

# Clinical psychology training in South Africa: A call to action

Anthony L Pillay<sup>1</sup>, Rashid Ahmed<sup>2</sup> and Umesh Bawa<sup>2</sup>

## Abstract

With the profession of clinical psychology and its formal training programmes less than 40 years old in South Africa, it is important that efforts are made to critically examine its challenges and the extent to which it is meeting the prevailing mental health needs. The profession has gone through a chequered history in South Africa and needs to look at how it realigns its goals and practices, to be in tune with the imperatives of democracy, and to ensure that mental health benefits accrue to all of the country's people, rather than a minority. To this end, the authors examine training issues, such as recruitment, curricula, and future directions. We assert that a clinical psychology that draws from current resources and foregrounds a primary health-care orientation can start to address some of the challenges facing training in South Africa.

## Keywords

Mental health, primary health care, psychologist, psychology, training

Although professional psychology is not new in South Africa, it is still relatively young, considering formal training in the sub-disciplines (e.g., clinical psychology) began less than 40 years ago. The field straddles both apartheid and post-apartheid eras and carries a significant history that has affected its development and recognition nationally and internationally. With the demise of apartheid, the accessibility of mental health training and services to all aspirant students and academics, as well as in the development and production of psychological and mental health knowledge, by a wider group of researchers is crucial.

South African psychology has come a long way, from its tainted history of association with apartheid (Cooper, Nicholas, Seedat, & Statman, 1990) to the point of organising and hosting the 2012 International Congress of Psychology (ICP 2012) and welcoming to its shores psychology colleagues from around the world. It is, therefore, an appropriate time to reflect on how South African psychology can consolidate some of the gains and focus on further developing clinical psychology training within the context of present day and historical challenges. Although research

<sup>1</sup>University of KwaZulu-Natal, South Africa

<sup>2</sup>University of the Western Cape, South Africa

## Corresponding author:

Anthony L Pillay, Fort Napier Hospital, PO Box 370, Pietermaritzburg 3200, South Africa.  
Email: [anthony.pillay@kznhealth.gov.za](mailto:anthony.pillay@kznhealth.gov.za)

has documented many of the challenges in both the profession and the field, this literature has focused largely on a 'critique' of the field and professional training or focused on transforming specific aspects of training (Ahmed & Pillay, 2004; Macleod, 2004; Mayekiso, Strydom, Jithoo, & Katz, 2004; Swartz, 1998). The aims of this article are to identify what we consider to be some of the key needs and challenges and to consider specific pathways to address them. The uneven and slow rate of progress in transforming clinical psychology training speaks to the urgency required to engage in further debate and action. In the first part, we draw largely from the South African literature to delineate the current contexts of training and emphasise what we consider to be the central issues of concern. Our focus then shifts to engage with possibilities for transformation of these training programmes. We conclude with a brief consideration of some of the challenges and the feasibility of their actual implementation.

## Clinical psychology training in South Africa

While there are aspects of clinical psychology training in South Africa that warrant criticism, it is reasonable to state that the training is generally of a high standard. This can be measured through many indices, not least of which are the international recognition of locally trained clinical psychologists and the eagerness of high-income countries to employ them (Pillay & Kramers, 2003). To date, the final 2 years of the academic training of clinical psychologists at many universities has been conducted jointly with students in counselling and educational psychology (Leach, Akhurst, & Basson, 2003). The practical internship differs, with clinical psychology students being required to serve the 12-month intern period in a health-care setting with at least 6 months in a psychiatric facility (Health Professions Council of South Africa [HPCSA], 2009). A further year of paid community service became mandatory in 2003 for clinical psychology trainees. However, the problem of the incomplete dissertation has continued to plague training programmes. This has unnecessarily lengthened periods of training, with many poor communities that would have been serviced by these Community Service psychologists being disadvantaged by the delays in their assumption of duty.

