which make up a community and which informed the researcher's experiences. The integrative framework provided by the ecosystemic approach can thus for example account for how the researcher's experiences in Mamelodi (social constructionism) were informed by the contexts of socioeconomic deprivation, historical legacies, poor education, rapid social change etc. and how these interact (systemic theory) (Mc Guckin & Minton, 2014; Tyler, 1996).

In sum the second-order postmodern ecosystemic approach is not a theory, it is an epistemological and ontological framework that allows for the integration of information and theorising at different logical levels (Gergen, 1995; Hoelson & Burton, 2012). The postmodern ecosystemic approach thus punctuates reality or experience on a continuum. This understanding conceptualises reality from the first-order micro-system of the individual

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person with all of their unique biological and psychic attributes, beliefs knowledge and so forth, to the larger and macro-system structures including, couples, families, communities and society. The multiverse and relativity of lived experience of all these system punctuations is then reflected upon from a second-order position.

Research methodology

The current study employs an autoethnographic method of qualitative inquiry. According to Graham and Langa (2015) autoethnography involves self-observation and self-reflexive inquiry. In other words, the researcher's own experiences in a given context are central and form the core of the research process. Autoethnography aims to describe and analyse personal experience in order to understand its sociocultural significance (Ellis, Adams, & Bochner, 2011). Autoethnography locates personal experience in contexts of gender, race, ethnicity, social privilege and socio-political power, consistent with the aforementioned ecosystemic frame (Boylorn & Orbe, 2013). In order to achieve this, the researcher uses aspects of autobiography and ethnography, the result is that autoethnography becomes a process and product (Ellis et al., 2011). This also implies that data collection and analysis are not discrete stages; they are an interdependent process of inquiry. The current study therefore employs a three stage research design as suggested by these authors.

Research design

Stage one of the research design involves the writing up of retrospective field notes by the autoethnographer (Ellis et al., 2011). In the present study these retrospective field notes take the form of vignettes of the researcher's personal experiences at Itsoseng clinic. The researcher thus writes vignettes about challenges experienced while using therapeutic psychology at Itsoseng clinic over the past three years. These are then grouped thematically, for example under "language challenges" (Atkinson, Delamont, & Coffey, 2004). The themes are formed inductively by the data itself and deductively from themes suggested by the literature review process. Themes for further inquiry are retained on the basis of richness of the data, availability of reference material for that theme, number of sub-themes and availability of specific instances in the researcher's experience to illustrate the theme.

Stage two involves unpacking the themes identified in step one into specific instances and providing detailed vignettes of instances where, for example, the researcher experienced "language challenges". Further subthemes are then also identified, for example: a sense of helplessness (Atkinson et al., 2004). These are also unpacked and linked to existing research.

Stage three involves the drawing of inferences and conclusions (Short, Turner, & Grant, 2013). This is done on the basis of findings from the themes and subthemes, thus making recommendations based on the experiences of the researcher, those of researchers in similar contexts and on the basis of what has been done thus far at Itsoseng to improve the use of therapeutic psychology in that context.

The aforementioned stages are guided by a trustworthiness philosophy and reflexive process. This process ensures that the work is an authentic reflection of the research context.

Trustworthiness

Autoethnography does not attempt to generalise findings, but rather comments on specific sociocultural contexts, such as Itsoseng clinic and limits its recommendations accordingly (Edwards & Skinner, 2010). Trustworthiness comes from reflexive inquiry and suggesting alternate ways to view the subjective experiences of the autoethnographer. The focus is on sharing the researcher's experiences authentically so that others may truly understand the context which informed those experiences (Edwards & Skinner, 2010). What follows are the ways employed by the current study to enhance trustworthiness.

Reflexivity

The essence of reflexivity is constant reflection and thoughtfulness about the sociocultural context in which the research takes place, with acknowledgement that research is informed by a worldview or standpoint (King & Horrocks, 2010). This acknowledgement serves to add value to the research and deepens the process, while acknowledging the impact of the researcher on what is observed in a critical way. According to Willig (2013) there are two types of reflexivity, namely personal reflexivity and epistemological reflexivity, reflecting different logical levels of reflection, consistent with the proposed study's theoretical

framework. Personal reflexivity, according to this author, involves continual reflection on one's own beliefs, values, ideology etc. while conducting the research process. Epistemological reflexivity takes this one step further and allows for consideration of our underlying ideas about reality and the research context, thus allowing reflection at the level of epistemology and ontology (Baloyi, 2009; Vermeulen, 2011). In the latter instance one could consider how the research question itself limits or defines what can be found or how the study is constructed with certain limits, as discussed and motivated in chapter 1. In sum reflexivity includes many techniques, listed below, which allow for constant scrutiny of beliefs, assumptions, perspectives, ideologies, values and understandings, to produce research which authentically reflects the experiences co-created by the autoethnographer and the context which he or she engages.

Triangulation

Triangulation refers to using either a combination of methods or multiple sources of data to gain a deeper clearer understanding of the phenomenon or area of research inquiry (Taylor, Bogdan, & DeVault, 2015). In the current study the development of autobiographical narratives themselves forms a basis for the triangulation process. The repeated linking of the data to existing research and inclusion of multiple instances accordingly provides a form of data triangulation (Quinn, 2008). This sort of reflexive analysis allows for multiple interpretations of the data and links the personal experiences of the researcher to larger sociocultural contexts, which informed the researcher's experience of the township community context.

Credibility

The contribution of autoethnography links in part to the researcher's credibility (Denzin, 2000). This refers to the researcher's depth of exposure to a context, time spent there and richness of experience. The researcher in the current study has been in the Itsoseng context for three years and has had sufficiently credible, repeated, prolonged and rich experiences, with persistent observation, to comment fairly, persuasively and with rich detail on the context.

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Transferability

The value of autoethnography can be gauged in part by the degree to which it allows readers to connect with the work and the degree to which it speaks to their own experiences (Leavy, 2014). Autoethnography thus offers transferability if readers can relate to the work and find it useful in comparable situations.

Dependability and confirmability

Confirmability is a way of addressing the dependability of autoethnographic research (Suleiman, 2011). In the context of the proposed study, this will be undertaken by firstly including the original vignettes in the appendices of the study, and secondly by quoting key sections of the text to demonstrate how the researcher arrived at interpretations and reflexively considered alternative interpretations of the text. A third aspect included in the current study to ensure dependability is the use of an audit trail. An audit trail includes a detailed account of approaches to data collection and decisions made during the research process. This enables other knowledgeable persons to retrace the research process and confirm whether they arrive at similar conclusions (Stommel & Wills, 2004). This level of transparency thus adds significantly to the dependability of the research findings.

Conclusion

In this chapter the current study's epistemological and theoretical framework were described and the research method outlined accordingly. The use of a social constructionist meta-epistemology and ontology was motivated, with the specific use of an ecosystemic epistemology. The research method is described and operationalized in the form of an autoethnographic research design with three interrelated stages. Finally, an overview is provided of measures taken to ensure and enhance the trustworthiness of the study.

CHAPTER 4

RESEARCH DATA SELECTION PROCESS AND

AUDIT TRAIL

Introduction

In this chapter the process by which data was selected, and significant research decisions made, are documented. Given that the research is autoethnographic, there is also a change from the use of a third person narrative, such as "the researcher", to a first person narrative, signalled by the use of "I" or "me". Important research decisions are indicated by the use of headings and italicised sub-headings called "*research decision*".

Inductive process

I have decided to start with an inductive process. The rationale for doing so is to allow for the possibility that I may have had unique experiences in Itsoseng clinic, which could generate new themes, beyond those suggested by literature.

Inductive free reflection and recall: my first step is to reflect on experiences which I felt were challenging in an unstructured free recall process. What follows is the list of themes generated by this process.

- Language, misunderstandings, lost in translation, use of translators, various approaches with translators, loss of intention and meaning.
- Psychology itself, alien idea of psychotherapy, a sense of misfit, expectation, social worker and doctor connotations.
- Commitment, desire for tangible treatments, sense of talking cure lacking,
- Group psychotherapy, superficial buy in, lack of sense of community, saying "yes" in desperation or politeness.
- Client volumes, massive need, socioeconomic context, hierarchy of needs, broader social issues, impact of one failed system on the next

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- Burnt-out, overwhelmed referral agents, overloaded system, backlogs from inappropriate referrals, and no shows.
- Cultural norms, perceived slights and insensitivities, managing a sense of failure
- The white sangoma element.
- Ambition, plans ideas, difficulty to get buy-in, working in the narrow formulation of clinical work, community project, slow starts-no starts.
- Fears and dangers of working in a township context.
- Training and supervision groups, individual training.

Deductive process

Systematically chosen themes suggested by the literature review process (chapter2): during the literature review of previously published research I noted a number of themes relating to challenges experienced when using therapeutic psychology in township contexts. What follows is a list of these themes.

- Psychology based on western epistemology and lived experience, different individuality and self-concepts, collective cultures, racialised post-apartheid context. Psychology legacy, broader social problems, mixed acculturation.
- Stigma of mental illness, attitude, beliefs about psychology and aetiology of mental illness. Lack of knowledge, unrealistic expectations, trust, cultural insensitivity.
- Inappropriate referrals, scope of practice concerns.
- Practitioner's burnout, sense of hopelessness, large volumes of clients new to psychology, problems usually are framed in the form of psychosomatic symptoms, spirit afflictions and general discomfort.
- Language affects all psychology practitioners in township contexts and relates to the diversity of people who present for problems, many of whom do not fluently speak one of South Africa's eleven official languages. Translators can contribute to misunderstandings, frustration, loss of context meaning and intention. Language barriers lead to stress, frustration, mistakes, and deep uncertainty.
- Representative of your cultural and ethnic group, stereotyping, old sensitivities.

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Grouping common inductive and deductive themes

I have decided at this point in the process to group common inductive (I) and deductive (D) themes under a larger theme suggested by the process. The themes are grouped and extracted from the inductive and deductive lists above, under a common theme that emerged from the process of making the lists of experiences for example; "Language difficulties".

I: Language difficulties misunderstandings, lost in translation, use of translators. Various approaches with translators, loss of intention and meaning.

D: Language difficulties: Language affects all psychology practitioners in township contexts and relates to the diversity of people who present for problems, many of whom do not fluently speak one of South Africa's eleven official languages. Translators can contribute to misunderstandings, frustration, loss of context meaning and intention. Language barriers lead to stress, frustration, mistakes, and deep uncertainty.

I: Difficulties with psychology itself: Alien idea of psychotherapy, a sense of misfit, expectation, and social worker and doctor connotations. Commitment to or desire for tangible treatments, sense of talking cure lacking worth, working in the narrow formulation of clinical work, attitude, beliefs about psychology and aetiology of mental illness, lack of psychological knowledge.

D: Difficulties with psychology itself: Psychology based on western epistemology and lived experience, different individuality and self-concepts, collectivistic cultures, racialised post-apartheid context, psychology legacy, broader social problems, mixed acculturation, clients new to psychology, problems usually are framed in the form of psychosomatic symptoms, spirit afflictions and general discomfort, group psychotherapy.

I: Cultural context and norms: Cultural norms, perceived slights and insensitivities, managing a sense of failure, the white sangoma element

D: Cultural context and norms: Representative of your cultural and ethnic group, stereotyping, old sensitivities, cultural insensitivity.

Research decision: I have decided to subdivide the next theme, as it has a mix of broader and more specific contextual issues. The text in italics represents the larger context. I will split

broader and specific contextual demands and challenges for clarity, thus making 5 broad themes and outlier themes as a 6th area of focus described below.

I: Contextual demands: *Client volumes, massive need, socioeconomic context, hierarchy of needs, broader social issues, impact of one failed system on the next.* Burnt out overwhelmed referral agents, overloaded system, backlogs from inappropriate referrals, no shows, practitioners burnout, sense of hopelessness, large volumes of clients, ambition, plans & ideas, difficulty to get buy in, superficial buy in, lack of sense of community, saying yes in desperation or politeness, community projects, slow starts and no starts, unrealistic expectations.

D: Contextual demands: Inappropriate referrals, scope of practice concerns.

Outlier themes

Outlier is a term that originally derives from statistics; however I use it here to refer to themes that were uncommon or not reflected in both the inductive and deductive process (Welles, 2014). The themes listed here may reflect those experiences unique to my experience of the Itsoseng context, the unique experiences of other researchers or possibly even widespread shared experiences that are underrepresented in current research. I have included the inductive outliers as possible reflections of my unique experience and the deductive outliers to determine whether there are experiences that I may have missed in the inductive process or not otherwise have thought off.

Research decision: Should there be deductive outlier themes that do not resonate with or reflect my experiences at Itsoseng I will isolate these and discuss possible reasons why they appear in research literature yet do not feature in my experiences.

Outlier inductive themes

Fears and dangers of working in a township context.

Outlier deductive themes

The stigma of mental illness.

Themes discussed in terms of specific instances and linked to literature.

Research decision: Now that I have identified the various themes to focus on for the study I will start writing chapter 5.

Research decision: I will start each theme with an opening vignette and further vignettes to illustrate as appropriate. This makes sense given that the focus is my own experiences. I can then reflect on the process that follows.

I will write an overview and introduce each theme based on the above selection process and reflected by the opening vignette.

Research decision: I have decided to order the themes from larger contextual elements to more specific, for example, I will start with psychology itself, given that it relates to people's epistemology, within which culture, language and norms are developed. This also fits with my ecosystemic framework and punctuation of system levels.

Research decision: I will extract subthemes from the vignettes themselves, to be added to the themes extracted and outlined above; this will precede linking to literature and further deepen the process of rich data extraction.

I will link all themes to literature and published research

I will reflect on sociocultural context

I will reflect on the researchers influence and impact what was experienced.

Research decision; In the process of writing chapter 5, I have observed that there are overarching themes or meta-themes emerging from the data. I will examine these under the discussion in chapter 6 as they form part of the findings.

Discussion of findings and recommendations per theme

Research decision: Now that I have analysed the identified themes and linked them to research I will start writing chapter 6. I will present the themes in the same order as chapter 5 for continuity. Each theme will start with a summary of the findings, followed by recommendations. Recommendations will include a reflection on what has worked to date at Itsoseng clinic, what I tried, what is indicated in research for similar contexts and finally my own further reflections or ideas.

