The State of Psychotherapy in South Africa: a Legacy of Apartheid and Western Biases

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Abstract:

As mental illness continues to burden the South African health care system tremendously, clinicians with the necessary cultural competence to effectively serve black African populations continue to remain small in number. This, in turn causes the gap between those who receive treatment and those who do not to grow substantially (Knight, 2013). Often referred to by mental health professionals as the "treatment gap," this gap encompasses the importance of analyzing issues of cultural relativism in contemporary psychological practices. The present findings concluded that current psychotherapeutic models applied in South Africa are both irrelevant and inappropriate; specifically when applied to black African populations. It is the intention of this essay to evaluate the overall effectiveness of applied psychotherapy in black South African communities by analyzing the causes of the existing treatment gap in the treatment of mental illness; as well as pervasive influence of western culture in psychotherapeutic practices.

Background:

The effectiveness of psychotherapeutic interventions in South Africa has long been debated within the field as a contentious point. As a practice that has been traditionally white, psychotherapy in a South African context is often viewed by black Africans as an elitist and hegemonic product of colonial oppression (Knight, 2013). Application of existing models have proven to be relatively inappropriate in South Africa, as current clinicians are lacking in the cultural competence necessary to serve populations outside of demographics consisting of white and upper class (Ahmed & Pillay, 2004). However, these models continue to be implemented in psychotherapeutic interventions across South Africa, with relatively little positive effect in black communities (Ahmed & Pillay, 2004). Psychotherapeutic practices, without cultural relativism or competence, reinforce western domination and continuously serve the legacy of white supremacy that apartheid has left behind. It is essential to adapt these practices in such a way that they are relevant to African culture and can

subsequently be applied appropriately.

Prevalence of Mental Illness in South Africa:

The existing psychotherapeutic models being currently utilized by clinicians in South Africa have proven relatively inappropriate and largely inaccessible to low-income populations. This is shown by the existing literature regarding the twelve-month prevalence rates of mental illness amongst South Africans. Being the first of its kind to collect such data, the SASH (South African Stress and Health Study) analyzed the prevalence of mental disorders from a large pool of participants (N = 4,351) from the years of 2002 to 2004 (Williams et al., 2007). The study found that 35% of participants suffered from a mild anxiety disorder (of any type), 46% were classified as having a moderate mood disorder, and nearly 95% were classified as having a "serious" alcohol dependence disorder (Williams et al., 2007).

These rates of twelve-month prevalence throughout the country are particularly striking, especially when one considers how often these disorders go untreated. The SASH study goes on to report that of the total number of participants suffering from a serious or moderate mental disorder, 72.4% do not receive any type of treatment (Williams et al., 2007). This statistic encompasses what is often referred to as the "treatment gap" and describes the lack of resources available in providing treatment for South Africans that are suffering.

The WHO (2005) reports that "South Africa has only one psychiatrist, eight psychiatric nurses, four psychologists and 20 social workers per 100,000 populations" (Williams et al., 2007, p. 217) The South African treatment gap in the intervention and treatment of mental illness exists for a number of reasons. Primarily, many of those residing in black African communities consider psychotherapy to be "un-African" and a product of colonial European hegemony (Knight, 2013). It is far more likely that a black African suffering from a diagnosable mental disorder will seek the counsel of a trusted indigenous healer within the surrounding community, rather than a trained psychologist or psychiatrist (Ahmed & Pillay, 2004).

Additionally, Knight (2013) discusses that the black Africans that can afford therapy are often referred to as "Black Diamonds" due to their exceptionally high socioeconomic status and the rarity of their individual circumstances. Second, the cost of psychotherapy is exceptionally high (relative to the median income of the average South African), with the average session costing 600 South African Rand (or roughly 60 U.S. dollars) per hour (Statistics South Africa, 2010). When compared to the median earnings of ordinary South Africans, therapy seems to be an unnecessary luxury reserved only for the nation's elite. The average domestic worker is reported in the Monthly Earnings of South Africans (2010) as earning approximately 1,000 ZAR (100 U.S. dollars) per month.

