Psychology, Mental Health Care and the Future: Is appropriate transformation in a future South Africa possible?

Vogelman, L. (1990). ***Psychology, Mental Health Care and the Future: Is appropriate transformation in a future South Africa possible?*** In *Social Science and Medicine*, Vol. 31, No. 4.

In ***Social Science and Medicine***, Vol. 31, No. 4, pp. 501-505, 1990.

Lloyd Vogelman is a founder and former Director of the Centre for the Study of Violence and Reconciliation.

Abstract

In accepting the principles that psychology and politics are intertwined and that major political transformation in South Africa is inevitable, the question that arises is to what extent appropriate transformation of the mental health care system is possible in a post-apartheid state. A variety of factors need to be considered in exploring this question: the affordability of extending the mental health service; the expense of tertiary care; the increased demand for treatment; apartheid mental health professionals' resistance to change; the inclusion of non-professionals within the care system, and community involvement; and the problems posed by having residential areas still occupied by certain racial groups in a post-apartheid society. All these factors are likely to make the transformation of psychology and the mental health care system more difficult to achieve.

Key words– **mental health, psychology, South Africa, apartheid, post-apartheid transformation, future, professionals.**

Acknowledgements

I would like to thank Jill Huber for her assistance.

Introduction

The last few years of South African psychology have seen increasing debate about the link between psychology, politics and apartheid (1-4). The debate has primarily revolved around whether one can practise psychology and avoid politics.

The purpose of this paper is not to further engage in this debate but to look beyond it, and isolate those factors which may inhibit the transformation of psychology and mental health in a future post-apartheid South Africa, particularly if a policy of nationalisation is adopted. Two major principles underlie this paper. The first is that because the politics of a country help to determine the life conditions and mental health of its people, psychology and politics are intertwined. The second is that the enormous social, economic and political contradictions in South African society will lead at some point to a major political transformation and a post-apartheid South Africa with a democratic government.

Criticisms of South Africa's mental health system are numerous (3-5). The American Psychiatric Association (6), for instance, reported that mental health care in South Africa is inequitable along racial lines, is inadequate, often absent, sometimes hazardous to the client's health and helps to reinforce the ideology of apartheid. While many aspects of the socio-political and health-care framework in South Africa have changed since 1979, many of the APA's criticism's still remain valid. In the sphere of foster care for example, state foster-care grants in 1987 were 79 Rand (approx. 19 pounds) per month for each child to African families, 123 Rand (approx. 30 pounds) for 'coloured' families and 152 Rand (approx. 37 pounds) for white families. Furthermore foster grants for African children were stopped when they reached 16 years of age, and the time taken to approve a state grant for a black child is sometimes two years (7).

By September 1988, there was still no in-patient psychiatric ward in Soweto, a city housing approximately two million African people. At present there are plans to build a 24 bed psychiatric in-patient ward at the Baragwanath Hospital in Soweto. The construction of this ward is to be welcomed. Unfortunately 24 beds will not nearly cater for the daily average of a hundred psychiatric patients admitted to the hospital daily, let alone the thousands of mentally-ill patients requiring out-patient psychiatric assistance in Soweto.

In the rural areas and within the so-called self-governing African states of South Africa the inadequacy and absence of mental health facilities remains. Kangwane, one of the

so-called self-governing ethnic black states in South Africa, which forms part of the apartheid framework, has an officially estimated population of 400,000 and one mental health clinic consisting of 24 beds.

While it is important to continue to document the gross inequities of mental health services and make criticisms about the injustice of mental health care in South Africa, it is also necessary to begin to examine the viability of alternatives.

One alternative that has gained growing acceptance amongst numerous anti-apartheid activists and practitioners in progressive health organisations, such as the National Medical and Dental Association (NAMDA) and the Organisation of Appropriate Social Services in South Africa (OASSSA), but does not yet have a groundswell of support amongst the medical and psychological community, the state and the private sector, is the establishment of a national health service in South Africa under a democratic government. This paper will explore some of the obstacles in developing this alternative.