Discussion and recommendations for meta-themes

Research decision: I will now discuss the overarching meta-themes, with reference to making recommendations. As with the aforementioned themes, recommendations on meta-themes will include a reflection on what has worked to date at Itsoseng clinic, what I tried, what is indicated in research for similar contexts and my own reflections or ideas.

Conclusion of the study process

Research decision: I have decided that the final chapters' conclusion will also include a meta-conclusion and integrative summary of this study. Furthermore I will reflect on the possibilities and avenues for further research suggested by the findings of this study.

CHAPTER 5

AUTOETHNOGRAPHIC ACCOUNT AND ANALYSIS

Introduction

In this chapter I outline and discuss my various challenging experiences of applying therapeutic psychology in the Itsoseng clinic context in Mamelodi, over the past three years. The experiences are introduced thematically and are illustrated in terms of specific instances that the researcher experienced. The process by which these themes were generated and selected is detailed in the research audit trail (chapter 4). Each theme is introduced with an opening vignette and an overview, illustrated with specific instances and linked to literature and published research. This is done with concurrent reflection on the sociocultural context of Itsoseng and continuous reflection on my influence and impact on what was experienced.

What is a psychologist? What do they do? Can you give me medication?

Vignette 1: Theme 1: Difficulties with psychology itself

Many clients entered my office with little understanding of the psychology context or understanding of a psychologist's role. For example, I frequently had clients ask me if I could prescribe them medication or renew their scripts. I myself by contrast grew up with exposure to things like television, where I saw movies, documentaries, sitcoms etc. which portrayed; albeit in stereotyped versions, the basic idea of the "talking cure". I also had formal school education, where I received at least a basic understanding that people with "mental problems" need to "talk to someone". This automatic understanding of the broader context, at least in stereotypical form, was often lacking for my clients in Mamelodi. For example one couple; a husband and wife that I saw; who had been referred by the court for counselling, asked if I could give them ARV'S. The wife explained that they had gone to the clinic and they had diagnosed her as HIV positive, but had not given her ARV's. My opening statement in therapy after the usual introductions had been to ask what brought the couple to see me. The couple had a letter from a social worker, indicating the referral issue as domestic violence

and relationship problems. When I inquired about the referral for counselling the wife had a better understanding of the role I played in this regard, her husband said he had no idea why they were there. I realised that I needed to start with psychoeducation and try to set the context. I imagined I had set the context well, except that near the end of the session they asked if they needed to come back. I realised that despite my efforts, that the couple still saw me in a way akin to a medical doctor or social worker. I also felt then that I had failed to meet their expectations. They seemed to have an expectation of a tangible outcome, like an injection or medication or some sort of directive information-driven encounter. As it turned out I saw the same couple for eleven sessions and they became very dedicated clients. I was elated to hear them speaking about us "working as a team" and working together to find a way forward. Somehow, despite everything, we had figured out a way to work together and for me to offer value and assistance in a relatable way.

Sub themes vignette 1

Role confusion, misunderstandings, misunderstanding of psychology, background and upbringing relative to psychological understanding, understanding of mental illness, medical model, tangible needs, hierarchy of needs, psychological inexperience, broad social problems, epistemological and cultural differences, surprises, relief, benefits, frustrations, collaboration.

Finding a fit

Much has been written about the misfit and difficulties of using therapeutic psychology techniques developed within a western epistemology in non-western contexts (Baloyi, 2009; Cooper, 2007; Foster, 2004; Johnston, 2015; Kagee, 2014; Long, 2013; Macleod, 2004; Mkhize, 2004; Ruane, 2010; Vermeulen, 2011). In the preceding vignette I came face to face with clients who had only tangential references to draw on in terms of my role, which they related to the more familiar contexts of a doctor or social worker and perhaps to some extent a sangoma (shaman). At this point it may seem as if I am initiating an argument for the incompatibility of westernised psychotherapy in the Itsoseng context. It is however not adequate to dismiss western psychological techniques, as they have been demonstrated to add value (Laher & Cockcroft, 2014). The difficulty that I experienced was one of having to first

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bridge the clients understanding of the context and educate them about western psychology. This is true of clients in most therapeutic contexts; however to a greater extent in a township context, where clients often lack previous exposure to therapeutic psychology (Blokland, 2014).The challenge also goes further than mere education, in the process of our interacting there was also the meeting of different basic cosmologies and epistemologies in the room (Baloyi, 2009; Vermeulen, 2011). There was always an underlying chasm across which we were working. Even at the end of our work together I still felt that these clients had experienced the process in a very different way to my own experience; beyond the expected subjectivity by which we experience our unique realities, and reflecting a very different interpretation of the context (Schweitzer, Rosbrook, & Kaiplinger, 2013). In other words, despite having co-created the space, the degree of consensus on what was happening and the meaning of the process seemed to significantly differ between us.

In the preceding vignette, I speak of my socialising including an understanding which came from growing up with an inherent view within my culture of the "mentally ill individual". The problem with this is that it is still based on a western epistemology and cosmology that cannot be divorced from its historical ontological formative structures, such as Christianity, ancient Greek philosophy and Newtonian physics (Baloyi, 2009; Mkhize, 2004; Vermeulen, 2011). The very notion of problems as embedded in the psyche creates challenges when working cross culturally. The fragmented conception of self, split into mind, soul and spirit does not necessarily apply with indigenous thinking. This in turn has an impact on ideas of locus of control, causality and pathology. Perhaps these factors too then account for some of challenges I experienced of psychoeducating clients at Itsoseng. I could also argue that my limited understanding of these clients own psychology, meant that they also needed to psychoeducate me in return from a more indigenous psychological perspective.

These particular clients were of an older generation, both being in their fifties. This bears mention as there is a vast difference in the experiences of the younger generation, the so called "born free", post-apartheid generation (Howarth, Wagner, Magnusson, & Sammut, 2014). Clients in this sociocultural cohort are on a very different part of the acculturation spectrum and have had far greater access to westernised psychological information. Thus while their resources may be limited, they tend to have a wider range of exposure than the older generation and a better familiarity with the broader idea of psychotherapy. In terms of improvements to township dwellers lives as a result of socio-political changes in South Africa subsequent to the end of apartheid, one could argue that access to psychotherapy

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reflects one such sociocultural change and improvement. However, the extremity of these clients' limited access to health care resources calls into question the true extent of that change (Darkey & Visagie, 2013).

Acculturation is a significant factor in terms of a person's fit with the current approaches and models of treatment used in clinical psychology practice. Psychotherapy is also in of itself a contributor in return to the acculturation process (Ferguson & Adams, 2015). Whether this is desirable, given that psychology still has a bias towards western thinking, is of course questionable.

There is a growing recognition of the value of indigenous healing modalities and knowledge globally and more recently in South Africa (Baloyi, 2009; Hwang, 2005; Mkhize, 2004). Just because clients in townships are becoming more familiar with and accultured towards western psychology, and more so with each new generation, does not mean that indigenous psychological knowledge is not important. I get the distinct sense that psychology as a field is "psychoeducating" and waiting for indigenous people to "catch-up" and the evidence of this is the supposed increasing fit with existing therapeutic models from the west and the claimed emergence of a "global psychology" (Stevens, & Gielen, 2012). This form of reasoning simply plays into the broader discourse of the so-called superiority of western knowledge (Fougère & Moulettes, 2007). In a way I was caught in this same trap with the aforementioned clients. I too offered westernised psychoeducation and set the context, in a way congruent with a psychotherapy session as conceived in the western world. Was my implied communication in doing so one of a need to acculturate my clients? My contribution to the framing of their presenting problem and the context still reflected my training in psychotherapeutic models imported to Africa from the west. This placed the onus on them to fit and adapt.

If psychology as I argue here is about a person's lived experience in context, then it is important that their therapist can relate, at least to some degree to their lives and way of being. As someone who grew up in a white middle-class home there were limits to how well I could relate to these clients worlds. For a start they both grew up under the apartheid system and carried the perpetual challenges of this legacy, a legacy which ended officially when I was merely a child. To be seen by a young white male psychologist still evoked strong feelings in my elderly black clients. I felt compelled to open this issue in the course of our sessions and experienced a clearing of an "elephant in the room" when I did. Despite both

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clients emphatically stating that they were comfortable with seeing me, there was a distinct settling that occurred after I opened the issue. Given that the issue was in the room and that by my understanding; psychotherapy is a microcosm of society, it seems that the larger sociocultural issues of South Africa are played out in psychology and specifically in therapeutic psychology (Yamada & Brekke, 2008). Psychology can be conceived as a nodal point or focal arena for engaging sociocultural phenomena. The challenge is to have a psychology that is reflexive enough to respond to the diverse needs of the people it serves in South Africa.

My experience of these clients reflects my own psychologising, inherited from sociocultural history, my own family, community, and of course my formal psychology training. In other words as a young white male South African I entered the psychotherapy space with a psychology informed by our shared history, which ultimately still placed me in a position of power and authority. My access to education, economic resources and social status allowed me to be at Itsoseng as a psychotherapist, and not as a client. Arguably of course this would have been the case with any other psychotherapist, given the aforementioned predominance of western thinking in psychology. In many cases black psychologists are experienced as being so accultured that their impact is similar to that of white psychologists (Ruane, 2010). Therefore while I am particularly aware of my presence and what I may represent, the impact may have more to do with the socioeconomic and educational difference, as opposed to the colour of my skin. Even though there was a difference in understanding of the "psychology" context that was left at the end of therapy with my aforementioned couple, they still left the process with a healthy view of me as a young middle class white male psychologist. If they had seen a therapist of the same ethnicity, it may have made communication simpler, but it would not necessarily have contributed in the same way. Either way, despite the issues with using psychology mentioned here, the clients in question benefitted from the process and we taught each other a great deal.

Breaking the bread line

Vignette 2: Theme 2: Broader Contextual demands

Many of my clients came from extremely harsh socioeconomic contexts where material deprivation was profound. Most had less than a breadline income, if any. I saw people who had no running water, no electricity, old barely functional clothing, and a wide range of physical illness. It was hardly surprising that they presented with "depressing" problems or the problems of a depressed context. I couldn't help but think about Maslow's hierarchy of needs and the challenges my clients faced, how could I begin to imply that part of their situation was self-fulfilling. I realised that my role in part was to work with them to find hope in what seemed to be a hopeless situation, yet the mountain of very real devastating poverty and mass disempowerment that we now both confronted seemed at times insurmountable.

I saw a family with an elderly grandmother who they brought to the clinic as the index client. I spoke to the family for an extended period of time taking the history of the presenting issue and getting collateral information. Present in the room was the Grandmother's next door neighbour; who had observed the clients strange behaviour, the index client's elderly husband and one of the clients middle aged daughters. They described a living situation that included no basic amenities, no income bar for the client's old age pension and no formal living space apart from a shared shack. The index client's condition was severe, to say the least, and she had blatant evidence of an organic condition including tremors and dementia. The people in the room had eaten pap (porridge) as their one and only meal for the day before setting off for the clinic. They had scrapped together the money for a taxi fare, with the neighbours help. They lived a considerable distance from the clinic, and had made the journey specifically to see me. In a very real way they had literally made a choice between seeing me or buying food for the day. As the case progressed a referral was needed for the client to see a psychiatrist and a neurologist. The implications for these referrals were travelling further in Mamelodi to a general hospital and to a hospital in Johannesburg to see a neurologist, after a waiting list period of upwards of 6 months. I felt as though this family had made so much effort to see me and while a plan was put into action to help them I wondered if they really felt helped or if what they received equated to the effort they had expended.

In another case I saw a male client in his twenties, who had minimal education from a special needs school, and had been receiving a social grant. The grant that he was receiving was

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supporting a family of five as their primary income. At the time of the referral to see me, the grant; which was temporary in nature, had not been renewed and now the pressure fell on me to give an opinion that literally would affect the families only immediate option for an income. The situation was further complicated by his apparent efforts at malingering. His grant was already declined by another assessment agent and now it fell on me to determine whether it be given on a psychological basis. It did not help his case when he disclosed on our assessment day that he was tired from working; given that a grant is only offered to someone who is not able to work. I could feel his desperation and part of me could understand the attempt to mislead me given the context.

Sub themes vignette 2

Social problems, material deprivation, extreme material deprivation, collective and community depression, individual and community struggles, prioritisation of needs, limited choices, hopelessness, harsh realities, care, humanity, concern, severe untreated medical problems, extreme hardship, difficult double-bind choices, escalating challenges, disappointment, treatment pressures, desperation, misuse of financial support structure, difficult treatment and ethical decisions, moral implications.

Holding the contradiction

It is well known and acknowledged that lower socioeconomic status and instances of mental health problems are related (Draine, 2013; Kramers-Olen, 2014; Rugema, Krantz, Mogren, Ntaganira, & Persson, 2015). Itsoseng clinic is positioned in a vast and rapidly expanding township context, where there is a distinct division between the rich and poor. For example on the left hand side of the road I used to get to Itsoseng was a new informal settlement. In the same space two years prior there was only veld (open grassland). Further along the same road was a relatively well to do suburban area with formal housing, streets and most of the other amenities of the wealthier suburbs. However, across the road was an extremely poor area, where people lived in squalor. In Mamelodi it was common place to see modern, Tuscan style homes, with security and modern amenities, directly positioned next to shacks, with no amenities; although both were likely to have satellite dishes. The township itself, with its varying degrees of living conditions, was as a whole separated from the formally

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"white" suburbs of Pretoria, which house a diverse populace, including many people who under the current dispensation, still have links to families and roots in the townships. Many of these individuals have complex extended family ties and responsibilities, and in some cases I have encountered resentment for having to maintain family members in the township, who expect assistance from those who were able to get out. One of the challenges at Itsoseng was how to offer psychological assistance and processes that would benefit both the more affluent Mamelodi populace and still address the needs of those who were barely making any living.

Virtually all psychotherapeutic frames in a western context aim to put the locus of change back within the clients grasp (Jones-Smith, 2014). Yet with the extent of the material deprivation described above it was hard to imagine how clients could really begin to challenge their helplessness. It was a helplessness that was contagious, in the sense that I felt helpless at times in response to the overwhelming social challenges my clients brought into the room. I experienced a great deal of frustration and felt that the onus for making psychology relevant and useful in a context of material deprivation fell on my shoulders. Of course this may have reflected my awareness of the client's expectations and a tendency of my own to feel pressure to meet the needs of others. For me to have responded in such a way would have maintained the powerless position of my clients and put me in the position of "the giver", rather than the facilitator of the client's process. To view outsiders as "givers" is a role and position familiar to township dwellers. In the many years I had spent in Mamelodi, I regularly observed projects and relief efforts that started with good intentions, which ultimately positioned the community as receivers of donations. The majority of these projects, aimed at the very social issues a mention here, failed to produce long term changes. More often than not, it was back to the same situation as before. Material deprivation, helplessness and accompanying sense of hopelessness in the face of these issues were a norm in Mamelodi and a constant challenge in psychotherapy.