Additionally, a sales clerk is reported as earning 2,400 ZAR (240 U.S. dollars) monthly (Statistics South Africa, 2010). Hence, someone employed as a domestic worker would have to pay more than half of their monthly earnings to merely attend one session of psychotherapy with a trained clinician; an unrealistic and unfathomable use of their precious earnings.

These economic discrepancies are largely to blame when one accounts for the treatment gap that currently exists in mental health services of South Africa; however, existing economic discrepancies are empirically supported as having obvious racial skews, as it is widely acknowledged that the majority of black Africans in South Africa continue to live in poverty.

Euro-American Biases and Psychological Mindedness:

Deemed as a product of "Western enlightenment", psychotherapy is inappropriate to utilize in the African context for a number of reasons (Banks, 2001). Primarily, psychotherapeutic interventions undeniably are saturated with a Euro-American bias in practice and application. The Euro-American worldview is interwoven within psychotherapeutic models, and includes notions of: individualism, competition, mastery over nature, universality, and roots in Christian doctrine (Banks, 2001). As a product of western individualism, psychotherapy (primarily psychoanalytic models) contradicts collectivist notions present in African cultures. For example, Ubuntu (a traditional South African worldview) expresses the interconnectedness of individuals within the social whole, and conveys the meaning of humanness as a result of this interconnection (Brack, Hill & Brack, 2012).

Modern ideas of western individualism go against the grain of African values of collectivism and community, and are therefore inappropriate to implement in an African setting without first undergoing a transformation. Additionally, an example of Western hegemony present in psychotherapy resides in the processes and classifications of diagnoses. Culture-bound syndromes (CBS) are listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM) and described by Mkize (1998) as "a form of disturbed behavior highly specific to certain cultural systems, which does not conform to Western nosological entities" (p. 329).

The classification of CBS presents an undeniable difference of cultures that are outside of a Western context. Specific to a South African framework, the classified CBS of Amafufunyane is described as a possession by spirits mainly afflicting South African women (Mkize, 1998). Amafufunyane is described by Mkize (1998) as an affliction in response to the invasive influx of overseas foreigners, further exemplifying the fundamental concept of the interconnectedness of people present in African cultural values and beliefs. Often interpreted as a direct response to

the atrocities of colonialism, the existence of Amafufunyane serves as evidence in the case of culture strongly influencing the expression and manifestation of mental illness. Often discussed within the Psychological community is the concept of "psychological mindedness" which has proven problematic within an African context as well.

Psychological mindedness has been defined as a collection of individualistic traits that gives the individual insight into the emotional states of themselves and others (Roxas & Glenwick, 2014). The concept of psychological mindedness has also been linked with adaptive coping skills in adults, and better psychotherapeutic outcomes (Roxas & Glenwick, 2014). However, concepts of psychological mindedness also heavily emphasize the active role of the individual and the passive role of social relationships; further serving a western ideal of an advanced or well-functioning society (Roxas & Glenwick, 2014). It is widely acknowledged that African cultures tend to express their psychological pain by verbalizing the somatic symptoms that are experienced; rather than utilizing emotion-focused coping.

Practical Implications:

The limitations of psychotherapy in South Africa vary in both scope and magnitude. The major shortcoming of psychotherapy in South Africa primarily revolves around the existing demographics of the psychologists being produced in the country. As of 2000, approximately 90% of trained clinicians identify as racially white (Pillay & Siyothula, 2013). This statistic is staggering, and comes of no surprise when one considers the limited number of black Africans seeking psychotherapy. Author Knight (2013) describes her experience as a white therapist working with a black client, when the client (Thembi) asks her to disclose her feelings about black people: "Did I like black people? Was I masquerading as anti-racist, was I, a white bitch, hiding and pretending with no black friends? Thembi's statement captured some of the racial tension and anxiety, and my silence embodied my defensiveness and instability." (p. 25) Knight's statement exemplifies that the therapy space, which is supposed to be considered safe and conducive to healing, can quickly become racialized in a post-apartheid South Africa. The racialized tension between client and therapist can sever any semblance of meaningful connection, and consequently hinders the therapeutic process. In the above anecdote detailed by Knight, Knight as the therapist represented a legacy of colonial oppression and institutionalized inequality. Knight presumably (like most white South African clinicians) did not speak any native African languages, and most likely did not know what it was like to live in abject poverty, as her client had experienced.