Although academic training programmes vary across the country in terms of their theoretical orientations and specialty focus areas, they still have much in common (cf. Ahmed & Pillay, 2004). All fall within the internationally dominant scientist-practitioner model (Pachana, Sofronoff, Scott, & Helmes, 2011) but may differ in terms of their theoretical orientation. There is a greater disparity in how established some programmes are relative to others. The historically 'Black' institutions tend to have much younger programmes, and some are located in non-urban areas, which make academic staff recruitment difficult. The political change in the country saw these institutions losing many experienced academics to historically 'White' universities (Vergnani, 2001). This is undoubtedly a significant challenge in the development of professional training programmes, and it is inevitable, then, that institutions previously disadvantaged by apartheid could continue to struggle against the tide, even in post-apartheid South Africa.

Recruitment of students into clinical psychology training programmes is generally not difficult, considering that the demand for professional training far outweighs available places. It is safe to estimate that the total number of training seats nationally is less than 150 per annum. However, universities generally find that they are oversubscribed, receiving between 10 and 20 times more applications than they can accommodate. One of the off-shoots of this highly competitive application process is the commitment and effort required by aspirant students, many of whom actively seek out mental health-related volunteer work in order to strengthen their applications. While selection criteria vary across universities, indices such as academic excellence, reflexivity, life experience, and a community orientation are used in an attempt to recruit the most appropriate

students to enter the profession. Given the gross under-representation of Black clinical psychologists as a consequence of higher education institutions' recruitment policies during apartheid, issues of equity and redress are also considered in the selection process. Although all universities have to take cognisance of this factor as a selection variable, it has been argued that a much more deliberate and concerted focus is needed nationally if this problem is to be meaningfully addressed (Ahmed & Pillay, 2004; Mayekiso et al., 2004). In addition, it must be realised that simply focusing on Black university students and critiquing their suitability for clinical psychology study is both unhelpful and deceptive. These students cannot be expected to compete on equal footing at university professional psychology selections when the primary and secondary schooling of many are deficient, particularly those from rural communities. A recent investigation found that 64% of rural first-year psychology students had never heard about psychology at school, with a similar percentage receiving no information about psychology from any source before enrolling at university. A further 77.5% knew of nobody in their community consulting a psychologist (Thwala & Pillay, 2012). Clearly then, much effort has to be put into the schooling system before such students can be considered on equal footing with others at postgraduate clinical psychology selections.

Given the relatively low intake of students in relation to the overall mental health societal needs and the large applicant pool, there are obviously some concerns about training a small group of students. The authors assert that the advantages of closely supervised, thorough, and intensive training far outweigh the disadvantages. It is also ethically correct – both for the practitioner and for the community that is served. The reflexivity required for psychological work and the wide-ranging scope of the skills and content covered suggest that the present training format and structure may be preferable to the mass production of clinical psychologists lacking in the requisite skills and personality requirements. Contextually, South African clinical psychology training programmes provide an excellent benchmark for developing professional training. The significant strengths in existing programmes and infrastructure must be balanced by an assessment of the significant inequities and failings in professional training.

Among the strongest conclusions drawn from scholarly reviews (Ahmed & Pillay, 2004; Leach et al., 2003; Watson & Fouche, 2007), and from more general scholarship, is the notion that mental health resources and training in South Africa remain substantially skewed, iniquitous, and minimally transformed. In a survey of 'race' distribution among 12 clinical psychology training programmes in South Africa across the period 1994–2004, Mayekiso et al. (2004) found that 'African'<sup>1</sup> students comprised between 25% and 31% of total student enrolments. Certainly, the years since the inception of democracy in South Africa have witnessed a progressive trend in the admission of 'Black' students into training programmes, spurred on by, inter alia, the stipulation by the HPCSA that 50% of all trainees should be 'Black' (Professional Board for Psychology, 2000). However, 'Black' psychologists are still by far the minority on the HPCSA Register of Psychologists. Racial exclusion is compounded by class exclusion. Commenting on the schooling shifts since democracy, Motala (2006) noted that the beneficiaries of improved access to higher quality schooling are a 'deracialised middle class' and that class-based inequity has replaced race-based inequities in schools. Her data convincingly show that 'Black' pupils who access institutions previously closed to them are largely from the middle class, and it is suggested that a similar process may be occurring at the professional psychology training level (Ahmed & Pillay, 2004).