Who am I?

In the context of profound social problems it was difficult to delineate the exact scope of practice of a clinical psychologist, or clinical community psychologist to be specific. A central difficulty I faced was the definition of my role. If we consider the broad conceptions of therapeutic psychology and the professionals who offer it, including registered counsellors, psychometrists and psychologists, then what comes to mind? I posed this question to many

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colleagues in my time at Itsoseng and almost without fail I got the same responses. Responses included counselling, psychotherapy and assessment for individuals; with some reference to couples, groups and family work and occasionally research. I do not dispute the value of interventions punctuated at these levels, however I found it to be a very narrow definition of the respective roles of the psychology professionals involved. I specifically am interested in the potential role that psychology professionals could play as a bridge between the people of Mamelodi and higher-order social structures. It is clear from the vignette above that a larger socio-political system is involved in the difficulties being experienced by the people of Mamelodi (Marmot, 2005). It is also abundantly clear that the people with psychological symptoms who come to the clinic are also themselves "the symptoms" of a broader system. Clearly, by limiting my role I was also limiting my impact, and like many service provides unwittingly perpetuating the maintenance of the larger contextual challenges in Mamelodi, which confound our attempts as psychologists to offer effective interventions.

Punctuating the problem

Vignette 2.1

As part of a community project for my second year of clinical psychology training I participated in an attempt to involve the community in a mental health project. More than 50 clients were invited to come and discuss their needs and how we could assist them. On the day we had about 30 people who came. We spoke for a long time and the people who attended described their needs and we "co-created" a plan for an on-going group process. We had tea and snacks and left with a sense of a job well done. The next week we arrived at the clinic hopeful and optimistic. Three people showed up, of which one had been at the meeting the week before; the other a mother and child were lost and looking for the clinic reception. In the time that followed we discussed the ins and outs of what happened but no consensus could be reached. Why did they not return, after they themselves had participated in the process? Clearly there was an unspoken problem that we missed or perhaps the community had agreed politely, but what we could offer did not fit their pressing needs? Or perhaps their needs were not foremost in the first place, because even though we consulted them, our repertoire of offerings was predetermined and limited to what was already on offer. I felt that our meeting covertly was still trying to get the community to buy into our

definition of how to assist them. It was a consultation with the community, with a predetermined range of outcomes and I suspect that the participants sensed this.

Sub themes vignette 2.1

Training, good intentions, teamwork, community engagement, effort, initial optimism, initial success, complete disappointment, project failure, superficial community by in, inability to find definitive reasons for failure, superficially enacted process, false engagement, preconceived ideas about psychology by practitioners, imposed ideas on community, misalignment of needs, attempts to force a fit, taboos of community psychology, possible incongruence of intentions, limits of psychological offerings, replication of previous projects at process level, nothing really new to offer, perpetuation of psychologists role definition, one sided superficial community collaborations.

The challenges of working in Mamelodi related to the application of psychology itself and how it is typically practiced in this context. I frequently encountered resistance to working beyond the aforementioned classical clinical psychology client punctuations or levels of intervention. Work at the level of social structures and policy was seen as "too big". Perhaps this assumption was what prevented attempts to work at this level. For example, in my training I was never taught how to affect change and treat pathology at a sociocultural level. This lack of social practice efficacy is a common weakness in professional psychology training (Constantine, Kindaichi, & Bryant, 2007). I learned about the problems at those levels, yet interventions were always at lower order punctuations of individuals, families or groups. Even in my training at master's level I observed that "clinical community psychology" was reduced to the application of clinical psychology in a township community, as in vignette 2.1. How is this any different from its application in another context? Is clinical community psychology in this form insensitive to context? I would argue that working with higher-order social structures extends into community psychotherapy rather than merely psychotherapy and assessment in a community. My own experience and observation is that working beyond the parameters of a stereotypical definition of therapeutic psychology requires a deep desire to genuinely assist and be part of a community. Practitioners who are simply using a community as a stepping stone or as part of a mandatory internship or

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community service as a means to an end, are unlikely to be invested beyond the definition of their role and duties. I have sensed resentment from clients in this regard as one middle age client said to me (with my own words and emphasis):

"You will go home today, back to your family, with your future and job in place. I am still here."

I don't know how many practitioners return to township communities or take on higher order social structures as "clients". However, I am certain that we cannot expect communities to buy in to therapeutic community psychology for them, if we do not do so ourselves. It is easier to locate the failure of projects as a function of a particular community, rather than to accept our role in perpetuating that disinterest, needs misfit and lack of service relevance.

The straws that broke the camel's back

Vignette 3: Theme 3: Context specific demands

I recall an instance where I phoned the uncle from a family who had presented for family therapy. They were "lucky" in that they had only waited a few weeks from the time of intake, to receiving a phone call for a booking. The uncle explained that they no longer "needed" the booking and had dealt with the issue themselves. He was very angry with the clinic and at that moment vented with myself. He could not understand the delay and demanded an explanation. I heard in his voice the echoed frustrations of a family elder trying to care for and protect his family. I heard the anguish of a family struggling, hurting, fearful and grasping in desperation for help, yet finding no immediate comfort. I heard the cries of an impoverished community, feeling betrayed by the systems tasked with holding, protecting, nurturing and sustaining them. His voice reverberated through me as I stood holding the phone, holding the space, holding the displaced hurt and holding the disappointment.

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Sub themes vignette 3

Pressure, responsibility, feelings of guilt, failure, disappointment, frustration, anger, hopelessness, delays, urgent need, displacement, sense of betrayal, desire to care and be cared for, sense of duty, impact on a trainee psychologist, feelings of helplessness for all concerned.

Feeling the strain

Itsoseng clinic is the only fully psychological service provider for over a million people. People are referred to Itsoseng from diverse sources, including schools, social workers, other medical care contexts and police stations, to name but a few. These referral sources themselves are often overloaded, and struggling to serve the great demand placed on them (Alexander, 2010; Atkinson, 2007; Marais, 2011; Manala, 2010).   The diversity of referral sources in of itself can create challenges for student clinical psychologists, for example with regard to potentially inappropriate referrals of cases that would be better suited to social workers or educational psychologists. This is however not clear cut, because there are frequently clinical psychological elements within a seemingly inappropriate referral, even though the presenting problem may not be blatantly psychological in nature (Ruane, 2010). It becomes the clinician's responsibility to filter through and determine how and if a clinical psychology intervention is applicable. This sort of filtering by the clinician is less pronounced in many of the other contexts where clinical psychology is practiced, for example, in a psychiatric hospital context. In these contexts the referral is likely to be framed psychologically and has passed through a psychologically informed channel such as a medical doctor, who acts as a filter and case manager (Kakuma et al., 2011). At Itsoseng clinic I found that I was often put into the position of being a "case manager" as a result of being the first form of professional contact for the client. This can be very challenging as it goes beyond the usual role of the clinical psychologist. An additional consideration regarding management of referrals is that clinicians have to be careful of their scope of practice (Pretorius, 2012). This was difficult given the range of issues brought to the clinic and the limited room for referrals. An example of this challenge is evident in the presence of educational psychologists in the same context as Itsoseng, yet the clinic may not make referrals directly to them. These sorts of stumbling blocks create frustration for all concerned and can be exacerbating. Furthermore, I did not have the safety net of a multi-disciplinary

team to cross refer clients. I would instead act as the central agent referring cases to numerous sources and tracking the overall process.

Managing and working through the huge numbers of referrals, at times created backlogs and delays in service delivery (Phala, 2009). This is in evident in the opening vignette and the uncles' frustration. His frustration is also likely to be displaced from engagement with the broader healthcare system in Mamelodi and other township contexts, where long delays in accessing medical care are common place (Maree, 2012). Patients are often left feeling frustrated, angry and shunted from pillar to post. Many patients came to the clinic with such experiences, which had often added to the problems they already had.

On the verge

Where things became particularly problematic was when referral sources to and from the clinic were so overwhelmed that they could not cope with any more clients. In these cases, when making a referral, phones would ring but go unanswered or clients would be referred only to find the person concerned was not available and worst of all clients would at times be referred in a circle back to where they started at the clinic. On many occasions I referred clients to social workers in Mamelodi only to find out later on that the case was not taken further. Many clients had previously seen social workers, but seemingly to no avail. A further example is referrals to police stations for clients in danger and requiring protection orders, when some of the clients arrived they were turned away or found that police responses were ineffective (Buur, 2006). In one case the police visited the clients house and according to her "drank a beer with the accused and told him to stop it". In another example a colleague saw a client who was actively suicidal and as was appropriate contacted the police to assist her. I observed my colleague making the call at around lunchtime, by 4pm when I left the clinic the police still had not responded. It would be easy at this juncture to enter into a blaming stance and suggest that the social structures in Mamelodi are doing their jobs poorly, however the situation and context is complex. None of these structures have developed in isolation; they have been co-created within a broader socio-political-historical context. An example of this is the number of people in dire social circumstance in Mamelodi and needing social assistance i.e. access to a social worker, an arguable legacy of South Africa's socio-economic and political past and failures by the current dispensation (Atkinson, 2007). This creates a context where a virtually endless and growing number of desperate people are referred to a limited

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number of practitioners, who have limited resources to assist them (Brown & Neku, 2005). It is not surprising then that people working in overburdened systems burn out and simply cannot do more.

Burnout is important to mention in the context of service delivery failure because of the impact on clients and the community at large. Known symptoms of burnout individually include, among others; apathy, cold detachment, depression, depersonalisation, anger outbursts and so forth (Dyrbye, West, & Shanafelt, 2009). I would further argue that the systems these individuals inhabit eventually function in similar apathetic, detached ways and this impact can arguably be seen right through the various system levels into the policies and governance systems that contain these collapsing social structures (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009). Yet the focus is often in my experience on the poor service delivery offered by under-resourced and overburdened health care providers, as if they should in isolation from their context improve their standards. I am clearly critical of this as it pertains to some extent to Itsoseng clinic. Over the years of my involvement at Itsoseng I frequently heard about the "problems at Itsoseng". Yet when I asked for specifics about the nature of the problems it seemed that it was hard to pin point them as such. Are there problems with Itsoseng or is it a challenging problematic context within which the clinic operates? In many ways Itsoseng is a focal point due to its attempts to assist all who seek assistance. The difficulty then is managing the huge demand of a community with few places to turn and considerable unsatisfied needs.

The pressure and case load was understandably high at Itsoseng, and there was at times a long frustrating waiting list for service, as experienced by the family in the opening vignette; despite a relatively short waiting period in their case. This is further complicated by the challenge of not having full-time psychologists on site, the services provided being mostly by by student psychologists, who have to split their time at the clinic with numerous other commitments. The net result is an overloaded system which has the challenging task of balancing quality, timeous service provision, massive demand and a very limited number of service providers. Clients are made aware of the need and reason for a waiting list; however this can be slim comfort for a person or family as discussed before, who is in urgent need of assistance. The most urgent cases at Itsoseng are prioritised and attended to as a priority, but even so there are times when the system simply cannot avoid delays, the opening vignette for this theme reflects one such instance. I experienced a great deal of anxiety and guilt at being confronted about the delays this client experienced. I found myself repeatedly having to

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explain the reasons for clients being put on waiting lists and then having to contain the anger, frustration and disappointments that come from feeling let down again by "the system".

Disillusionment

The experience and complications of waiting for service also played out in other ways; alluded to in the opening vignette, where the client concerned said "we dealt with it ourselves." I often found that clients who were called for appointments after an extended time would either say they no longer needed the appointment, had resolved the issue, made peace with the problem or had found some alternate resource or solution. Others had even forgotten that they had come in to ask for an appointment in the first place. In retrospect, I wondered if this was a coping response that was reflective of the broader coping style employed by Mamelodi township dwellers. Township dwellers seem to have learned to cope without formal social structures in their own way (Moller, 2005). I am aware of at least one case where a former Itsoseng client started a support group in his section of Mamelodi from his house. This is an example of an adaptive community response, facilitated by engagement with Itsoseng. The coping employed by the community may of course also be less adaptive at times, as reflected by activities such as mob justice and vigilantism (Steinberg, 2011). An example of this was a family I saw at Itsoseng following a mob justice attack where their home, belongings and vehicles were burnt, following an accusation that the father had committed a crime. In perceived and or actual absence of adequate policing, people in Mamelodi often take matters into their own hands (Buur, 2006). Thus when clients told me that they had dealt with their issues themselves, I could not help but make the link between these processes and wonder whether the community sees failures by overwhelmed health care providers in the same light. The emotions of the uncle in the opening vignette towards the clinic were often reflected in psychotherapy sessions when clients referred to other social structures that they perceived as failing to meet their needs. Being confronted as a representative of a "social structure" in this way felt devastating and left me with feelings of anxiety, pressure, excessive responsibility, guilt, failure, disappointment, frustration, anger and helplessness. Ironically, this reflects very accurately my countertransference with the clients. In other words, I was left with the same unresolved feelings as the clients; the same feelings that are expressed by other health and social providers in Mamelodi, by social

providers in other township contexts and similarly reiterated at all the larger social system levels.

Another common and complex phenomenon at Itsoseng may also in part be a response to delays in service provision, namely "no shows". The so-called "no show" is a generic term for clients who fail to show up for appointments (Defife, Conklin, Smith, & Poole, 2010). Clients who I called to book for sessions after longer waiting periods were far less likely to show for appointments, especially first appointments. Waiting and preparing for sessions with clients who don't come is by no means unique to Itsoseng clinic, however it does seem that the specific contextual challenges described here do aggravate the situation.