Many current practicing clinicians are reported by Ahmed and Pillay (2004) as avoiding consultations with patients who

do not speak fluent English or Afrikaans. Discrepancies in language further perpetuate perceptions and realistic implications of psychotherapy as being an elitist and white-dominated practice. Due to existing structural inequalities as a result of the apartheid era, black psychologists are few and far between; and the ones that are currently practicing are in high demand and bombarded with patients (Ahmed and Pillay, 2004).

As mentioned previously, the mere cost of psychotherapy sessions stands as a barrier in terms of accessibility to many South Africans. At 600 ZAR per hour, it is unreasonable to expect the average South African earning 2,000 ZAR per month to pay a psychologist's fees (Statistics South Africa, 2010). For an average of one session per week, the average South African earner would pay well over their monthly income. The inaccessibility of psychological services further perpetuates inequality and places economic barriers on the mental health services that every human being is rightfully entitled to. The current selection and training processes of clinicians are lacking in the necessary cultural competence that is desperately needed in South African contexts.

Feasible Solutions:

In order to improve the situation of psychotherapy in South Africa, it is widely recognized within the field that clinicians adopt cultural relativism into their practices. Recognizing the Euro-American biases that exist in practice is central to this. For example, most (if not all) clinicians should be trained in native African languages. Training in indigenous languages would provide clinicians with the cultural competence that is necessary to connect with black African patients.

The importance of cultural relativism in psychotherapy cannot be understated, as Banks (2001) asserts that anything less than the adoption of a cultural relativistic framework from which psychotherapy is oppressive and perpetuates racist post-apartheid ideologies. Psychotherapy must also move away from individualistic orientations in order to assimilate to the collectivist nature of African cultures. In a study conducted by Petersen et al. (2014) found that group therapy interventions for HIV positive patients suffering from a comorbid diagnosis of depression had significant effects in self-reported depression scores between pretest and posttest conditions; as the means of depression scores decreased 8.53 points between pretest (M = 15.47) and posttest (M = 6.94) conditions. The group counselling intervention implemented by the study proved relatively cost-effective, making psychotherapeutic interventions accessible to those it would have not been previously (Petersen et al., 2014). Group counselling interventions are also conducive to collectivist worldviews that are often found in South African culture. Implementing therapeutic processes that emphasize the interconnectedness of the individual to the social whole (essentially, the very notion of Ubuntu) would ultimately make the concept of psychotherapy less foreign and more appropriate to South Africans in an

African context.

Discussion:

The state of which current psychotherapeutic models exist is inappropriate for an African context. These models are ultimately products of what is often referred to as "western enlightenment" but are more accurately products of Euro-American biases and colonialist thought. The notions of contemporary "culture bound syndromes" demonstrate the Euro-American bias, because they pathologize what is considered within the norms for one culture and abnormal for western culture. All current models are based off western cultural values such as individualism and competition; sharply contrasting African cultures that value collectivism and a sense of community.

Practical implications of western psychotherapeutic models include the relative cost of psychotherapy, in which one session could easily cost more than half the average South African worker's monthly income. Due to the faulty theoretical and practical implications, current psychotherapeutic models are both inappropriate and oppressive to apply to a South African setting. Possible solutions to these dilemmas include group-based therapeutic interventions that require fewer resources and are more accessible to South Africans.

Group-based interventions are not only cost-effective and use fewer resources, but are also conducive to notions of collectivist cultures (e.g., South African worldview of Ubuntu). Initiating a movement of psychotherapy from a white-dominated, elitist practice to a practice that is conducive to collectivist notions of social cohesion is imperative to the application of psychotherapy beyond the geographical boundaries of western cultures. Implementing psychotherapeutic models that not only acknowledge but actively practice collectivism will develop psychotherapy into a practice that is no longer hegemonic and accessible for black Africans living in South Africa.

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