According to Kleczkowski et al (8), a national health service should ideally operate under a single national department of health, with centralised co-ordination and planning but allow for decentralised decision-making in geographical areas so as to encourage initiative and adaptation to local requirements. For a national health service to supply an equal and decent standard of mental health care to all, it will need to include some basic ingredients: a multi-disciplinary team approach; preventative interventions (which require specialised and in-patient treatment); the appropriate use of mental health professionals; an efficient and democratic management system; and finally community involvement, to ensure that the care system is accountable and adaptive to the communities' needs.

Within such an alternative, and in the context of a post-apartheid democratic government, will psychology as it is practised at present survive? Today in South Africa the major constituency of clinical psychological expertise and skills are the socially privileged and white population group (2, 9, 10). There are some primary factors which account for this. Firstly, the concept of the talking cure and the culture of psychology with its strong American and European influence is alien to many African people in South Africa. It is also argued (although no reliable figures are available) that the majority of African people prefer to consult traditional healers (11) for their psychological difficulties (12, 13). Secondly, psychology is inaccessible because most clinicians are white and tend to practice in areas and among clients who can afford their services. This often makes them inaccessible to black people who reside in satellite townships. Thirdly, much of the psychological practice is privatised and those who can afford it are generally the financially comfortable who in South Africa mostly comprise the white population. Fourthly, the practice of psychology, because it has given little attention to the difficulties and pathologies of the African working class, has been of little significance to this group of people.

Assuming the psychological 'status quo' does not change, there is little reason why a post-apartheid government, pressed financially and presumably committed to the African working class, would want to allocate funds to psychological work and training. As Dawes (14), taking from the writings of Abdi (15) comments, if psychology has little usefulness to the majority of South Africans, the question that arises is 'why bother with it?' (14, p.43). The work of organisations such as OASSSA, a national grouping of mental health practitioners, has begun to show why psychology is worth bothering

about. OASSSA has been able to make a psychological contribution, primarily through counselling, training and research to black working class communities. Although such work is embryonic, it is beginning to reflect a demonstrable usage of psychology for the future (10).

The economic approach of a post-apartheid government will be a further determining factor of psychology's relevance. In order to stimulate development, it may only stress investing in the physical elements of national growth (e.g. industry) rather than in consumption areas, for example psychological services (16). Although South Africa is a country rich with material resources and a well-developed economic infrastructure, the poor state of (black) housing, education, hospitals and community conditions is likely to mean that most financial resources will be channelled into these areas. This may result in little attention being given to the development of mental health services.

Assuming the perspective that mental health as an important priority does dominate, a number of obstacles for a successful national mental health service remain. Buch and De Beer (17) have identified a number of obstacles in transforming health care in South Africa. This paper considers some of these obstacles with reference to mental health.

Extending the Service

In order to rectify the situation where most South Africans do not have access to basic mental health care, a costly development and extension of community mental health centres and staff is necessary. Finance for this expansion could be accrued through the dismantling of an expensive bureaucracy and duplicatory and fragmented mental health services. It should be noted that apartheid ideology demands that each ethnic group have its separate living quarters and its own political infrastructure. The result is that at present South Africa has 14 health departments.

The dismantling of the Bantustan bureaucracies is likely to highlight a number of problems. The first is that bureaucrats in the various structures will be resistant to change since they will fear the loss of their jobs. Secondly, the attempt to improve mental health services will heighten expectations, thus increasing demands. The majority of people will have been dissatisfied with second-rate services and will demand of the government services equal to those previously available to whites and the privileged sectors of South African society. Heightened demands besides, problematising budgeting, has the potential to create animosity if they are unmet. The non-achievement of people's expectations lays the foundation for frustration and aggression (18), it thus becomes important that individuals in the present do not make wild promises about the wonders of a mental health service in a post-apartheid South Africa. For, in the future, if promises are not kept, antagonism towards those who are attempting to reconstruct a more equitable health service will develop, making the process of transformation even more difficult.