No shows raised a number of concerns and I was left with a great deal of unresolved feelings when clients failed to come for appointments. Invariably a failure by a client to show for a session would result in me questioning what I had done and trying to find a reason on my part for it. Although, this fits with a pattern I am aware of in myself as a therapist; for taking excessive responsibility for others, it does not detract from the fact that I share a role in the existence of the problem. The questions I was usually left with were about the extent of my contribution and how? I observed that it was commonplace for myself and colleagues to be waiting at the clinics reception for a client to arrive and after a given interval to hear the words "no show" enter the conversation with whomever was present. On one level I always viewed the responsibility for coming to sessions as being a client's responsibility, and in the process mirroring the goals of psychotherapy which include the taking of responsibility for self, developing a sense of mastery over ones environment, individuation, growth, healthy autonomy and a sense of self-efficacy. The conundrum I see in this is that it places the responsibility again wholly on the clients for change as individuals. While this fits with westernised cultures conceptions of self and a healthy internal locus of control and individuality it may be at odds with more traditional African conceptions of self (Mkhize, 2004). More accultured westernised clients generally committed to psychotherapy and tended to have sufficient resources to attend weekly sessions. The issue of resources is a significant factor for clients who struggle to pay taxi fares to attend sessions. Mamelodi is a vast sprawling community and people often had to travel very far to get to Itsoseng. The irony of myself driving a relatively short distance into Mamelodi in a comfortable air conditioned car with sufficient food and comfortable clothing was a bitter irony not lost on me at the time. This was especially so given that my clients, who I expected to arrive on time and consistently, literally had to plan their entire day around making a similar journey, late

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coming and no shows in this regard were common and perhaps understandable. This does of course challenge the boundaries and interpretation of psychological reasons for late coming and missed appointments that would fit with a private practice context in a well off middle class income suburb. Whatever the reason behind it, no shows were a frustrating and administratively irritating challenge.

Always back to square one

The no show phenomenon had a knock-on effect contributing significantly to failed projects as mentioned before regarding the second year clinical masters community project I participated in (Vignette 2.1). I had also at various times in my involvement at Itsoseng tried running groups, with very limited success. In all cases I attributed the discontinuation as being due to no-shows for group sessions and my interpretation of this as a communication of disinterest. I later framed the failure of the groups as a communication of misfit with the community's needs rather than disinterest, as this had a blaming connotation and made me feel very passive and helpless. There were groups that ran successfully at Itsoseng, for example many of the groups for children. There was often an overlap with an existing community need that assisted in the continuation of successful groups. The children's groups as a case in point overlapped with a need for a safe place for children to go during the school holidays or after school. The key here seems to be meeting the community half-way and on their terms.

Walking on thin ice

Vignette 4: Theme 4: Challenging sociocultural context and norms

I found myself on occasion being an unwitting representative of my cultural and ethnic group at Itsoseng. At other times I represented something of a curiosity, given that I am also a traditional healer or shaman; The African shaman of course being the sangoma or inyanga. Culture and ethnicity was a frequent and often very important aspect of my work at Itsoseng, providing both opportunities for shared cross-cultural learning, as well as the potential for sensitivities, misunderstandings, stereotypes and perceived slights.

I saw a 30 year old woman that had grown up in a very conservative home; her family had a mixed belief system including indigenous African beliefs and Christian religious fundamentals. Her father was trained as a pastor, but had also been initiated earlier in life as a sangoma. When she walked into my office her first reaction was to state that she could not work with me. I felt an immediate sense of rejection and wondered whether this was typical of her relational style. After all she did not know me and yet had dismissed me out of hand. Upon inquiry she explained that as a Christian she could not condone working with a "sangoma", let alone a white sangoma. She had of course noticed the red and white beads that I wear, which cued her to the fact that I am a shaman. While I appreciated her overt reason for not wanting to see me, I also realised that there was an important implied communication of discomfort with difference and possibly the use of her beliefs to maintain or evoke distance interpersonally. I reassured her that I was seeing her from a medical clinical treatment frame of reference and that I would only discuss the differences in our beliefs as they pertained to her psychotherapy. I suspected that she unconsciously was trying to get me to reject her on the basis of our "incompatible" beliefs. I could also feel in my countertransference a desire to simply agree with her and terminate the process. Instead I engaged her gently and respectfully, exploring the depth and breadth of her concerns. This immediacy allowed for a workable therapeutic relationship. As it turned out, the sessions that followed lead to an incredible, deeply healing therapeutic process. I represented many of the conflicts she had with her father and his mixed beliefs. She also projected a great deal of her own existential ambivalence and uncertainty on to me. Perhaps we saw in each other the challenge of reconciling mixed and seemingly contradictory beliefs into a coherent identity. The inevitable and necessary transference and countertransference provided valuable material and a phenomenal context within which to punctuate meaning. It was in the end a vital difference. Bridging the difference interpersonally and thus symbolically in intrapsychic terms, facilitated the therapeutic and healing process in a way that may not have otherwise had such an impact. In fairness the therapeutic process was relatively short term in nature and while there was value in the difference, there was always a tension around it. No amount of bringing the tension into our process could ever fully resolve it and I suspect that in a longer term therapy that it may have proven very difficult to navigate. Perhaps represented in the room was the focal meeting point of a larger collective process in South Africa and to expect complete resolution of it was unrealistic.

Sub themes vignette 4

Cultural identity, representation of culture, cultural norms, belief, tension, sensitivities, misunderstandings, stereotypes, cultural value, difference, bridging, acculturation, hesitancy, defensiveness, hurt, rejection, fear, identity markers, unspoken dis-ease, culture and belief as an excuse to not connect, a way forward, conflict, conflicted, ambivalence, healing, collective processes.

What is the Difference?

Differences in culture and ethnicity of client and clinician invariably have an impact when conducting psychotherapy (Tseng & Streltzer, 2008). Managing and productively channelling these differences into valuable aspects of the process are vital if psychotherapy is going to succeed in cross cultural contexts. In South Africa, and specifically in township contexts, there is a heightened sensitivity to culture and difference, given our socio-political history and the history of South African psychology (as discussed in chapter 2). The result can be the potential for perceived or even actual insensitivities, which pertain to cultural norms, beliefs, discourses, stereotypes and expectations (Ruane, 2010).

One way of attempting to deal with cultural difference is to match client and psychotherapist more closely. There are recognised advantages to pairing therapists and clients of the same ethnicity as this can reduce the potential for slights or insensitivities (Cabral & Smith, 2011). However, my experience has been that difference can be of value in of itself, despite the challenges. When I saw clients who differed significantly in sociocultural background I usually had to seek more confirmation of my understanding, which deepened the therapeutic process (Grobler, Schenck, & Du Toit, 2003). I had to spend more time checking and actively being empathic, rather than taking things for granted, as I may have done with someone from my own cultural group. There is also arguably a larger collective corrective experience at work on cross cultural psychotherapy, where participants who socially would be unlikely to interact spontaneously are able to demystify each other (Kirmayer, 2007). In the case of South Africa, with an ethnically segregated past, this allows for important healing to take place.

Part of the challenge is that people from different cultural groups in Mamelodi and other township contexts have generally had limited intimate cross-cultural interactions or engagement. Cross-cultural interaction for township inhabitants is far more common in terms

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of socially structured interaction, such as going to the shops, or work, where contact with diverse people is regulated through roles and boundaries of the context. There is limited opportunity to actively sit and discuss differences in belief, values and understanding (Dixon et al., 2010). Despite the socio-political changes since the inception of democracy in South Africa in 1994, there is still limited opportunity to openly discuss tensions or co-evolve new understandings (Durrheim, Mtose, & Brown, 2011). Many of my clients at Itsoseng were engaging in an intimate discussion with a white person for the first time in their lives. They typically only had the historical context, social stereotypes and ideas from social media to draw on for a context of how a white psychologist may be. I saw this in comments that clients made with reference to my assumed culture, for example, one client alluded to the value that white people place on possessions. While this may be true of some white people it certainly does not describe all white people. Some clients revealed in the course of psychotherapy that they had deep reservations upon hearing that they were going to see a white psychologist and that they initially had attended sessions with a "see how it goes" approach. I understood their reservations about my perceived ability to relate to their experiences and of course the stereotypes mentioned in this section. There was also an issue of trust and whether it was safe to share vulnerabilities with a white person (Ruane, 2010). Some clients acknowledged being mistrustful of me at first and fearing that I may have some unspoken agenda; this is not farfetched given the historical context in South Africa and lingering legacy of apartheid. Other clients expressed relief at seeing a white psychologist, because they knew that I would leave the clinic and not discuss their problems in the community. This seemed to be an issue in Mamelodi where rumours were a particular issue and concern for clients. Rumours were often enough to incite the community in Mamelodi, and people live in fear of accusations from participation in crime, to witchcraft, which can result in mob justice.

Cultural differences and stereotypes also extended into various discourses that were at play in the psychotherapy room. Discourses around masculinity, femininity and gender were particularly pronounced. For example, clients had very specific ideas about the sexuality and virility of African men, and also the differences between black men and white men. As a white male I then represented the presence of these ideas in the room. Female clients generally seemed to view black men as more virile than white men, usually with reference to them having multiple sex partners and cheating on their partners (Harrison, O'Sullivan, Hoffman, Dolezal, & Morrell, 2006; Jewkes, Sikweyiya, Morrell, & Dunkle, 2011). Some female clients would then wonder if I could relate to experience of black men. One client in

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particular asked if white men are the same, her question thus implying that as a white male I could speak for all white men or perhaps seeking to place this phenomenon as a broader masculine trait. Another observation I made was the lack of men in my psychotherapy room. A significant proportion of my clients were women. This fitted with the social role women played in the community as the over-responsible and usually overburdened caregivers and problem solvers in in couples and families (Jewkes & Morrell, 2010). I also observed in relation to this a very distinct patriarchy in Mamelodi and this had a particularly challenging impact on psychotherapy. Post 1994 research has charted a revitalisation movement in masculine identity in the face of rapid acculturation and in particular how it impacts on HIV prevention and woman's rights (Walker, 2005). The positioning of men socially in Mamelodi influenced how I was perceived by female clients in early sessions, who generally assumed passive, submissive and frequently resentful one-down roles with me. The issue being that they in most cases were bringing presenting complaints of spousal or more commonly partner abuse, rape, neglect and infidelity into the room. Many such clients had a passive acceptance of the issues, despite overt communications of no longer wanting to be in unfulfilling damaging relationships (Abrahams, Jewkes, Martin, Mathews, Vetten, & Lombard, 2009). Men by contrast assumed that I would have similar values and often said things like "you know how it is for us guys", in what I therapeutically interpreted as manoeuvres for coalition or seeking my approval for harmful behaviour towards women. It was very difficult to challenge underlying beliefs driving risky behaviours like unprotected sex in the context of these hyper masculine beliefs (Harrison et al., 2006; Ratele, 2013). From this example it is evident that psychotherapy could approach first order changes in terms of re-negotiating the dynamics of the issue within the current context for these clients. However I frequently ran into barriers with second order changes, such as changing the fundamental definition, or balance of power in relationships. This was the case for the client in the opening vignette who had a pattern of dating irresponsible, dependant and abusive men to whom she played the equally unhealthy logical overfunctioner compliment. For her it was possible to see and to some extent change the patterns, however when it came to actively choosing a healthy relationship she viewed it as wholly beyond her control, for her in particular it was divine fate who she ended up with. This reflected from my perspective an excessive external locus of control and fatalistic way of living, which stood in stark contrast to her relatively acculturated, self-directed westernised identity. Yet her behaviour was consistent with the norms and gendered roles of woman in the Mamelodi and other township contexts (Eagle & Long, 2011). This clients' family told her she would not find a better partner and should

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make peace with her current relationship. This was a common familial response to partner abuse and one I heard in different words many times from different clients. This was accompanied by comments to the effect of how "men are" and the limits of relationship options for women. In a different example I saw a female client whose partner was consistently sleeping with other women, who engaged in unprotected sex and had in addition to my client impregnated several other women. My client, said "but Justin this is how men are, I must just accept it". This story was the same with the running theme being one of passive acceptance in the face of unchallengeable norms and discourses. I found myself feeling ineffective after a certain point in this psychotherapy process and facing a dilemma of how to punctuate the process. I could not decide whether I should proceed from the norms of my psychotherapy training or whether to simply accept the same limitations my client brought to the room, the latter leaving me feeling helpless in the same way my client felt to change the situation. It was hard for me to understand the cultural context of these relational dynamics, and perhaps hard for my client too. The cultural context in Mamelodi is fluid and emergent, making it hard for the inhabitants to know where they stand and what these new accultured cross pollinated identities represent. It makes it that much harder for an outsider to relate and appreciate the depth of the cultural issues and belief brought into the psychotherapy room (Ward, Bochner, & Furnham, 2005).

These cultural challenges also extended into the realm spiritual belief, practice and approaches to healing for the majority of my clients in Mamelodi. Religious and spiritual beliefs played a significant role in the sociocultural fabric of Mamelodi and had an important impact on the lives of many of my clients (Garner, 2000). Most clients I saw held a mix of traditional spiritual beliefs including traditional medicine use, consultations with sangomas, inyangas, prophets and priests. Some clients, including the one in the opening vignette, had developed an intense religiosity, which provided a way of countering the "immoral" hazards of township life. Her religiosity provided hope in a desperate situation and placing your life in the hands of divinity or fate perhaps fitted to some extent with traditional cultural beliefs, which provide for a more external locus of control (Mkhize, 2004). Other clients held on staunchly to traditional beliefs and were trying hard to reconcile them with the westernised "Americanised" values that pervade "township culture". In essence the challenges at a cultural level of working psychotherapeutically in Mamelodi are the same the same challenges facing its inhabitants, namely how to interface diverse beliefs and cultural values in a meaningful and functional way.

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What is this place?

Mamelodi has a very distinct contextually derived township culture, which developed in its own way in interaction with historical, political and acculturation influences. Township culture includes a mix of beliefs, values, morals and ideals that reflect both modern urban ways of living and a number of revitalised re-interpreted cultural artefacts from pre-colonial Africa (Walker, 2005). I realised that in order for me to assist my clients I had to move beyond emotional containment and structural changes in their lives, to clients underlying ontology and epistemology, which contained and maintained significant aspects of their difficulties (Becvar & Becvar, 2006). Yet in doing so I was always referencing my own heavily westernised and psychologised beliefs. There was ultimately a limit on the degree to which I could truly relate to my clients culture generally, and township culture specifically. This had significant implications for demonstrating cultural sensitivity, which had been a concern for clients at Itsoseng as documented in previous research in the context (Ruane, 2010). Like most psychologists from outside the Mamelodi community, I brought in a strongly accultured background or westernised way of thinking and being into the context. My way of living was far removed from that of the average Mamelodi inhabitant and resulted in us working across a divide. This is a significant challenge considering that it speaks to the fundamentals of any psychotherapy process namely the relationship, built on the ability to relate to a persons lived experience. One of the most significant factors in relating and which embodies culture is language, the theme of the following section.