The relevance debate that emerged in the 1980s is central to an understanding of the transformation of clinical psychology training. First, community psychology in South Africa emerged as a notable response to help shape the scope and form of South African psychology (Ahmed & Pillay, 2004; Seedat, Lockhat, Kaminer, Zungu-Dirwayi, & Stein, 2001) as a consequence of the discipline's failure to engage with issues such as racial oppression, social inequality, and the great need

to heal the psyche of the South African nation. Most professional psychology training programmes have thus integrated a community psychology component into their training (Gibson, Sandenbergh, & Swartz, 2001). While it has been helpful to frame 'relevance' in training as a critical-community psychology (Ahmed & Pillay, 2004), the link to an African (Dawes, 1985) or an indigenous psychology (Lazarus, 2006) has received far less attention. The lack of substantial engagement with what constitutes an 'indigenous' psychology led Bandawe (2005) to conclude that an African philosophy is absent in professional training.

### *Realigning the foci in training programmes*

In many poor countries, the need for brief psychological interventions that are aimed at alleviating symptoms of distress, such as those associated with trauma, anxiety, and depression, has been highlighted (Patel et al., 2007). Research in a typical primary health-care facility that served low-income African communities in South Africa confirmed this, noting that the primary mental health problem for which help was requested included mainly psychosocial problems, anxiety, financial difficulties, learning problems, and violence. The average number of sessions attended was not more than two (Seedat, Kruger, & Bode, 2003). Authors argued that, in addition to psychotherapeutic services, mental health facilities should be developing support programmes as well as psycho-educational initiatives to assist community members trying to manage stressful life events. Moreover, research also points to the need for these aims to be achievable in as short a time as possible.

There is certainly exposure to different short-term modalities in training and some expanded input on evidence-based methods at some institutions. Short-term psychodynamic psychotherapy, the eclectic use of cognitive behavioural therapy (CBT) and psychodynamic ideas and techniques, crisis intervention, trauma counselling, and solution-focused therapy point to contentious but rich engagements with short-term modalities. For example, in his review of CBT in South Africa, Young (2009) argued for the utility of CBT in South Africa to address the challenges around service provision. While short-term modalities are being taught, the authors believe these should not be applied uncritically and in a formulaic, acontextual manner. Interventions should be tailored to meet the culturally diverse and contextually varied demands of a mental health population. For example, considering the high prevalence of stressful and traumatic responses in South African society, it is suggested that considerably more training time is given to the various evidence-based crisis intervention and problem-solving models that are indicated in cases presenting in primary care, as well as district- and regional-level health services.

A comprehensive review of treatment effectiveness research in low- and middle-income countries concluded that in addition to individual psychotherapy, group psychological interventions showed very favourable results in the treatment of depressive conditions (Patel et al., 2007). The authors assert that the value of the group-based interventions may lie in its representation as an extension of the traditional social support mechanisms, hence the level of success. Of course, an additional consideration is the cost-effectiveness of group-based treatments, which is particularly relevant in the context of low- and middle-income countries. Similar to short-term psychotherapeutic work, students have varying degrees of exposure to group-based interventions. However, group-based interventions need to become part of the basket of core competencies in all training programmes.

In recent years, countries like China have conducted randomised control trials that have demonstrated the benefits of support programmes and psycho-education in assisting individuals and families of those affected by schizophrenia (Chien, Chan, & Thompson, 2006; Li & Arthur, 2005). Such findings have important implications for the management of serious mental disorders and for the well-being of family members, who are very often forgotten when the focus of treatment is primarily

on pharmacological interventions. The role of clinical psychologists in the holistic management of the more severe mental disorders needs to be recognised in poorer countries if affected individuals and their families are to be optimally treated. This is particularly relevant in low- to middle-income contexts, where the numbers of psychiatrists are also seriously deficient (World Health Organization, 2005). While clinical psychology training programmes generally do include teaching on psychotic disorders, the current bias in psychiatry towards pharmacological interventions is pronounced and tends to work against the development of adjunctive psychosocial interventions. Existing programmes could easily accommodate a more structured focus on this aspect of intervention, given the evidence for the positive impact of psychological intervention in first-episode psychosis, among other stages of the illness (Gaynor, Dooley, Lawlor, Lawoyin, & O'Callaghan, 2011). The shift from individual, relatively longer term orientations to other therapeutic modalities and psycho-educational interventions is certainly attainable within the existing training structure. However, such shifts start to question established traditions and the accepted foundations of clinical psychology training and may be the reasons for the slow progress in this area.

