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Counselling Psychology in South Africa

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Abstract

The origin and development of counselling psychology in South Africa has been profoundly influenced by the country's socio-political history and the impact of apartheid. As a result of this, counselling psychologists in the country face a number of challenges and opportunities for the future. In this paper we provide a portrait of counselling psychology in South Africa by describing the current character of the specialty and the context in which South African psychologists work. We critically discuss the challenges that the specialty faces to meet the country's mental health care needs, contest the current Scope of Practice; affirm multiculturalism without essentializing or reifying race and ethnicity, and build an evidence base for community interventions in the country. We also consider how, in the future, counselling psychologists in South Africa may make a more meaningful contribution within public health and the country's health care and education systems.

Keywords

Counselling psychology; South Africa; roles; challenges; future directions

Counselling psychology (CP) in South Africa (SA) has a fairly brief and exclusionary history and many of the challenges the specialty faces today reflect the country's colonial past and the socio-political and economic consequences of apartheid. Despite a four-decade history, CP in post-apartheid SA has yet to achieve a recognisable, coherent and socially-relevant professional identity that differentiates the speciality from the other branches of applied psychology (Leach, Akhurst & Basson, 2003; Watson & Fouche, 2007; Young, 2013). In this paper we briefly describe the origins of the specialty in SA. We consider the current character of CP, describe the contemporary context in which SA counselling psychologists (CPs) practice and discuss the challenges faced by the profession.

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A brief history of counselling psychology in SA

Although scholars such as Painter and Terre Blanche (2004) and Van Ommen and Painter (2008) have chronicled the history of psychology in SA, the development of CP is relatively poorly documented. One exception is the work of Leach et al. (2003) who claim that the origin of CP can be traced to Stellenbosch University (an Afrikaans-language tertiary institution considered to be the intellectual cradle of Afrikaner nationalism) and the appointment of H. F. Verwoerd (one of the major architects of apartheid) to the position of professor of applied psychology in 1927. These authors assert that from its inception, CP was set up in opposition to clinical psychology and was primarily concerned with serving the goals of the nationalist government and addressing the needs of the minority White Afrikaans-speaking citizens of the country (Cooper, Nicholas, Seedat, & Statman, 1990; Foster, 1993; Leach et al., 2003).

At the time, clinical psychology in SA was associated with English-medium universities, was focused on psychopathology, and was aligned with more politically liberal and progressive psychology departments (Foster, 1993; Leach et al., 2003; Painter & Terre Blanche, 2004). Leach et al. (2003) argue that CP thrived in SA because Afrikaner academics wished to establish a sub-discipline separate from clinical psychology and focused on promoting the career development and psychological well-being of White Afrikaans speaking citizens. This focus on vocational issues and health promotion in the development of CP in SA mirrors the evolution of the specialty in the United States (Cook & Visser, 1986). However, unlike in the USA, the new discipline of CP in SA sought explicitly to uplift economically marginalized Whites in order to retain economic power in the hands of the White minority (Leach et al., 2003).

It was not until 1974 that the professional category of “Counselling Psychologist” was recognized in SA (Government Gazette, 1974) and professional training programmes were established at four Afrikaans-speaking universities (Stellenbosch, Port Elizabeth, Bloemfontein, and Rand Afrikaans) and at one English-speaking university (The University of Natal, Pietermaritzburg) (Leach et al., 2003), all of which were at the time only accessible to White students. CP has thus been inaccessible to the majority of South Africans for most of the last century. Initially the specialty was dominated by White Afrikaans speaking men, reflecting the discipline’s disproportionate presence in Afrikaans speaking White-only universities. More recently professional training programmes have been initiated at a number of English speaking universities and at universities which were previously reserved for Black students. Today, CP programmes are located at English- and Afrikaans-language universities, and historically-white and historically-black universities. In total, 13 institutions are accredited to offer postgraduate CP training (though two of these programmes are currently in abeyance) (Daffue, personal communication, 2014).

Credentialing of counselling psychologists in SA

To practice as a counselling psychologist in SA it is necessary to register with the Health Professions Council of SA (HPCSA). Prerequisites for registration are successful completion of a four year degree in psychology, an accredited master’s degree in CP (1

year), a one year internship, and successful completion of the Board Examination (HPCSA, 2013a). While clinical psychologists and other members of the medical and allied health professions, are required to complete a compulsory year of community service before they may practice independently, there is no such requirement for CPs.