Relating while translating

Vignette 5: Theme 5: Language difficulties

A family came for therapy on referral after their son had started an individual psychotherapy process and the attending psychologist had observed that family dynamics were contributing significantly to the problem. I took the case and before seeing the family arranged the services of a translator as I did not speak the same language as the family and their understanding of English and Afrikaans was reported as limited. I had some background from the referral note, intake form and sparse information from the phone call made to book our session. As we sat down for the session I observed the families choice of seating, and who chose to sit closer together etc. I observed that mom and dad sat on opposite ends of the

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room and that the brother and sister sat between the parents. I introduced myself and asked the translator to relay as closely as possible what I said. As the session proceeded I got a sense of a growing discrepancy between my intention and the feedback coming to me via the translator. My questions on the impact of the discussion on the various participants and the feeling this evoked seemed to be missing the mark. My translator also seemed very uncomfortable with the content of the discussion and the questions which to her seemed very personal and inappropriate. I could see her struggling not only to communicate the content of what I said in terms of language equivalents, but also she struggled with the cultural context of openly discussing sensitive issues in front of everyone present. It also become clear that my translator felt pressure to respond to the questions posed to her directly. Given that she could understand directly it was hard for her not to respond. My instinct was to then discuss the awkwardness in the room and pull it into the process. I said something to the effect of "I sense that it is uncomfortable for you (the family) to talk openly like this about issues, what is your experience of this?" My translator hesitated then reluctantly conveyed my question. The family responded with a deafening silence and bemused puzzled looks. This was followed by further attempts to clarify what I had asked by the translator, and finally laughter as if I must have told a very funny joke. In all the confusion I too eventually laughed anxiously. The family members eventually responded by saying that they were unsure what I was doing and were confused. To my relief their son; the index client, was able to make sense of it all and explain to the others what I was attempting to do. Ironically it gave him a space to have a voice, and reflected one of the communication issues at home.

Sub themes vignette 5

Translation issues, need for a translator, limited common language, sparse information, western psychology training perspective, distance, discrepancy in communication, loss of intention and meaning, content focussed discussions, loss of process, missing the mark, discomfort, culturally appropriate topics for translator and client, language challenges for translators, language equivalents, focus on translator, silence, extended efforts, confusion, humour, anxiety, stress, confused confounded context, therapeutic utility, value despite odds.

Talking the talk

Language challenges affect all psychology practitioners in township contexts and relate to the diversity of people who present for therapeutic assistance, many of whom do not fluently speak one of South Africa's eleven official languages (Deumert, 2010; Drennan, 1999; Drennan & Swartz, 2002; Kilian, 2013; Schlemmer & Mash, 2006). This is highly significant because lived experience or "psychology" is profoundly shaped through language and culture (Baloyi, 2008). Language shapes the way we think, feel, reason and relate. Language shapes reality and contains epistemological and ontological beliefs that are intergenerationally and socially transmitted to each adherent of a sociocultural group (Becvar & Becvar, 2006). Access to client's experiential realities in psychotherapy is to a large extent verbal or linguistic, and goes back to the birth of western psychology, with its father Freud, who established the formal roots of the "talking cure". A great deal of communication is also non-verbal in the form of body language, reading context, reading process and so forth, however confirmation of these nonverbal cues is usually sought verbally (Siegman & Feldstein, 2014). Additionally, when there is incongruence between verbal and nonverbal communications this is viewed as significant in psychotherapy (Vorster, Roos, & Beukes, 2013). At Itsoseng clinic I was confronted with a number of linguistic challenges on multiple levels, while conducting psychotherapy and psychological assessment, and for the most part my response was the use of a translator or interpreter to assist the process.

Translate this!

It is necessary at this point to clarify my use of this terms "translator" and "interpreter" as the meaning of these terms can vary according to context. Translation is a term that mostly refers to the use of written text, and interpretation to oral language use (Smart & Smart, 1995). In research on the use of translators and interpreters the terms are frequently blurred or used interchangeably. I will use the term interpreter primarily here as my focus is on oral language challenges. When I use the term translation it will refer to the direct "translation" of words in one language into other languages nearest equivalents; which in of itself requires an element of "interpretation" and not the process of written text translation.

In my definitions of the term translation and interpretation I hint at one of the most challenging aspects of working cross-linguistically: the lack of similar words across

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languages and the need to either use similar terms or define a word that has no equivalent in another language (Elkington & Talbot, 2016; Hagan et al., 2013). This can be especially problematic when translating words for emotions that have a specific meaning in one language and not in another. Feelings of shame, anxiety and depression may fall under emotional categorisations outside of the English language. Depression may fall under feelings of sadness for example. When attempting to translate language it is often not feasible to translate directly from language to another in terms of literal equivalents. As a result there is often a loss of meaning when using an interpreter, because not only does the language itself change, but the subtleties, culture specific terms, underlying ideas and so forth are frequently lost in translation (Pugh, & Vetere, 2009). Essentially the problem with translation of language is that it cannot be divorced from the total culture that is at play within the communication process (Smart & Smart, 1995). Interpretation into direct language equivalents is thus not enough, and this places the onus on interpreters to "figure" out what a client is trying to say (Deumert, 2010; Kilian, Swartz, & Joska, 2010). The psychologist then has to use this crude, often rather concrete translation, to infer a basic and deeper understanding of the client and the presenting problem. Various studies have demonstrated that interpreted language and translations tends to be less emotive and more factual resulting in a more shallow communication of experience (Pugh & Vetere, 2009). Another challenge I experienced was that interviews with an interpreter would often end up following something of a checklist format of questions and answers. When I asked open-ended or reflective questions they would tend to be met with silence or short answers; one such common short answer that was very disempowering and "cut me off at the knees" was "I'm fine". The net result is that it was very hard to interpret such responses and easy to misinterpret them as apathy or disinterest (Kilian, 2013). I was left with the feeling that I had poorly understood the client, which in all likelihood is how they felt. This would result in feelings of frustration and discomfort for myself, and based on the nonverbal communications, similar feelings for such clients. The process was fraught with possibilities for miscommunications and as such required a lot more time and effort for all parties concerned (Hussey, 2012). This is a challenge of note, given the long waiting list and need for efficient service at the clinic, which added to the pressure and stress of an already challenging situation.

A further complication of using interpreters was the reaction of clients to the situation (Raval, & Tribe, 2014). Even though clients gave consent, some of them were visibly less comfortable with the addition of the interpreter to the room. Other clients' would look at the

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interpreter or ask the interpreter questions. Many interpreters felt pressure from the clients to provide an answer. This situation was made worse when interpreters would on occasion "play' psychologist, because they felt they understood the client better. The situation was more complex depending on the age and gender of the interpreter, which would evoke cultural taboos or norms. For example an older male client would potentially be very uncomfortable with a young female interpreter, especially if the presenting problem had a sexual nature; it was difficult enough talking to a young white male psychologist as is. I tried different techniques with this difficulty, such as matching interpreters as carefully as possible to clients and varied the seating position of interpreters, so that they looked at me and not clients. These met with different degrees of success. Having the interpreter look at me directly helped the clients to focus on me and vice versa, but there were times where clients would then lean over to grab the interpreters' attention if the process went askew for some reason. It seemed that there were times where the interpreter needed to see the client to make out what was being said. Perhaps this is because so much communication; even when being interpreted, relies on visual cues. A particularly frustrating situation would be when clients and interpreters would set off on a long clearly complex dialogue without me. This was made even worse when after several minutes of exchanges, the interpreter would offer a one line interpretation such as "he says he is angry with his wife". When I inquired about the rest the interpreter would say "it was all about his wife and how angry he is with her". Clearly I had missed out on all the nuances and potentially important elements in the communication and had no other way to get them.

An additional concern with interpreters was the impact of some clients and content of the session on them. This was most notable with angry clients, or with clients who shared traumatic experiences. As a psychologist I received extensive training and supervision and had access to my own psychotherapy to deal with the emotional impact of the work. The informal interpreters I used at Itsoseng had limited support in this regard and I usually had to debrief them after sessions, especially when they felt vicariously traumatised by the experience. This of course added to the workload and made the already challenging job for the interpreters that much harder to cope with.

Call the problem by its name

In a context of miscommunications, misunderstandings and problematic interpretations there was a heightened risk of misdiagnosis as well as inaccurate estimation of the degree of illness or the extent of a problem (Bezuidenhout & Borry, 2009; Kilian, Swartz, Dowling, Dlali, & Chiliza, 2014; Kilian, Swartz, & Chiliza, 2015). In the case of clients who say "I'm fine" and where the collateral information is from an interpreter, there may be little to go on, making it hard to work out if there was indeed a clinical psychological problem.

Vignette 5.1

I saw a 16 year old adolescent male client who spoke a moderate amount of English and his mother very little. According to my adolescent client he had no problems, he was happy at home, he was passing and doing well at school and he could not think of any reason he should be at the clinic. According to his intake form the presenting problem was depression. When I spoke to his mother to get collateral information I was assisted by an interpreter. She revealed during the interview that she was concerned because they lived apart and she seldom saw him and when she did he only wanted to watch television and not spend time with her. When I tried to inquire about his mood and affect things became very challenging, my interpreter was using the word depression, yet when I asked further about sleeping patterns, appetite, his affect, his feelings about the future, suicidality, and so forth she became vague and struggled to respond to many of my questions. I proceeded to ask about their relationship, which she said was good, and she then repeated that he seemed "different", but she could not pin point how. Something had bought these clients to the clinic. The one thing I was certain of was that I had a mother who cared deeply about her sons wellbeing and wanted to assist him, and a son who my own observation and his account was doing well.

I realised in retrospect that part of the challenge with this case had been my own language issue, in that I was trying to find a presenting problem that fitted with my "clinical language" and in a way I expected the clients to language the issue in I way I could work with. This was of course not the clients' responsibility but in fact mine. With enough psychoeducation and after my own somewhat misguided focus on the mother-son relationship as a focal point for psychotherapy for three sessions, I was able to determine that the presenting problem was somatic headaches in response to stress with school work and dealing with living conditions

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at his grandmother's house. As it turned out his grandmother had been relaying her concerns to my clients' mother, hence her vague description of her sons' difficulties. His rebuffing of his mother's attempts to assist had heightened her concerns and she made the appointment at the clinic for him. My initial challenges in understanding and getting information from my clinical interviews at the start had made it hard to work out where I should punctuate psychotherapy. I had erroneously diagnosed relationship problems, given that my clients lived apart and in the apparent absence of any obvious psychological symptoms.

The language barrier was ultimately manageable in the aforementioned case and once I was able to appropriately diagnose the clinical issue, it was possible to move forward. The implications however are significant, and things do not always work out the way they did in this case. It can be very difficult in some cases to distinguish the difference between mild cognitive impairment and limited language; this is then made worse when collateral assessments are in English (Kilian, 2013). Even the reduced culture assessments need to be administered with instructions that in my case can only be given in English or Afrikaans.

Language barriers therefore created a great deal of stress and uncertainty for me, especially given that I was always aware of my ethical responsibilities to clients. It was hard to feel like a competent professional while stumbling through a clinical interview and not knowing what I was really dealing with or what the clients were really trying to address.

Tensions rise

The language challenge had another consequence that was very difficult to navigate in terms of the allocations of work or cases at Itsoseng. Many clients who came to the clinic would indicate a preference for a psychologist who spoke a particular language. Furthermore, clients often needed someone who could administer assessments and translate them at the same time. These conditions would result in a higher number of clients being a "fit" for psychologists who could speak the same language. This meant that they were allocated more clients, which at times led to feelings of resentment about doing more than a fair share. The case load and difficulties in allocating of clients, combined with the challenges documented in the preceding and following sections, meant that myself and my colleagues would work hard to keep up with the need and demand for service, but along the way the stress and tension would sometimes boil over into disagreements and displaced venting of feelings. The tension around

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case allocations was further aggravated by the fact that clients who could speak English and were thus able to more easily fit for westernised psychotherapeutic frameworks and assessments were primarily paired with English-speaking only therapists. This would bias English speaking therapists in terms of getting cases that were easier to formulate for case presentations and other training requirements. This phenomenon was particularly evident with children needing cognitive assessment, who frequently had a limited range of English. The issue was poignant given that conducting a cognitive assessment via a translator would be ethically questionable and not feasible for timed items where adjustment would need to be made for interpretation delays. It would also be hard to ensure that the interpreter did not unwittingly assist or bias responses (Kilian, Swartz, & Joska, 2010). The combination of ethical requirements and practical realities of language contributed to tense and frustrating compromises when determining how best to attend to clients.

Always the odd one out

Outlier themes

In this section consideration is given to those themes that were unique to either the deductive or inductive thematic selection process described in chapter 4. These themes were deductively suggested by relevant literature and inductively by the autoethnographers unique experiences. The outlier themes were not common to both processes and as such reflect themes that were less apparent or underrepresented in literature on the use of therapeutic psychology in township contexts.

People will think I'm crazy

Mental illness has always had a negative connotation and is generally perceived negatively by society at large (Henderson & Thornicroft, 2009; Hugo, Boshoff, Traut, Zungu-Dirwayi, & Stein, 2003; Kakuma et al., 2010). As a result it carries a heavy stigma, which consequently can influence people's willingness to access psychological services and get the assistance they need. I have however chosen to address this important issue as outlier theme, and it is thus necessary to provide a brief rationale for doing so. During my initial inductive

theme selection process, it did not occur to me to include stigma of mental illness as a challenge of working at Itsoseng. It was only when I proceeded with the deductive process that I realised I had missed the issue and recalled instances where it had indeed been a significant challenge. My hypothesis in this regard is that it may be due to my own habituation to mental illness, due to exposure to psychological work and training, combined with my own inclination to be open-minded and a personal ethic of non- judgement as far as possible. Perhaps it also reflects a degree of psychological egocentrism on my part, in that I assumed that others are as comfortable with mental illness and equally fascinated by it as I. Furthermore, it may reflect the evolution and gradual acceptance of mental illness within my socioeconomic class as a middle-class white South African, which I projected into the Mamelodi context. Although even this has limits, as I can't imagine any person of any socioeconomic standing readily talking about a psychological diagnosis without some sense of being judged or viewed as "odd" or "could snap at any time".