### *A clinical-community psychology?*

It is virtually impossible to think about or even conceptualise professional training outside of a community psychology in the South African context. From its roots in the early 1980s, the presence of an 'indigenous' community psychology has been ever present in the discourse around transformation in psychology and mental health. Although there are differing definitions of community psychology (Gibson et al., 2001), with varying theoretical leanings, most clinical psychology training programmes include exposure to some form of community psychology, at the theoretical level and/or at the practical level. One of the major outcomes of this focus on community psychology has been an increasing acceptance of less traditional roles for professional psychologists in South Africa (Ahmed & Pillay, 2004; Leach et al., 2003; Watson & Fouche, 2007). We believe that this shift affords many more opportunities for transforming clinical psychology training, some of which are explored below.

With the educational and socio-economic disadvantages in poorer countries, there is still much stigma, ignorance, and a lack of information surrounding mental health problems. It has been determined that the stigma associated with behavioural and mental health problems is the single most significant barrier that has to be overcome in efforts to promote well-being (World Health Organization, 2001). The issue of stigma and its effects on help-seeking among people affected by mental health problems has also been tabled in a recent submission to the South African Human Rights Commission public enquiry into access to mental health services (Rangaka, 2007).

The World Health Organization (2001) has advocated various strategies, including public information campaigns to educate communities about mental health problems, improving access to mental health care, deinstitutionalising the mentally ill, and promoting community mental health. Tackling the stigma that has historically been associated with mental illness is essential if individuals and communities are to improve their mental health because the stigma represents a strong deterrent to help-seeking. Ruane (2010) found stigma to be a significant barrier in accessing psychological services in a low-income community in South Africa. For this reason, even with the most sophisticated mental health service infrastructure, individuals seem likely to avoid accessing the facilities, due to the fear of prejudice, embarrassment, or ridicule that may arise when others learn of their illness, thus impeding their recovery (Wahl, 2011). It has been suggested that mental health workers are not sufficiently or robustly engaged in fighting stigma and discrimination associated with mental illness, with the result that these factors remain the major obstacles

to improving the mental health of communities (Sartorius, 2002). Governments have also been criticised for actions that reinforce the prejudice against those with mental illness (Sartorius, 2007). Considering their training in human behaviour and mental health, psychologists are well placed to tackle this issue.

Health promotion and mental illness prevention remain central to South African community psychology and should continue to be a critical focus on the nation's mental health agenda. Even though mental health promotion and illness prevention must be considered essential in all countries, the cost-benefit values for low- and middle-income countries are significant and need to be recognised by governments. For example, considering the prevalence of depressive illness (American Psychiatric Association, 2000), the prevention and early treatment of this condition can have massive financial benefits (not to mention the obvious health and social benefits) for national economies. A large recent investigation confirmed this with evidence showing that individuals having a history of depression or suicide attempts are at increased risk for death due to ischemic health disease (Shah, Veledar, Hong, Bremner, & Vaccarino, 2012). There is a consistent body of evidence attesting to the benefits of various prevention initiatives. Research in China showed encouraging results in reducing the development of depressive symptoms in schoolchildren through the use of various cognitive techniques that included problem-solving skills (Yu & Seligman, 2002). The establishment of helplines or 'hotlines' and crisis centres has a significant role to play in the early detection and prevention of self-destructive behaviours (Goldsmith, Pellmar, Kleinman, & Bunney, 2002). The teaching of problem-solving skills, especially within the school contexts, can also be a significant contributor to reducing suicidal behaviours (Roskar, Zorko, Bucik, & Marusic, 2007).