The place of counselling psychology in SA's health system

SA is a country characterised by high rates of mental disorders and inadequate mental health care services (Herman et al., 2009). Health care services are also unequally distributed within the country and are delivered via a government funded public health care system (which serves the majority of the country's citizens) and a private health care system (which serves the comparatively small group of wealthy people).

The integration of CPs into the SA public health system has been an ongoing point of contestation. At present the state mental health system only has posts for clinical psychologists, although this was not always the case. In 1996 the number of CPs in full-time state employment was significantly larger than the number of clinical psychologists and approximately 17% of the country's CPs were employed in the public service (Pillay & Petersen, 1996). The most recent SA survey, conducted in 2014, suggests that this proportion may now be as little as 4% (reference to survey).

The limited employment opportunities for CPs in the country's public health care system has resulted in a decline in the popularity of counselling training programmes with many masters students instead electing training in clinical psychology so as to improve their employment opportunities. Some universities (for example, Stellenbosch University and the University of the Western Cape) have also discontinued their counselling masters programmes partly as a result of this trend. Towards the end of 2014, there were 1661 counselling psychologists registered with the Health Professions Council, which constituted 21% of all registered psychologists (Daffue, personal communication, 2014), representing a decline from 2002 when CPs constituted approximately 35% of all registered psychologists (Leach et al., 2003).

A senior official in the national Department of Health has indicated the need for a change in the status quo so that CPs may find employment in the public health system (Freeman, personal communication, December 8, 2014). We argue that CPs can be effectively used within clinical settings at the interface of medicine, psychiatry and psychology. In this context, the absence of formal training and practice opportunities in health psychology in SA is significant. We believe that, in keeping with many other parts of the world, CPs in SA as practitioners of health psychology have a role to play in general medical settings, for example, in helping patients with issues such as adherence to treatment, management of chronic illness, diseases of lifestyle, pain-management, the psychological issues associated with disability, and family functioning in the context of disability and chronic illness.

In spite of the lack of CP posts within the public health care system, CPs in SA can be found in a variety of public and private sectors, including the police services, military, universities, schools, NGOs, community organisations, social service organisations, and industry (Watson

& Fouche, 2007). Yet, recent data show that the range of employment options for CPs outside of private practice and higher education are limited. Currently, almost half of all CPs (48.9%) work in private practice, a setting that excludes the economically marginalised mostly black residents of the country. Another third are employed by universities (13.6% at university counselling centres; 15.8% at university psychology departments; and 3.2% in other university departments) (reference to survey). The results of such limited employment opportunities outside of private practice is that many CPs must adopt an entrepreneurial rather than an altruistic approach to their work, an emphasis that does not fit very well with the values of CP (Packard, 2009; Young, 2013).

Another factor that has contributed to inaccessibility of services is that most CPs in the country do not speak the indigenous languages of the Black majority (De la Rey & Ipser, 2004; Watson & Fouche, 2007).

Professional organizations in SA

The statutory registration of psychologists is governed by the Health Professions Council of SA (HPCSA), a body that comprises 12 Professional Boards, one of which is the Professional Board for Psychology (Health Professions Act 56, 1974). The Professional Board for Psychology recognizes clinical, counselling, research, industrial, educational, forensic, and neuro-psychology as separate categories of registration and mandates separate scopes of practice for each sub-discipline (Government Gazette, 2011).. The HPCSA has also made provision for the registration of professional counsellors (who have completed four years of university training) to practice in a limited capacity offering counselling services.

Professional psychology in SA is organized by the Psychological Society of SA (PsySSA). PsySSA was established in 1994, the same year in which SA had its first democratic elections. The organisation has several divisions of which the Association for CP is one. PsySSA publishes the country's only general-interest psychology journal, the *South African Journal of Psychology* (SAJP), and hosts the annual South African Psychology Congress (Cooper, 2014). Unlike the HPCSA, membership of the organisation is voluntary.