The issue of mental illness stigma was particularly salient in the Mamelodi context. People who came to the clinic frequently spoke about feelings of shame, fears of being perceived as weak, or fears of family members and the community seeing them as "crazy" or ostracizing them (Wahl, 1999). Some clients were also caught in a vicious cycle where they experienced discouragement, hurt, anger, and lowered self-esteem as results of community stigmatization. This then aggravated their problems and led to them needing more treatment in an escalating cycle. Fears about the stigma of mental illness often meant that by the time I saw clients their problems had already reached extreme proportions. Disorders such a depression; which in more affluent contexts would be likely to receive attention, would frequently go undiagnosed for years in Mamelodi. Lack of awareness of mental illness would then aggravate the situation and in the case of neurocognitive disorders patients would often be severely impaired before getting assistance.

Many clients also had a great deal of guilt and self-blame, and were in many cases scapegoated for the problems of their families and communities as the cause of the problem (Livingston & Boyd, 2010). Clients would then present for treatment with the impossible burden of solving the problems of a whole family, of the community, or attempting to solve all the issues in an intimate relationship. In such cases I observed that the other participants in the problem i.e. the non-present family or community members quite happily bought into the idea of the "crazy individual", especially given that it freed them of responsibility for the issue (Minuchin, Rosman, & Baker, 2009). In the same way that people in Mamelodi fear

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accusations of witchcraft or criminality, they also in many cases fear accusations of madness or being "crazy". Perhaps one of the downsides to rapid acculturation is the potential for expanding the repertoire of scapegoating tactics from more the traditional roles of witchcraft, into the industrialised western scapegoat roles of "mad", "crazy "and "mentally ill".

The association of mental illness with such phenomena as sorcery and witchcraft in turn played into further stigmatisation of mentally ill people in Mamelodi and further impeded access by community members to appropriate treatment. Severe cases of schizophrenia were often attended to by traditional healers, without concurrent psychiatric and psychological care. The community tended to see the basis of the problem as rooted in possession, witchcraft or other metaphysical origins and would only seek psychiatric treatment after these traditional approaches had failed (Ashforth, 2005). In a different version of this scenario, patients would be fully aware of the possibility that the issue was psychiatric, but would try all other avenues of treatment first to avoid the stigma of mental illness. This would frequently delay access to treatment, and result in the problem getting worse.

Stigma and a lack of psychological education in the Mamelodi context thus created a significant challenge and a great deal of the work at Itsoseng involved appropriate psychoeducation and information dissemination. One of the great values of Itsoseng is its function in this regard as a psychological service provider.

Facing your fears

Vignette 6

I was in my office at the clinic one morning waiting for a client when I heard a commotion outside in the corridor. A client who had managed to get to the clinic was loudly describing how she had slipped through a protest which had now reached the gate of the premises. The protestors had now started burning tyres, throwing stones and breaking bottles. I went outside and watched in amazement as the standoff between police and protestors escalated in the street. The protestors moved in waves and the police rebuffed them in a seemingly endless volley of engagements. I watched the faces of the enraged young protestors as they ran forward to throw a bottle or a stone at the police and the faces of the police as they stood visibly tense, poised and feverously holding back. The black smoke from the tyres was thick in the air and passed over the sun creating ominous shades in the sky and shadows on the earth.

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My first thought was how I will get home if the protest does not pass by the time I want to leave? I had flashes of the burnt out husk of a car I had seen that morning on the side of the road, I wondered if my car was at risk? I wondered how I would get to the clinic the following week if my car was taken? I wondered if the owner of the vehicle had been beaten or injured? I wondered if my clients would be safe? I wondered if I would be safe? I wondered, I worried and I kept on working.

Sub themes vignette 6

Tensions, fear, risk, anger, frustration, violence, displacement, shock, surprise, helplessness, passivity, sense of foreboding, self-concern, personal safety, imagined fears, real fears, worry for others, pushing through.

In the process of conducting the literature review for this study I was surprised to find a limited amount of research into or reflecting on fear and the centrality of this emotion in township contexts, for both health care professionals and the community members themselves. In the preceding sections I have spoken about the fears community members had with regard to accusations of criminality, witchcraft and being seen as "crazy". Furthermore I touched on how community members live in perpetual fear of crime and in many cases fear of the police.

As a psychologist working in the Mamelodi my fears centred on my own personal safety and that of my clients. I was very aware of my "difference" in Mamelodi, as a young white male I not only stood out physically in the community, but also represented an object of projection, given the legacy and socio-political history in South Africa. Mamelodi always had an air of volatility for me in the many years I spent there. It would wax and wane but there was for me an underlying tension waiting to erupt, and it frequently did so in the form of riots, protests, wild car chases with police pursuing suspected criminals, helicopters surveying and trailing suspects, police barricades and so forth. There was an expectation by the inhabitants of Mamelodi and other townships that violence could break out at any time and that you would need to preserve your life (Kynoch, 2005). In one example a colleague shared a story from a hail storm, where hail the size of tennis balls had fallen on the clinic and surrounds, creating massive amounts of damage. During the storm my colleague had been with a client in

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session. Upon hearing the hail on the clinics metal roof he (the client) dived out of his chair and hid under the table, shouting at my colleague "they are shooting, they are shooting". Afterwards the client explained that gunshots were a regular event in his part of Mamelodi, hence this seemed to be the most likely source of the sound.

Vignette 6.1

During the latter part of my first year of masters training it was arranged for us to have psychotherapy lectures at the universities Mamelodi campus; to better place us as students in the context of the work we were doing. As I was driving into Mamelodi I reached a road block and the police indicated that there was danger ahead and I should use an alternate route to the clinic. I turned around and looked for another way into Mamelodi, as I drove I found myself heading further and further away from the clinic. Eventually tar roads gave way to sand and road signs disappeared completely. I realised I was lost. I drove down small dirt roads surrounded by shacks (informal houses) as sense of panic began to set in. Eventually I found a taxi and followed it hoping that it would lead me to larger roads. I struggled to follow it over sand roads, over pavements and through what appeared to be people's back yards. Eventually I found what seemed to be a main road and followed it, as it lead me in a roundabout way to the clinic. I was probably not in any real danger, and the vast majority of people in Mamelodi are welcoming of outsiders, especially those who bring services or donations. Yet I was made very aware of being out of context and that while I had become accustomed to working in a foreign context it did not take much to jolt me from my comfort. I realised I had developed a sort of conscious obliviousness to the potential dangers, which allowed me to function as if it was not there.

Townships have a history of violence stretching back to their inception under the apartheid government in South Africa (Kynoch, 2005). This legacy is pervasive in townships like Mamelodi and many of the clients I saw had stories that included themes of rape, assault, murder, and intimidation robbery and other violent crimes, police brutality and vigilantism (Seedat, Van Niekerk, Jewkes, Suffla, & Ratele, 2009). Part of the challenge in this context is the management of extensive clinical trauma with clients who frequently have had multiple traumatic experiences, usually accompanied by post-traumatic stress (Straker, 1992). At one

point virtually every woman I saw at the clinic had been raped at some point in her life and there was not one client who had not been exposed to violent crime either directly or through the experience of a close friend or family member. For a significant proportion of clients it was "normal" to have terrifying life-threatening experiences every few years and to still be trying to cope with the impact of one traumatic event when the next followed (Masuku, 2006). The impact on me as a person exposed to this much trauma may well have been to form an excessively fearful perception of the township context and to view it as more dangerous than it really is. I was on a weekly basis exposed to a sample of the population who had been victimized and it was easy to assume that Mamelodi at large was a hostile dangerous context. This was made worse by exposure to events such as those in the vignettes included in this section, which then seemed to provide evidence for my fears. It made it hard to rationalise away the dangers and my accompanying fears. It also made it very hard to remain neutral, in a way I could understand why the community reacted with mob justice. I felt a collective countertransference of my own anger as I over-identified with my clients. Occasionally I found myself falling into the trap of blaming the perpetrators of these violent acts and having to stop myself and return to a meta-perspective and view the larger context. It was relatively easy to fall into the maintaining the duality of victim and perpetrator set out by the community and maintained by the larger contextual dynamics.

It was rare to hear people speaking about fear openly and even clients did so only within the safe confines of the psychotherapy room. Fear was a regular part of the work for me in Mamelodi, and despite the taboos about saying so; it was a challenge that had to be attended to on a regular basis.

Conclusion

In this chapter the researcher (autoethnographer) outlines and discusses his various challenging experiences of applying therapeutic psychology in the Itsoseng context over the past three years. The experiences are introduced thematically and are illustrated in terms of specific instances that the researcher experienced. Each theme is introduced with an overview, illustrated with specific instances and linked to literature and research. This is done with concurrent reflection on the sociocultural context of Itsoseng and continuous reflect on researchers influence and impact on what was experienced.

CHAPTER 6

DISCUSSION, RECOMMMEDATIONS AND

CONCLUSION

Introduction

In this chapter the findings of the autoethnographic account and analysis in chapter 5 are discussed. The chapter starts with a discussion of the findings of each specific theme from chapter 5, with reference to making recommendations for managing the potential challenges experienced in the Itsoseng context. This is followed by a summary of the underlying meta-themes which were found to be present across the findings. Finally a conclusion for the study as a whole is provided, including recommendations for further research in the Itsoseng and Mamelodi context.

Discussion and recommendations

In this section the findings of each specific theme from chapter 5 are discussed and recommendations for managing the potential challenges experienced in the Itsoseng context are made. Recommendations include suggestions for first-order changes at the level of Itsoseng clinic itself, as well as changes at a second-order level, including the wider community, broad socio-cultural contexts and knowledge systems or ways of knowing i.e. epistemology and ontology (Becvar & Becvar, 2006). Therefore the broader ecology, of which Itsoseng clinic is a part, is considered from micro to macro level and recommendations are offered in an integrated way.

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Discussion and recommendations theme 1: Difficulties with psychology itself

The findings from chapter 5 suggest that the practice of therapeutic psychology had a number of challenges in the Itsoseng context, which to a large extent stem from the fact that it is conceived within a westernised epistemological and ontological framework. Therapeutic psychology is not a perfect fit in township contexts and tends to benefit those clients who are more accultured into westernised lifestyles. Furthermore it is generally of greater benefit to individuals who have their basic living needs met. Despite this it is clear that therapeutic psychology does add value and with the gradual inclusion of indigenous psychologies has the roots of being more contextually sensitive. In this section the researcher considers some of the efforts made to find a fit for therapeutic psychology at Itsoseng and suggests some additional possibilities for how to do so.

My own response over the years I spent at Itsoseng was to spend a great deal more time on thoroughly setting the context with clients and making sure I understood how much exposure to psychology or the concept of psychotherapy itself clients had. I learned like many other community psychologists to be patient in the process of psychoeducating and systematically discussing the ins and outs of what psychotherapy could offer clients, how long it would take and how psychotherapy fitted into the broader treatment picture (Asmal et al., 2011). I found that clients would usually say that they understood what all of this entailed, however it was useful to ask them to describe it back in their own words. This simple technique would frequently reveal that clients only had a partial understanding and generally would say they understood out of politeness or not wanting to question an authority figure. It was very helpful to work with clients own understanding of the content in this way and from my experience and observation this led to better therapeutic "buy-in" over the long term. It was also a valuable context for opening up basic differences in understanding of treatment and aetiology, which fed into expectations such as immediate tangible outcomes for treatment.

Another avenue for psychoeducation in context is the running of groups within community structures (Brown, & Brown, 2011). I am aware of instances where groups were run in Mamelodi schools, which again resulted in links being formed and a relationship being built with Itsoseng clinic. The groups also served the needs of more clients at one time and gave an initial introduction to the psychotherapy experience. In most of these cases this would be

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followed by individual or family bookings at the clinic. I would argue that psychoeducation in this sort of context is vital and lays a great deal of the groundwork prior to a client presenting for psychotherapy. There are many community structures in Mamelodi which could serve as such contexts including, churches, hospitals, clinics, community centres and so forth. Perhaps part of the challenge to actually doing this lies in viewing this sort of engagement as part of the clinical psychologists job. I argue here that these community structures are themselves "clients" and building a bridge between them and Itsoseng clinic is "community psychotherapy" in a manner akin to something like family psychotherapy. The only difference being that the punctuation of the "problem" is at a macro level. In order for this to work it would be necessary for work with the community as a "client" to be recognised as clinical work, for example when student psychologists attend their supervision to be able to present such work as "a case". Clinical psychology has traditionally struggled to move beyond the individual, couple, family and groups as clients (Schensul, & Trickett, 2009). Work in township contexts is an ideal opportunity for expanding the response repertoire of clinicians and offering community psychology and community psychotherapy instead of simply clinical psychology in a community.

The other side of the coin with psychoeducation is "psychoeducating" the clinicians who work in township contexts. For example I am aware of at least two tertiary institutions who offer a dedicated African Epistemology class as part of masters level clinical psychology training. This facilitates understanding of the clients they see in townships contexts and enables the building of bridges between clients' ways of being and the westernised treatment models used in psychotherapy. It also places the onus for adaptation on clients and clinicians, rather than expecting clients alone to adapt and find a fit.

Psychoeducating clinicians on indigenous cosmologies allows for the incorporation of traditional psychological healing techniques into current clinical practice. One example which added value, which I used to great success at Itsoseng was the "talking stick". Talking sticks or stones are a technique used in virtually all indigenous cultures for facilitating discussion of important matters (Fujioka, 1998). The talking stick in my current example is introduced by the psychologist with the instruction that only the person holding the stick may speak at that point in time, while others listen. When the stick is passed to another present in the room that person may speak and so forth. This is an incredible facilitation tool due to the egalitarian context it creates. It is also a tool that resonates with many indigenous people who often at the very least recognise it as a culturally known artefact and technique. The talking

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stick also is of value in that it does not contradict the process of group or family psychotherapy as conceived in western psychology, which also aims in most cases to provide a safe space where individuals are validated can speak freely, while learning about themselves and others from the group or family dynamics. The talking stick is just one example of meeting cultural and epistemological difference half way and co-creating a third space or "more functional reality" (Becvar and Becvar, 2006).