Prevention work could also be extended to include advocacy and policy work. Psychologists have valuable contributions to make in national mental health policy development, research into mental health problems and care, as well as to national plans for managing the human component of major disasters and trauma. It is known, for example, that disasters affect people in poorer countries considerably more than people in wealthy countries by a ratio of about 166:1 (Ibanez et al., 2003). Therefore, the need for these nations to establish action plans and response strategies is very evident. With the importance accorded to community psychology in many programmes, the shifts suggested could easily be accommodated within the current parameters of clinical training. The challenge is the extent to which a balance can be found between individual clinical work and community-level interventions.

## **Psychological services: towards an implementation model**

With the backdrop of the preceding analysis, the type of structure that would be needed to accommodate the proposed changes needs to be carefully considered. The authors attempt to provide a possible model to stimulate discussion and debate. Our attempt in the model is to combine the strengths and successes of current clinical psychology training and practice, with the changes that are required for the South African context and its emerging challenges. The current restructuring of the health-care system along primary health-care lines and proposals such as the National Health Insurance Scheme are considerations in the proposed model. However, we believe it is possible to also have a higher level of care within a primary health-care framework.

Among the various service delivery options for clinical psychology services in poorer countries are the establishment of a few metropolitan mental health complexes and centres of excellence in the large cities. It is, however, vital that these are linked to universities and other academic tertiary institutions. The development of a small number of specialised centres is essential, as they serve to

provide a backbone for the rest of the nation's mental health (psychological) services. These centres should be staffed by complete multidisciplinary mental health teams. While their roles would be specialised, they would also be multifaceted to include the following:

1. Clinical service provision
2. Academic teaching and training
3. Research
4. Advisory and consultative

The advisory and consultative role is crucial in relation to mental health service development in low- and middle-income countries. Professionals employed in this sector have a responsibility to advise government and municipal structures on strategic approaches to the most economical mental health service delivery systems in underserved areas. It is accepted that no country (even high-income countries) will be able to provide tertiary-level specialised mental health services in every remote part. Therefore, it makes sense to locate the more expensive service structures in the metropolitan complexes, where they can serve multiple functions (i.e., clinical service, teaching, research, telehealth consultations, and others). However, an additional component to their duties and responsibilities must be (1) to develop the mental health service structure in outlying areas, (2) to provide support and training to the primary health-care providers in the non-urban areas, and (3) involvement with prevention initiatives. This can be accomplished in various ways, including the delivery of clinical services as well as training to primary-level service providers in rural and peri-urban areas. The role of clinical psychologists in this type of service involves (1) rendering clinical services such as crisis intervention and brief psychotherapy and counselling and (2) training primary care practitioners and others to identify common mental health problems, implement basic interventions, and make appropriate referrals when necessary. Itinerant psychological services to non-urban areas can also be provided using a combination of a core group of permanent mental health service providers as well as 'specialists' visiting these areas for designated periods, offering both clinical services and training and support. The Phelophepa Health train, which has been a significant innovation in South African health care since 1994, is a good example of such a model (Transnet Foundation, 2012). The Red Cross Air Mercy Service is another example, in which health-care practitioners, including mental health-care professionals, render services in remote underserved areas (South African Red Cross Air Mercy Service, 2006).

The staffing resource pool could be considerably bigger if more senior-level students could be incorporated as volunteers, provided that various factors such as legislation, ethics, and appropriate training are regulated to permit students to perform clinical work. Under the present system, students can only undertake supervised clinical work in the final year of academic study, which is quite different to medical and nursing students, for example, who are involved in patient care much earlier. This idea would be in line with Petersen's (2004) argument for the need for additional levels of service provision. The HPCSA noted, however, that students training as Registered Counsellors can perform their 6-month practicum from the third year of their 4-year degree (HPCSA, 2012). While a number of universities have stopped providing this category of training, for various reasons, the concept of an intermediary-level generalist mental health worker may need to be not only re-examined but also modified and more appropriately regulated. The latter is a serious issue, considering the initial idea behind the Registered Counsellor category was ground-level service provision to enable easy access to the poor, rather than private practice configurations. An AB Psych programme that is fully integrated into proposed mental health service delivery

framework could help address some of the challenges identified previously (Abel & Louw, 2007; Johnson, 2006).