Counselling psychology's relationship to clinical psychology and other health care workers

While CP in SA is considered to be distinct from clinical psychology, there is a considerable overlap between the two sub-fields. Several training institutions combine clinical and counselling training which serves to further diffuse differences between the two sub-fields. Compared to countries such as the USA and the United Kingdom, CPs in SA do not possess a distinct professional identity that is separate from their clinical psychology counterparts.

In 2011 a new scope of practice (SoP) for the Psychology Profession was promulgated into law in SA (Government Gazette, 2011). The SoP has sought to re-define overlapping but essentially separate scopes of practice for clinical and CP. Within this framework clinical psychologists are restricted to work that entails "identifying psychopathology in psychiatric

disorders and psychological conditions" (Government Gazette, 2011, p. 6) and "identifying, and diagnosing psychiatric disorders and psychological conditions" (Government Gazette, 2011, p. 6). The work of CPs, on the other hand, is delineated as "assessing, diagnosing, and intervening in clients dealing with life challenges, and developmental problems to optimise psychological wellbeing" (Government Gazette, 2011 p. 7) and "assessing cognitive, personality, emotional and neuropsychological functions in relation to life challenges and developmental problems" (Government Gazette, 2011, p. 7). The SoP thus makes a distinction between *psychopathology* and *life challenges / wellbeing / adjustment*. It states explicitly that psychopathology is the domain of clinical psychologists and that CPs are concerned only with healthy development, as if these two domains are distinct and easily differentiated. Explicit in the new SoP is the directive that clinical psychologists focus on "treating psychological and psychiatric conditions," (Government Gazette, 2011, p.6) and CPs focus on "offering counselling interventions to resolve development issues and adjustment disorders" (Government Gazette, 2011, p. 7). Though the practical implications of the SoP remain unclear, some practitioners have already interpreted the SoP very narrowly to mean that CPs should not intervene to remediate psychopathology (Botha, 2011). The training and practice of counselling and clinical psychology in SA have always overlapped considerably (Leach, et al., 2003; Pillay & Petersen, 1996). As such, many CPs, especially the large proportion who earn their living by offering psychotherapy in private practice, are wary of any revisions to their SoP that might curtail aspects of their professional work and negate part of their experience and training. The wording of the SoP explicitly focuses CP on so-called "life challenges" and "adjustment and developmental problems". A narrow interpretation of the SoP implies that the practice of CP in SA is inextricably tied up with: 'typical problems of living' (Government Gazette, 2011). These problems include educational problems, relationship difficulties, divorce, bereavement, crime, accidents, substance use, retirement, unemployment, physical illness and disability. However, they may also more broadly refer to social problems such as poverty, unemployment and social inequality (Seekings & Nattrass, 2006); gender-based (Abrahams et al., 2009) and other forms of interpersonal violence (Kaminer, Grimsrud, Myer, Stein & Williams, 2008); and an HIV prevalence that is amongst the highest in the world (Department of Health, 2012), occurring in a context of severe HIV stigma (Kalichman et al., 2005). Furthermore a broad interpretation of *life challenges, adjustment and developmental problems* arguably also includes many of the mild-to-moderate anxiety, eating, substance abuse, trauma and depressive disorders that are typically borne by people who continue to meet, for the most part, their social and occupational obligations. This broad reading of the SoP is consistent with the various international definitions of CP (Pelling, 2004; Young, 2013).

The source of much of the confusion about the SoP of CP is related to its traditional emphasis on people's strengths. Yet, as Bedi et al. (2011, p. 131) argue, a "[f]ocus on strengths does not imply a particular scope of practice; rather, it represents an instance where the field's philosophical orientation infuses multiple areas of its practice." Thus while developmental work is considered a defining feature of CP (Savickas, 2007), surveys in the USA have revealed that, as the discipline has matured, there has been a gradual shift in the practice of CPs towards clinical remediation (Goodyear et al., 2008). While CPs in SA have

an important role to play in remediating psychopathology, this need not be at the expense of prevention and development (Young, 2013).