A further step in understanding indigenous psychology can also came from collaboration with traditional healers in township context (Robertson, 2006). Many of my clients chose traditional healers as a first point of contact. Working with them towards mutual psychoeducation as I argue for here lays important groundwork for a referral base and assisting clients to access the help they need from both perspectives.

Collaboration and psychoeducation also extends into working with other helping professionals such as medical doctors and social workers in Mamelodi. Raising awareness of the clinics role and what constitutes a psychological referral with such colleagues could assist greatly in the initial psychoeducation phase and create important cross referral links (Kates et al., 2011).

Finally I argue for the role of psychoeducation to be extended into the broader sociocultural and policy level contexts. For example just as awareness campaigns have made a significant difference in the arena of HIV and AIDS awareness, so too campaigns to psychoeducate and raise awareness of mental health could be of tremendous value in townships like Mamelodi. I argue that this form of intervention should be advocated for by clinical psychologists, viewing policy makers and local government as "clients" and that this level of work can and should be part of community psychology training at postgraduate level in psychology. A policy development project or awareness campaign could be run and handed over year to year as part of a community psychology module during masters level training in clinical psychology, with Itsoseng as a base of operations. This makes a significant change from limiting the role clinicians' play and expands their impact dramatically.

Discussion and recommendations theme 2: Broader Contextual demands

The findings from chapter 5 suggest that material deprivation and poor access to healthcare in general and specifically mental healthcare have a profound impact on the Mamelodi community and its inhabitants. The socioeconomic challenges faced by the Mamelodi inhabitants contribute significantly to the incidence of mental health issues and to poor health of the people in general. This presents a major challenge for psychologists who are amongst other things trying to facilitate change and build clients sense of self efficacy. The nature of profound deprivation is that it can become debilitating and disempowering, leaving people with limited choices and thus "cutting of therapeutic options at the knees." Many clients came to Itsoseng clinic feeling hopeless, helpless and voiceless. This larger context challenges the role repertoire of the psychologist and where they punctuate their interventions. Working only with the individuals, couples, families or groups at the clinic limits the impact that interventions have and allows for an arguably complicit perpetuation of the social processes that maintain clients' problems. It is not sufficient to challenge clients to change their circumstances and response-ability if we as practitioners will not do the same for ourselves.

As in the previous sections recommendations for psychology itself, the recommendations made here extend beyond the traditional role of the clinical psychologist. One such recommendation is for the clinician to act as a bridge between the micro and macro social system levels. By this I am arguing that clinicians take up the challenge of facilitating a process whereby clients and communities are able to find voice and be heard by the larger social structures, which have the capacity to affect and assist with the severe material deprivation they faced. This extends the clinicians role into the realm of policy development, advocacy and broader public awareness (Herschell, Kolko, Baumann, & Davis, 2010). I will use the metaphor of a family to demonstrate my argument. In a family where a child (a community) is neglected by the parents (social structures) the intervention cannot only focus on treating the child, but must also attend to the parents. Family therapy (community/ social psychotherapy) in this regard would create a context where the family (stakeholders) can meet, empathise with each other's positions and co-construct a way forward. The family (community) therapist acts as the bridge, so that participants can "see" and "hear" each other. It is my contention that stakeholders in this example are no less valid clients that an

individual client in psychotherapy and the facilitation of this process is no less of a treatment than psychotherapy in more conventional punctuations of problems. The primary recommendation from this section is that clinicians at Itsoseng be exposed to supervised interventions at this level of clinical community work, which has a reciprocal impact on the nature of the issues that clients present with at Itsoseng clinic.

Discussion and recommendations theme 3: Context specific demands

Findings from the data analysis on context specific demands in chapter 5 suggests that Itsoseng clinic faces a number of challenges in offering therapeutic psychology services to the Mamelodi community. The experiences of the researcher included reflections on the large number of referrals faced by clinic staff which at times created an overload of cases. The overload was challenging to manage, and made more so by the overload experienced by referral agents such as social workers, who referred clients from their own systems. This would result in challenges for clinicians at Itsoseng who needed to refer clients in return, and often resulted in difficulties for clients who struggled to get the help they needed. A related difficulty was that the researcher often found himself acting as a central case manager, which made the effective handling of cases a challenging and time consuming task. The back-logs, difficulties in making referrals, and central role of the clinician, made it hard to stick to the limits of the clinical psychologists' scope of practice. For example referrals to educational psychologists were particularly challenging and there was a thin line between intellectual assessment and educational assessment. In chapter 5 it was clear that the various challenges listed here placed the clinicians in a position where they had to work hard not to replicate the frustrating experiences clients were having with the larger healthcare system in Mamelodi and continue to offer quality service to the community. It was also evident that two of the major challenges faced by the researcher, namely no-shows and various failed projects including group therapies, were related, but not limited to the challenges of the specific context.

As in the previous sections my initial recommendations for the context specific demands extend into the relationship the clinic has with the community followed by more specific possible approaches within the clinic itself. For example if the clinicians at Itsoseng are

actively involved with a group psychotherapy process at a school and make referrals from this context to Itsoseng clinic, it is likely that these clients will be psychoeducated and potentially screened for motivation for individual psychotherapy. The knock on effect of engaging in the community at large is a potential reduction in context specific challenges, such as no-shows, failed projects or unsuccessful groups. Furthermore it meets the community halfway and "takes therapy to the clients" (Dworkin, Pinto, Hunter, Rapkin, & Remien, 2008). In return a relationship is established with Itsoseng clinic in a reciprocal way. In my current example it moves the process from an expectation that the learners at the school come to seek treatment on our (the professionals) terms alone to a mutually defined space. This approach could be applied across the board and creates a context for active buy-in to the treatment process. The implication is that Itsoseng clinic is positioned as a base of operations with the clinic as well as treatment focal point. The outreach into the community provides the vital nodal points to access community trust and participation.

Various in-house ideas and solutions have been employed by the researcher and his colleagues for managing challenges directly within the context of Itsoseng clinic itself. I will reflect on what has been tried within the Itsoseng context by the researcher and what is proposed to address no-shows and unsuccessful projects, backlogs of service, difficulties with referrals in and out of Itsoseng clinic and the central of the clinician as a case manager.

The challenge of "no shows"

My approach to the no-show issue with individuals, groups and community projects within the clinic itself was to start with thorough psychoeducation, as discussed at the start of this chapter. In the process of doing so I could also gauge psychological mindedness, previous exposure to psychology, understanding of the concept of psychotherapy and motivation for seeking psychotherapy (Margison & Brown, 2007). My understanding was that people were not returning because they did not perceive a fit with their needs and what was on offer at the clinic. I got the distinct sense that they left disappointed and in at least some cases why after all the "talking" was done they had not been "treated". I took it upon myself to draw some initial links between their presenting problem and how psychotherapy could assist them; this approach has documented success in improving psychotherapy treatment adherence and outcome in South Africa (Trump & Hugo, 2006). I made it clear that psychotherapy itself was a treatment. At times this required the drawing of links between the psychological aspect

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of the concern and how it related to more concrete needs. For example I saw a woman who was in an abusive relationship and wanted me to help her find somewhere safe to live. As part of our early sessions in addition to containing her feelings, we discussed depression and what symptoms led me to that diagnosis. We drew it all on a piece of paper together and mapped it out, with appropriate references to psychoeducation in general. I also took time to discuss the cycle of abuse and her contribution to the problems maintenance within the dynamics of the relationship. I then explained at how coming to therapy and the relationship with me could be of value in solving the problem and ultimately contribute back to her more concrete concern about a new place to live. All of these steps occur in any clinical context, what is different is the time and extent to which I utilised them in a township context. Another difference was the focus on drawing links specifically to how psychotherapy aims to assist people and its methodology. For this client psychotherapy was not only an experiential process, but initially had a large information and psychoeducational element. Later on the experiential aspect became the focus. I often found that I would have what seemed to be a good session, where I connected with clients and build seemingly good rapport only to have them be a no-show the following week. I realised that less psychologically experienced clients tended not to come back if I focused too heavily on the therapeutic process and less on setting the context early on. It was not enough for them to feel contained, if they did not sense that the problem would be solved or that all the "talking" was actually going somewhere. I used a similar process in the latter stages of my time at Itsoseng with groups and other projects. I took time to not only co-evolve the group or project with clients, but also to draw out how it aimed to psychologically assist them and how this would relate to the concerns they had brought in the first place. While my approach was time consuming, it allowed me to build a relationship with clients. Co-evolving an understanding of what was to follow gave us time to get to know each other, and reassured both parties of the commitment to the process. On the down side I was at risk of being in a put in a position of trying to "sell psychotherapy" to clients and the potential to define my role and the therapeutic relationship in such a way. My approach to the no-show issue was thus one that I applied consciously and in adapted depending on the client.

Dealing with backlogs and high caseloads

Responding effectively and efficiently to clients that present for psychotherapy was challenging at Itsoseng. The clinic had a limited number of staff, student psychologists, intern counsellors and psychometrists, and volunteers who attend to cases. The majority of the staff could only work part time at the clinic and had other commitments to balance with seeing clients. This was compounded by the fact that the community had a great need for service and limited psychological service provider access. The result was that backlogs were inevitable and clients had to be put on a waiting list, which was a frustrating situation for all concerned. The knee jerk response I have observed to high pressure situations where clients demand service in other similar contexts is to suggest that clients be attended to more promptly. The problem with this is that it would place the clinic and its staff in a double bind of wanting to attend to everyone but not having the time to effectively do so. This then adds pressure in an escalating cycle of more of the same; hence I will not make this a proposed recommendation. The underlying issue was one of needing for more staff, on a consistent basis, who had a reasonable amount of time between their other duties and commitments, combined with finding the most efficient management of cases that was possible given the limitations of the context.

One of the approaches that helped with regard to staffing was the difference in participation of masters' student psychologists in the first and second year of their studies. In the first year I only started in April after receiving initial training and then gradually found my feet at the clinic. By the second year I was able to continue with my clients from January. In this way there was no time where the clinic remained unstaffed. The second year masters students would carry as much workload as possible and would attend to cases needing more experienced therapists and would then be joined later in the year by the first year masters students. This also allowed for cases to be handed over from one leaving M2 group to the next.

Another approach which could be of value to assisting with staffing would be the possible addition of community service psychologists to the Itsoseng context. A yearly rotation of full time community service psychologists could offer tremendous value to the Itsoseng context and provide a much needed service to the community. These practitioners would not have the same split work loyalties as student psychologists and have a great deal more experience by

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this point in their careers. The addition of community service psychologists would dramatically reduce the backlog and waiting period for clients.

With regards to case management Itsoseng had a policy of prioritising and flagging urgent cases such as trauma for attention first. This worked well in my experience, it was however hard to separate out degrees of urgency. One could argue that most cases are urgent. However in practice it was possible to distinguish cases that needed instant attention vs. those which could be booked at a longer interval. All cases were seen for an initial intake and no clients were turned away. The primary issue was then that the wait for a follow-up could at times be quite long, such as cases that needed assessment, which take time and are highly in demand. Having the assistance of psychometrists was very helpful in this regard and contributed significantly to speeding up assessment waiting periods.

The central role of the clinician in township contexts

In chapter 5 it was argued that the clinician takes on a central case management role in the township context, which is usually done by medial doctors in other contexts. There is no easy answer to managing this situation as it results from the dynamics of the work in a township context explored in chapter 5. My approach in this regard was to develop a good network of reliable referral agents to refer to and to also follow up with them. This helps establish a relationship with them and helped reduce the problem of referring clients into a void. It is my contention that working in townships or any other medical context is about building relationships with clients, the community and the network of other helping and medical professionals in that context. This does admittedly perpetuate the psychologists' central role, but it also well placed within our range of skills to build rapport and bridges between people. The difficulty is that it is very time consuming and can infringe on the time needed other therapeutic work.

Discussion and recommendations theme 4: Challenging sociocultural context and norms

The findings from chapter 5 suggest that cultural, epistemological and ontological differences between clients and psychologists have an important influence on the therapeutic psychology context. These differences have the potential to create misunderstandings and insensitivities for all parties concerned. These challenges occur in the form of difference in discourses, beliefs, assumptions about cultural groups, stereotypes, and cultural norms. Such differences impact on gender roles, social roles and which people, of which ages, may interact socially, locus of control and ideas about causality. These of course in turn impact on the therapeutic relationship and process. Furthermore the findings from chapter 5 highlight the fluidity of culture, which is not a fixed construct, but rather an evolving entity. This can be seen in differences of acculturation of clients who present at Itsoseng clinic, who find themselves at different positions on the acculturation continuum. The complexity of culture and the evolution of phenomena such as township culture and acculturation make for a challenging therapeutic context which requires sensitivity and awareness on the part of psychologists who work in townships.

My overarching approach to difference at Itsoseng was to enter the space from an active potion of curiosity, interest and respect. My aim was always to build a bridge between myself and the client(s). The primary tools I employed for doing so were empathy and as needed "cultural" self-disclosure i.e. for us to see and "get" each other I had to bring some of myself into the space. I framed the difference between my culture and that of my clients as being valuable and used the difference as a reminder that I always needed to confirm my understanding of the clients' experiences (Pedersen, 2013). If anything this resulted in better or, more accurate empathy than I would have had with a person of my own culture, because I took less experiences for granted as being similar to mine. Empathy in cross cultural contexts takes more work and as a result psychotherapists tend to make fewer assumptions than they would with someone from their own culture (Grobler, Schenck, & Du Toit, 2003). Respectful engagements of this sort are important in township contexts as people from different cultural backgrounds have had limited intimate contact in South Africa due to our socio-political past. Cultural differences and assumptions about other cultures fed into a mistrust of psychologists by some clients at Itsoseng clinic (Ruane, 2010). Clients also had concerns about all the psychologists' ability to relate to their experiences, because all of them were accultured by

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the formal psychology and tertiary training experiences. In my experience the best way to work through the trust concerns was to open them up in the therapeutic space, to bring in the discomfort and unspoken fears and allow this process to build a relationship with transparency, congruence and genuine care. There was no room for being "fake" or "just doing your job". The "social and political" was in the room and needed to be engaged in a way which seldom happens in South African society at large.

Another approach which is often advocated in literature about cross cultural psychotherapy is the pairing of psychologist and client (Cabral & Smith, 2011). The most obvious benefits being that a fit could be easier, although my arguments on empathy before suggest this may have its own pitfalls. Another problem with this idea is that it perpetuates separation of difference, a difference which is vital for leaning and growth of all parties concerned. It is also unrealistic in a context such as Itsoseng where psychologists are invariably more accultured (westernised) that the majority of the community members.