Current initiatives such as training lay counsellors are present in many communities and can be extended and coordinated to provide further levels of support, if properly legislated and controlled. The mandatory community service year for clinical psychologists also provides an opportunity for psychologists to develop mental health services over a sustained period of time in specific underserved communities. However, the latter needs a committed approach that sees consistency in the placement of community service clinical psychologists in underserved areas, rather than the current situation in some parts of the country where communities and hospitals are allocated a service for 1 year but not the next.

Of late, innovative technological approaches such as ‘telemedicine’ or ‘telehealth’ have been gaining recognition as an adjunctive system of health-care provision. This is another avenue that will need to be explored and maximised for the benefit of mental health care in underserved areas (McLaren, 2003). While ‘telehealth’ or ‘telemedicine’ has rather specific meanings and implications in general health care, for mental health care especially in poorer countries, the value would lie in using the electronic and technological communication networks to provide support as well as consultation opportunities for primary care and other non-specialised workers. In clinical psychology practice, there have been various ethical, legal, and other concerns, which will need to be addressed (Perle, Langsam, & Nierenberg, 2011). Nevertheless, this technological innovation in health care offers numerous opportunities and possibilities for psychological services, and psychologists need to devise creative ways in which this new era approach can be used to improve the mental well-being of disadvantaged communities.

### *Problematising the call to action*

This article is a response to what we consider to be the slow and uneven pace of transformation in professional training. There is a relative paucity of critical research on training since initial reviews (Ahmed & Pillay, 2004), and the changes at the national level have been largely confined to the development of the community service requirement and re-examination of the master’s dissertation completion period. Institutions have also differed in pace, form, and scope of transformation. For example, in addition to their clinical psychology course, some also offer community counselling programmes and others offer critical-community psychology as part of their clinical psychology training.

The transformation agenda has to be centralised, coordinated, and driven by the HPCSA and all relevant stakeholders. The proposed solutions are meant to stimulate discussion about transformation and not to minimise the complexity of the issues and the enormity of the challenges. They are meant to facilitate transformation while providing indices to assess progress. For example, in consultation with relevant stakeholders, there is a need for minimum proportional requirements in community and short-term work in the curriculum. While this may evoke robust debate, it is also a way in which training programmes could become more accountable and introduce greater standardisation. Whereas transformation is a collective venture, leaving the transformation agenda to individual training institutions is unlikely to facilitate progress and may even exacerbate existing inequities.

The model described in this article is motivated by pragmatic considerations that draw from existing resources rather than an attempt to redefine the profession. Framing clinical psychology as a primary health-care initiative will not only help align it with health more broadly but also provide some pathways to develop the resource pool and address existing inequities with the utilisation of existing resources.

While some of the suggestions offered are already part of some existing programmes, there are still huge challenges. We identify four of the key challenges. First, the balance between programmes structured to facilitate relatively longer, individual work with interventions that can draw from this but require very different competencies, some of which are not specific to clinical psychologists' framework, is a major challenge. Second, there is an enormous danger of a tale of two psychologies, a psychology serving the rich and a critical-community psychology of sorts serving the poor (Carolissen, Rohleder, Bozalek, Swartz, & Leibowitz, 2010). Third, poverty and inequity remain two of the most significant challenges facing post-apartheid South Africa. Some scholars argue that apartheid economic inequalities have not only been maintained in the post-apartheid period but also worsened (Bond, 2004). Bond (2004) suggests that the gap between the rich and the poor increased in line with global economic trends and that Black household income has dropped in the post-apartheid period. Fourth, one of the central issues in what constitutes a relevant training is an engagement with the relationship between culture and mental health (Kleinman, 2004; Swartz, 1998). This issue has evoked long-standing interest and contemplation, with the issue of cultural competence (Jackson, 2004; La Roche & Maxie, 2003; Marsella & Pedersen, 2004; Vera & Speight, 2003) gaining prominence in the international literature. In the South African context, diversity and cultural competence are sometimes often proposed as unproblematic solutions. Much of the work, however, is marked by a Eurocentric bias and does not adequately locate an analysis of culture within conditions of social inequality and injustice. Vera and Speight (2003) draw attention to this situation and point to the difficulties in engaging with decontextualised descriptions of culture. They argue that it is not meaningful to explore cultural competence without engaging with the issue of social inequality. Similarly, it is found that diversity is often used interchangeably with 'race' but without a substantive engagement with the related issue of racism.