Major issues, opportunities and threats for counselling psychology in SA

By virtue of SA's history and the country's current socio-cultural and mental health care context, CP faces a number of challenges. These include finding ways to overcome apartheid's legacy of inequality and engage critically with the call to advance a social justice agenda and work as agents of change while embracing the evidence based practice movement. The specialty also needs to achieve greater racial diversity, make a meaningful contribution to meeting the country's mental health care needs, apply psychological knowledge to promote physical health and well-being, and respond to the call to indigenize the practice of psychology. Each of these challenges is described and critically discussed below.

Overcoming Apartheid's legacy of inequality and adopting a social justice agenda

SA continues to grapple with the enduring legacy of apartheid, a system of oppressive educational, economic, social, political and geographical measures that deprived the majority of black South Africans from full citizenship, adequate social services, skills and life opportunities, in order to sustain white economic privilege. Despite the transition to democratic rule in 1994, deep inequalities remain a feature of SA society. The challenge to CPs is to adopt the agenda of community psychology and find a way to utilise their skills and knowledge to promote economic liberation in SA and disrupt current social structures that maintain inequality.

In the last decade SA's CPs have increasingly come under fire for failing to be relevant and to practice their specialty in a socially responsible way. Leach et al. (2003) maintain that CPs need to prove their viability to other professions and the community at large by addressing the social ills currently facing the country. Critics have also noted the specialty's need to adopt an increasingly greater advocacy role (Foster, 2004) and play a more proactive role in addressing educational, social, racial, and gender issues (De la Rey & Ipser, 2004). It has been suggested that CPs need to extend their reach and adopt advocacy roles; engage in community interventions; become integrally involved in policy formation and actively change social structures (Vera & Speight, 2003; Young, 1990). It is not only SA's CPs who are being challenged to expand their practice to incorporate the social justice agenda; CPs in the USA are heeding calls from critical, community, and liberation psychologists to reclaim a social advocacy agenda and make social justice work integral to their practice (Ivey & Collins, 2003).

Counselling psychology and cultural relevance

Critics have called attention to CP's Euro-American bias (Painter & Terre Blanche, 2004) and its propensity to employ theoretical models developed for wealthy White western individuals. CPs have thus been prompted to engage actively with the indigenisation of counselling theory and practice in SA (Stead & Watson, 2006), which is in keeping with multiculturalism as a "fourth force" in psychological practice. Given the historical bias of

CP towards Euro-American psychological theories and models, as well as the lack of access of most Black South Africans to psychological services, it is incumbent on contemporary SA CPs to imagine ways in which the specialty may be indigenised. While we acknowledge the need for culturally sensitive psychological interventions we take issue with the assumption among some practitioners of indigenous psychology that an African worldview is uniquely different from a non-African worldview. We caution against an essentializing view of culture that seeks to construct non-western cultural practices as exotic and mysterious; such practices create a false dichotomy by constructing “African” and “western” cultural contexts and systems of healing as discrete entities. Globalization has seen to it that many countries in the global South, including SA, probably share more cultural currency with the global North than is usually considered.. It is more likely that Southern African countries, including SA, occupy a hybrid cultural space that straddles “western” and African cultures. In such a context hybrid psychological interventions may be well-placed as long as they provide measurable benefit to help-seekers. Many African countries, including SA, are characterised by concerns such as migration, urbanisation, township and suburban life, social media and its attendant deluge of information. To this extent, a single monolithic African culture does not exist and it is necessary for CP to make itself relevant to this culturally complex context.

The evidence to date is encouraging and suggests that models developed in western contexts may be effectively adapted and applied in a variety of African settings (e.g., Bolton et al., 2003; Bolton et al., 2007; Igreja, Kleijn, Screuder, van Dijk, & Verschuur, 2004; Neuner et al., 2008). The challenge for CP in SA is thus to integrate its essential principles of multiculturalism with an acknowledgement of the multi-cultural and multi-ethnic character of the country without essentializing and reifying race and ethnicity.

Building an evidence-base for community interventions

Community psychology is a well-developed sub-discipline in SA and overlaps with CP and is an integral component of professional CP training. Community psychology interventions in SA as well as other sub-Saharan African countries place a focus on topical issues such as school bullying, youth at risk for crime, teenage pregnancy, safer sex, anti-violence programmes and parenting skills. While empirical evidence for these interventions may not always exist, we take the view that psychologists-in-training should be exposed to treatment protocols informed by the best available evidence if the interventions they apply in community settings are to be optimally effective. The implicit challenge to CPs in SA is to contribute to establishing a body of knowledge and evidence to support their community interventions.