The Expense of Tertiary Care

With reference to tertiary care, a question requiring exploration is whether a national health service which sees its goals as providing basic mental health care to all can, for example, afford long-term treatment for extreme pathologies, such as schizophrenia or for pathologies which are specific to minority groups, for instance anorexia nervosa, a disorder most commonly found among the wealthier classes. This poses serious ethical questions. Buch and De Beer (17), with reference to specific physical ailments which affect a minority of people, state:

> **How does an egalitarian society make decisions about who gets renal dialysis and who dies? If such care is offered, we confront the problem of cost spirals. (17, p.3)**

In addition to the question of expense is that the economically and racially privileged have grown accustomed to a particular standard of living and care. It is unlikely that they will passively accept any reduction in the quality of their living and the treatment of pathologies specific to them. Their resistance may take the form of withdrawal of their considerable skills, through emigration. The threat of emigration invariably also gives more potency to their bargaining position.

The Demand for Treatment

Community psychologists have placed much emphasis on primary prevention (19-21). The latter of course may mean different things to different community practitioners. For example, some may see primary prevention as ridding South Africa of its political injustices, migrant labour, racism, etc. On the other hand, some primary preventative programmes only focus on a particular community rather than the society as a whole. Some practitioners attempt to straddle the link between community-specific deficiencies and the broader social context. It would appear that, whatever approach people adopt, most community practitioners emphasise that where possible primary prevention be given more priority than treatment. But in South Africa treatment facilities are often absent or inadequate. The potential for massive state financing of primary preventative mental health programmes, for example, education, is limited, considering people's need for relief of their psychological difficulties. This potential is further heightened because the absence of preventative care is less noticeable, has fewer political repercussions and its benefits are only manifest in the long term (17).

The Power of Mental Health Professionals

The establishment of a national health service invariably demands the participation of particular mental health professionals – social workers, psychiatrists and psychologists. Their departure from private practice, and the policy that practitioners may have to work where jobs are available, will probably result in practitioners earning less. It will also involve more, especially new, graduates having to work in rural and poverty-stricken regions for a period of time.

Since nationalisation involves greater centralisation of mental health programmes and planning as well as a multi-disciplinary approach, mental health professionals will be required to work together more cohesively. This requirement is in contradiction to the

present situation where, for example, there is animosity between psychiatrists and psychologists, primarily because of the former's more senior status and the different treatment approaches that each adopt.

The fact that most mental health professionals in South Africa are white and middle-class has divorced many from the value and needs of the majority of South Africans who are working-class blacks. There is at present, with few exceptions, little evidence to indicate that mental health professionals are serious about sharing their skills and knowledge with the African underprivileged. Furthermore, community mental health care is accorded less status professionally and academically than other areas of clinical work.

Political transformation, less economic privilege, changed social relationships, and major shifts in the type of mental health work, will not be easily accepted by mental health professionals. As suggested, a primary complicating factor is that new mental health policy and practice is likely to conflict with past training and professional registration in America and Europe. This is because there may be a shift towards briefer term work, the inclusion of traditional healers, and greater emphasis on the educative aspects of mental health work. The difficulty that mental health professionals are likely to have in adapting to numerous changes may result in South Africa finding itself in a similar situation to Nicaragua, where many mental health professionals emigrated because of their opposition to the new social, economic and community mental health programme of the Sandanista government (22).

The Acceptability of Mental Health Non-professionals

The expense of training clinical psychologists is a growing concern and is likely to intensify in the future. For a primary mental health care approach to be successful, other individuals will have to receive some clinical training. This may include medical practitioners, who are often the first to make contact with individuals suffering psychological difficulties; prominent and credible community members, such as religious ministers, who are often visited and consulted by community residents; and ordinary community members. These and other groupings of individuals could be trained to detect pathology, monitor high-risk groups, counsel, help in aftercare treatment, for example administering medication, and provide family support (23).

The broadening of clinical skills to other groups may pose an economic and social threat to clinical psychologists, since clinical skills would no longer be their exclusive domain. It is also probable that the training of non-professionals will make the issues of registration and who is permitted to conduct certain treatment procedures highly contentious.