I also argued in chapter 5 that it would be of value to add training for clinical psychologists who are going to work in townships in African epistemology. The training sensitises student psychologists to the cultural, epistemological and ontological experience of their clients, which in turn assists with the building of rapport and ability to relate to a wider range of clients (Vermeulen, 2011).

Discussion and recommendations theme 5: Language difficulties

The findings in chapter 5 suggest that language difficulties pose a significant challenge in township contexts and had a significant impact on the researchers' psychotherapeutic work. It was argued that language affects all psychologists in townships contexts and is significant because it underlies lived experience, is used to construct reality, and thus shaped a person's psychology. Language shapes and impacts how people feel, think reason and relate. The language challenge when working in township contexts has resulted in the use of interpreters becoming commonplace. This however has its own set of challenges due to languages not having similar terminology, words, concepts or equivalents. This can result in a loss of meaning and context, which puts interpreters in the dubious position of "figuring out" what clients are trying to say, creating pressure, stress and frustration for all concerned. An

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additional concern is that interpretations tend to be more concrete with an emphasis on content of what is said over process. Research also suggests that interpreted language is less emotive and abstract. My own experience was also that interpreted language often resulted in short blunt answers, which was not only frustrating, but made it hard to gauge the extent of a presenting complaint, the depth of the concern and the nature of the issue. This then had the potential to affect the accuracy of diagnoses and efficacy of treatment. It was also suggested by the findings that the interpreters' presence in the room impacted on the clients and vice versa, such as when interpreters needed debriefing after being exposed vicariously to the trauma of clients' experiences. As a final point the language difficulties were found to increase tension amongst psychologists in terms of allocation of cases, whereby practitioners who spoke African languages would get more clients for assessment due to the need to translate during administration. A further issue in this regard was that clients who spoke English and were generally a better fit with western psychology models and theories of practice would be seen largely by English speakers. This would result in a point of contention among the student psychologists, who among other difficulties had to present cases in supervision and formal evaluations.

In an ideal world clients should have the option to see a psychologist who speaks their own language (Smart & Smart, 1995). Unfortunately the realities of psychotherapy in township contexts as they stand preclude this and necessitate the use of interpreters. During my time at Itsoseng I tried different approaches with interpreters; the most successful of these was to employ the use of interpreters who had some psychological training and knowledge. For example interpreters who were busy with undergraduate studies in psychology, who volunteered at Itsoseng clinic to gain practical exposure to the field. It was also very helpful to brief the interpreters' prior to sessions. I would specifically set aside time to discuss in short the client(s) with pertinent information that would assist the interpreter. This was of course not always possible, especially if a client was new to the clinic and an interpreter had to assist on the spot. However, for the most part, this was an effective way of defining a working system with the interpreter. It is generally accepted that interpreters who receive formal training are in a far better position to assist in mental health contexts (Raval & Tribe, 2014). It could be very helpful to run a series of workshops; over the course of each year, for interpreters, facilitated by student psychologists as part of their work at Itsoseng clinic. Workshops of this sort would potentially develop a relationship between the student psychologists and interpreters, which would follow through to psychotherapy sessions with

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clients. The workshops should ideally include psychological knowledge and teaching of key psychological concepts. Issues about equivalency of terms, such as language for emotions, could also be addressed in such a context. It would also be possible then to do role plays and receive feedback on the process from peers. The training I suggest here is bidirectional and aimed at assisting both psychologists and interpreters to effectively engage in an interpretation context. Finally the workshops could be extended into on-going peer supervision groups to engage interpretation challenges and debrief as need be (Smart & Smart, 1995).

The role of the interpreter can also be extended into cultural consultation, to assist the psychologist to better understand social norms of an unfamiliar culture (Smart & Smart, 1995). This could help psychologists understand why some topics may be off limit, especially early on in sessions. It also would help place behaviour in context, to gauge acceptability vs. deviance from cultural norms when considering mental illness or psychopathology.

An additional technique that I employed was to learn at least the basics of the clients' languages at Itsoseng, especially greetings and key words. For example I was afforded a form of "credibility' for speaking about "first born" children and "last born", where in my own culture we would say youngest and eldest child.

Picking up the "lingo" showed effort and made me more relatable; even if I was at times fumbling in my attempts to do so. Clients were quite forgiving and could see I was trying my best. A further recommendation in this regard is for psychologists to consider formally training in at least one African language. If you are going to practice in a South African context it will be a benefit to speak an African language, be it in townships or the glistening rooms of an affluent suburban practice.

In this section I have focussed on the use of interpreters, due to the fact that in the Itsoseng clinic context, it would have a knock on effect with the other aforementioned language related issues, such as tensions around case allocation due to language limits. Investing time and resources into the role of interpreters will go a long way towards enhancing service provision by all the practitioners at Itsoseng clinic to the community.

Discussion and recommendations: Outlier themes

Stigma of mental illness

The findings in chapter 5 suggest that people suffering with mental illness faced a great deal of stigma in township contexts, which had a detrimental impact with regards to accessing appropriate care and treatment. This stigma was aggravated by association of mental illness with witchcraft. In a similar way to witchcraft, accusations functioned as a means to potentially scapegoat familial and community problems onto individuals. Clients often experienced discouragement, hurt, anger, and lowered self-esteem as a result and found it hard to openly admit that they were in treatment.

The very presence of Itsoseng clinic and its role in the Mamelodi community already serves to offer appropriate psychoeducation to individuals, couples, families and groups as well as raise awareness of mental illness as a treatable, manageable, medical condition. As I have argued in preceding sections it would be of value to extend this into a broader scale project, by advocating mental health awareness through the various social structures in Mamelodi, and appropriate health care structures at local government level who allocate money and other resources to the broader health system. Raising awareness about the reciprocal impact of mental health on general medical health and how this cycle in fact increases treatment costs can be shown to be a preventative cost saving way of assisting community members (Robson & Gray, 2007). Psychologists with their expertise in patterns and process and communication skills are arguably are well-placed to build these bridges and initiate broader community initiatives to challenge the stigma surrounding mental illness in Mamelodi.

Fear

In chapter 5 it was argued that the experience of fear is pervasive in township contexts like Mamelodi. It is an experience that all members of the community can resonate with and which medical practitioners have to face. Fear is multifaceted and ranges from fear of violence, to fear of change, or even fear of difference; and chronic fear of this sort impacts significantly on mental and physical health (Stafford, Chandola, & Marmot, 2007).

For myself as a psychologist in a township context, I viewed fear as my own accurate countertransference and it helped to relate effectively to the daily realities of my clients.

There was however, a complacency that set in over the course of time and this served to place me at risk due to my habituation to the context.

I dealt with my fear in various ways, including opening up fear as a legitimate topic in psychotherapy. I was honest with clients who spoke about their legitimate rational fears and admitted to having my own, as and where appropriate. This form of psychotherapist self-disclosure ultimately can assist in moving through the experience and serves to build rapport (Henretty & Levitt, 2010).

I also took my fears to supervision and sought guidance on how to work through the feelings evoked by working in a potentially hostile context. In addition to this I was also realistic and had to remind myself not to be reckless with my own safety. My commitment to my clients had to be balanced with a realistic sense of my own safety. After all, if something did happen to me I would not be able to continue with the work we had started. The overall lesson was "don't be a hero", do your best, but don't take unnecessary risks, as it is not in the best interests of your clients' or yourself.

Perhaps the greatest challenge is admitting to having fear when working in a township context. It felt in my experience to be a taboo topic and not one that was readily accessible to discussion with peers, particularly in a group context. It seemed to be a sensitive issue and perhaps linked unconsciously back to our socio-political history. My challenge in this regard was that not openly talking about it felt like getting stuck in more of the same cycle. Most of my clients found it hard to discuss their fears, if as a psychologist I do the same, then nothing changes. It may thus be useful to have group supervisions for the student psychologists at Itsoseng, to amongst other things have a space to reflect on their fears and offer each other support in the process.

Meta-themes and recommendations

In the following section the underlying meta-themes that emerged from the autoethnography process and which were present across the aforementioned themes are discussed and recommendations are made accordingly.

Meta-theme one and two

The first two meta-themes relate to (1) the meeting of cosmologies, ontologies and epistemologies and, (2) the profound social problems resulting in unmet needs in township contexts. These themes were present and underlying for all the experiences included in chapter 5. These themes are addressed respectively under the sections on the challenges with psychology itself and broader contextual demands in chapters 5 and 6, thus forming a broader contextualised discussion of the use of therapeutic psychology in township contexts and my corresponding experiences at Itsoseng clinic. I will thus not repeat the findings and recommendations here. It is important however to note that these two themes were prominent and underlying factors in all the challenges I experienced and that while I have separated them out as distinct in chapters 5 and 6, they actually informed and influenced all the specific challenges I encountered at Itsoseng. For clarity on how these two meta-themes underlie the others presented in chapter 5 and 6 I provide the following example. The language difficulties I experienced in psychotherapy at Itsoseng in part stemmed from the challenges clients had in accessing appropriate schooling in the broader Mamelodi context, which in turn stemmed in part from broader social deprivation in the community. This also impacted on access to resources such as healthcare in general and limited exposure to psychotherapy. Language also carried and held experience and reality, which reflected underlying epistemological and ontological assumptions or psychology. This in turn related to potential misfits with western psychology and the way it languages problems.

Meta-theme three

The third meta-theme which has not been dealt with in the preceding sections is that of the emotions and affective experience of clients and myself which were present across all the themes and which presented a challenge to effectively working with therapeutic psychology in a township context.

Shared feelings

I have repeatedly in the course of this research spoken about my feelings as a form of countertransference reflecting the experience of my clients and the community. These feelings were present across the various themes presented in this study and were both informed by, and served to form, my experience of applying therapeutic psychology in a township context. The predominant challenging feeling was one of frustration for me, and I mention this repeatedly in the preceding vignettes, fear and anger were equally prevalent. It is worth noting that these three feelings were also dominant in the presenting problems of the majority of my clients at Itsoseng. For clients the feeling usually centred around frustration with their harsh living conditions and sense of voicelessness. They were afraid of the dangers in their lives and in particular violent crimes like rape, robberies and murder. They were also usually angry with the social structures in Mamelodi and various individuals who had harmed them. These were followed by disappointment, hopelessness and confusion; again regular experiences my clients brought to psychotherapy. Other less prevalent but regular emotions present in the preceding work included ambivalence, hurt, rejection, a sense of conflict, anxiety, passivity, and hesitancy. A sense of hopelessness was common and usually reflected the culmination of years of negative damaging, experiences which had become the running theme in so many clients' lives. The sheer extent of the trauma and degree thereof was hard to handle as a psychologist, and taxed my empathy and compassion to the point of fatigue. The feelings presented here reflect my experience emotionally of the various aforementioned challenges and in turn became a challenge in and of themselves.

Coping with disappointment, disillusionment, and frustration is an under-addressed area of clinical training. It has the potential to see psychologists and other healthcare or social service providers internalise the negative experiences of clients in deprived contexts (Newell & MacNeil, 2010). This can result in apathy, hopelessness and a sense of helplessness about the

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work and dire needs of the community. I have observed in the many years I have spent in community psychology work, how colleagues are harmed by the emotional challenges of psychotherapy in township contexts, and as a result leave the community to find contexts where the emotional drain is less extreme.

Some of the best ways I found to handle this was through my own psychotherapy and taking the experiences to supervision. It would, however, have been useful to have had a facilitated space to discuss my experiences in a facilitated form with my colleagues. I am aware of many clinical psychology training programmes that use facilitated group processes as part of clinical training, this would potentially be beneficial in this regard, allowing a space for catharsis and unloading of pent up feelings (O'donovan, Halford, & Walters, 2011).

<center>Hope</center>

Despite the range of underlying harmful or negative emotions and experiences I had in the application of therapeutic psychology in a township context, there were also good, rewarding and enlivening experiences. I mention these here not as a challenge to be resolved as has been the preceding focus, but because they create hope. Hope for both the community psychologists and the community members they serve. They are part of what kept me going, even when I felt like giving up. Such feelings and experiences include; levity, care, humanity, concern, genuineness, congruence, value, humour, morality, collaboration, change, beauty, tears of joy and sorrow, dignity, mutual validation, ubuntu, belonging, community, respect and finally a sense of doing something that matters, even if only to the life of one particular person.

Conclusion

In this chapter the researcher discussed the findings from chapter 5 and made recommendations on how to potentially respond to the challenges of applying therapeutic psychology in a township context. Findings from each theme in chapter 5 were summarised and recommendations were made that attempt to address aspects of the challenge from the micro to the macro system levels of the township community. In addition to this the three underlying meta-themes that emerged from the findings in chapter 5 were discussed and recommendations for the third meta-theme were added.

Meta-conclusion

The challenges the researcher experienced at Itsoseng clinic and the challenges of applying therapeutic psychology in a township context are arguably those of South African society at large. Itsoseng clinic and Mamelodi are merely microcosms of the broader socio-political and sociocultural dynamics and processes which are unfolding in South Africa. These need to be engaged actively to be resolved.

The challenges the researcher experienced can be addressed and potentially resolved. The recommendations made in this chapter in conjunction with the efforts of many other dedicated clinical community psychologists offer pragmatic, reasonable ways of approaching the application of therapeutic psychology in a challenging context

It is clear from the nature of the township context that people are in need of psychologists' services and that the application of psychotherapeutic interventions, in the various forms described in this study, can evolve to better meet the community's needs. Therapeutic psychology has a vital role to play because if people cannot talk they will invariably enact driven by unresolved feelings and a need to be heard. The whole point of the talking cure is to create a space for healing, co-construction, co-evolution and growth. It is a space where people and communities can find voice. It is our duty as clinical psychologists to respond and assist them accordingly.

Recommendations for further research

It is clear from the findings of this study that a great deal of research on the fit of western psychology in African contexts is still needed. Such studies could poetically look at the interface between western and African cultures and how to address psychotherapy in this complex evolving context.

Research into the impact of language differences on psychotherapy is also an avenue for research. A key area of inquiry could be how to most effectively address the use of interpreters in psychotherapy.

Finally, an under researched area of clinical practice, which was repeatedly discussed in this study, is how to apply clinical community psychology interventions at a community and sociocultural context level and the role of clinical psychologists in this regard.

CHAPTER 7

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