One possibility for addressing some of the challenges above is to explicitly frame mental health service delivery within a human rights framework. Unlike other sectors like education (Veriava, 2005; Wilson, 2004), transformation of mental health services has not been explicitly informed by a human rights framework. Section 27 of the Constitution of the Republic of South Africa (Republic of South Africa, 1996) specifies these rights as follows:

*1. Everyone has the right to have access to*

- a. health care services, including reproductive health care;
- b. sufficient food and water; and
- c. social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.

2. The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

3. No one may be refused emergency medical treatment. (Section 27, Chapter 2)

If we include mental health under health-care services, the constitutional mandate is that the government is accountable to afford mental health the same standing with basic needs such as food, water, and social security. The marginalisation of mental health in any form then runs counter to the importance accorded to mental health as a human right within this interpretation of the constitution. In this context, it is worth noting that the Mental Health Care Act No 17 of 2002 (Republic of South Africa, 2002) makes it clear that 'Every mental health care user must receive care, treatment

and rehabilitation services according to the standards equivalent to those applicable to any other health care user' (Section 10(2)).

In unravelling the complex relationship between culture, social inequality, and mental health, we suggest a critical conceptualisation of culture (Mkhize, 2004) and propose that culture is a complex, dynamic relationship between the unique group-based practices and ideas and the material realities of lives across contexts such as gender, race, and class. The international literature has questioned the value of mainstream thought and its failure to engage with issues of diversity (Jackson, 2004; La Roche & Maxie, 2003; Marsella & Pedersen, 2004). We argue for a programme that draws from the international arena but has a unique local identity that fully accommodates indigenous knowledge systems. In the South African context, there needs to be a far greater integration between approaches that focus on the African worldview and philosophy and those that adopt a critical-community orientation. We believe it is possible to acknowledge the magnitude of challenges and issues, while holding training institutions and the profession accountable to pragmatic and achievable transformation goals in the short term.

Indigenous healing is an important aspect of health care, especially in poorer communities, and their use of such services is acknowledged. Properly controlled and regulated, indigenous healing systems remain a viable complementary service. Research clearly indicates that clients in different cultural contexts access both the medical and alternative healing systems (Kleinman, 2004). South African research in rural communities noted that 40% of rural patients prefer to consult both 'Western' medical doctors and indigenous healers (Muelelwa, Sodi, & Maake, 1998). However, the current state of mental health service delivery suggests that for them to be accommodated within the existing structure, significant changes are required if alternative health-care systems are to be complementary. The hierarchy and power associated with different understandings tend to favour Western 'scientific' orientations. Within this mainstream hegemony, alternative approaches are sometimes considered as being, at best, not harmful (rather than helpful), and at worst, unscientific and dangerous. Clearly, engagement on these issues is necessary in order to best serve the wider South African society.

## Conclusion

There is a need to urgently re-examine the provision of clinical psychology services and very importantly the training of clinical psychologists in South Africa. This needs to be done conjointly to ensure that

- (1) such services are provided appropriately and equitably and geared towards community and individual needs, rather than any traditional model of clinical psychology practice that failed to include the less privileged and
- (2) the training of clinical psychologists is in line with the vision described in (1) above, unlike the clinical psychology training of the 1970s and 1980s that saw Black trainees, for example, not allowed to consult White patients, and Black patients having much less access to mental health resources than their White counterparts.

The authors believe that any review of clinical psychology in South Africa will reveal much positive development but that more concerted focus on areas such as equity in training and service provision and realigned teaching content and service delivery approaches are required. From a human rights perspective that takes mental health as a constitutional right, transformation is not confined to professionals but can be evoked as the civic duty of all citizens.

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## Note

1. The authors do not accept these racial apartheid tags, the divisions they create, and the racist discourse they engender. However, they are aware that these are constructions along which people may relate to their social world.

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