Traditional Healers

In South Africa many Africans use a traditional healer in their first attempt to repair physical or psychological injuries (13). Their integration into a national health service is therefore central. This raises a number of problems. First is the competitiveness between traditional healers and Western practitioners and the suspicion that they

have of each other's treatment procedures. Secondly, the respective treatment philosophies are so vastly different; how does one integrate them into the same health system? It would appear that the starting point for dealing with this problem is for clinical practitioners and traditional healers each to learn about the other's successes and failures. In this way a psychologist may begin to discover when it is best to refer a client to a traditional healer and who the responsible and effective traditional healers are, and vice versa.

Community Involvement

A democratic national health service demands that it be sensitive to the needs of the people. The professional ethos sometimes breeds a sense of superiority which inhibits the psychologist from learning about mental health from the ordinary folk of a community. Most importantly, the establishing of community mental health projects requires joint participation, constant consultation and informed consent before implementing new policies. The latter practice is contrary to the prevailing work ethic in everyday private professional life which largely comprises individual decision-making. While joint participation may be more democratic it is a lengthier process and this in itself can be exasperating for professionals, who often place great emphasis on efficiency and their centrality in decision-making processes.

Residential Apartheid in Post-Apartheid Society

The ills of apartheid society, one of which is residential apartheid, may remain long after its demise, not because of Group Areas Act legislation but as a result of economic and historical factors (17). At present the majority of psychiatric institutions and mental health centres are located in white areas, and thus are often far from black townships. Presuming there is no fundamental shift in the racial make-up of living areas, this situation will persist. Considering that a post-apartheid government may need to concern itself with providing adequate housing and nutrition to the majority of South Africans, will South Africa be able to afford the building of new psychiatric institutions and community mental health centres in what would have previously been known as the African townships?

If the answer is negative, it is likely that inadequate mental health care will be maintained. This is because, even though there may be a non-racial mental health service, township residents will have to, just as they do at present, spend much time and cost to go to the relevant institution. This is problematic because, as Marsh and Meacher (23) point out, poor accessibility leads to under-utilisation of the service provided. Thus one of the prerequisites of appropriate mental health care, namely that it needs to be based in the community, may not be met.

The inadequacy of facilities in the living areas housing primarily African people may become more stark if there is mass migration to urban centres. The latter is of course dependent on future agricultural policies and the promotion, for example, of peasant farming. However, if new agricultural policies do not stem the tide of people to the urban areas, it would seem that the removal of influx control and the desire of people to be reunited and live with their families will increase the populations of cities rapidly (17).

While noting the above, many will still remain in the rural areas. Since rurally based individuals tend to be less organised, their needs are often not well expressed. This is in contrast to those in the better organised urban areas. This differentiation in the articulation of needs, as well as the power of different constituencies, is important in the light of the post-apartheid government wanting, like most governments, to maintain its credibility with the mass of people. This may mean that it will prefer to satisfy the urbanites at the expense of the ruralites. This then may result in the continuation of a situation whereby those in rural areas who are the worst off and therefore require the most assistance, get the least (17).

Conclusion

The difficulties with transforming mental health care are numerous. Buch and De Beer (17) state that:

> **At transformation there will be two options: to be totally true to the characteristics of a national health service or to go for a compromise as an interim step. The compromises include: the maintenance of some private health care; … setting equity as only a medium- or long-term goal; compromising with professionals; and treading softly … with … health-manager practice. (17, p.7)**

Whether compromises should be made and, if so, what form will they take, are questions that require urgent attention. Whatever the answers to these questions, transforming mental health care in South Africa will not be an event. It will be a long and arduous process. Psychologists should therefore attempt to create a vision of the future in the present. This requires working towards removing apartheid, finding spaces that permit the appropriate social application of psychology and the acquisition of relevant psychological skills. It is crucial for psychologists and mental health practitioners committed to this task to continually remember that the present never remains the same and the future must never be relegated to the forgotten.

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This would include healers in the Zionist Church.

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