Counselling psychology and the evidence-based movement

A significant anomaly is apparent in the new scope of practice in that clinical psychologists are explicitly required to offer evidence-based interventions, while no such prescription is incumbent on CP. The wording of the current SoP and the important omission of references to interventions which are evidence-based is important and reflects a greater problem in the practice of professional psychology in SA. The evidence-based movement in psychology seeks to promote effective psychological practice in the service of contributing to public

health. It does so by adhering to empirically supported principles in the context of psychological assessment, formulation of individual cases, establishing the therapeutic relationship, and implementing psychological interventions (American Psychological Association, 2015). Adhering to evidence-based practice in SA is an important issue, especially given the limited mental health care resources and the need to ensure that interventions are effective.

Kagee (2006) has argued that this notable absence may be in part due to the nature of clinical and CP training programmes that themselves place an inordinate emphasis on poorly validated therapeutic procedures while over-valuing clinical intuition. CP

Achieving greater diversity within the specialty

SA, a country with a population of approximately 53 million (The World Bank, 2015), is served by 10 961 registered psychologists and 799 psychiatrists (HPCSA, 2013b). Table 1 below shows the racial and gender distribution of psychologists by categories of registration as at 2nd February 2015 (HPCSA, private communication). It is apparent from Table 1 that a although a gender transformation has occurred as a result of the feminisation of the specialty, the racial profile still fails to reflect the country's racial and language demographics. There is a clear need for transformation and diversification of the specialty within the country.

Meeting the mental health care needs of the country

SA has a high prevalence of mental disorders but inadequate mental health care. A survey of a nationally representative cohort of adults found that 30.3% of the sample reported having a mental disorder at some point in their lives, (Herman et al., 2009). Evidence indicates that 15.9% of people living in SA had received some form of medical or psychological treatment in the past 12 months, while only 25.2% of individuals with a mental disorder had sought treatment within the general medical sector, and only 5.7% had received care from a mental health care professional (Seedat et al., 2009). These findings suggest that a large number of South Africans experience symptoms of psychological distress but that there is a substantial treatment gap with very few receiving the care they need. A lack of resources is not the only factor that restricts access to mental health care in SA. Cultural barriers, including stigma associated with seeking mental health services, also reduce the likelihood of people receiving the treatment they need.

Given the high rates of mental disorders and the significant lack of access to mental health care services, there is an implicit challenge to CPs in SA to apply their knowledge and skill in order to help close this treatment gap. In the context of the small number of CPs in many LMIC's, one option for the provision of comparable services is the deployment of non-specialists such as primary health care staff including nurses, nursing assistants, professional counsellors, as well as lay community health workers. Such professionals and para-professionals may provide a range of services such as screening, assessment, counselling, and evaluation of symptoms of common mental disorders and problems in living. The challenge to CPs will be to find a way to support this task-shifting and provide on-going supervision and training of those tasked with providing mental health care.

Making a contribution to the promotion of health

Many SA communities are characterized by high rates of communicable diseases such as HIV and tuberculosis as well as non-communicable diseases such as diabetes, hypertension, and heart disease. SA has for many years been the country with the largest number of persons living with HIV and AIDS (PLWHA). PLWHA have an elevated risk of being diagnosed with a mental disorder compared to the general population (Freeman, Nkomo, Kaffar, & Kelly, 2008; Olley, Seedat, Nei, & Stein, 2004). In addition, common mental disorders are associated with a lower likelihood of receiving antiretroviral treatment (ART) (Turner, Laine, Cosler, & Hauck, 2003) and lower rates of adherence to ART (Ammassari et al., 2002; Catz, Kelly, Bogart, Benotsch, & McAuliffe, 2000; Spire et al., 2002). However, the integration of mental health interventions into HIV/AIDS care and treatment in most developing countries has been slow (Freeman, Patel, Collins, & Bertolote, 2005). In SA, providing psychological support and patient advocacy has been taken up mainly by counsellors and lay persons who have rudimentary counselling training. The need thus exists for CPs to avail themselves to fulfill this important role.

Responding to the mental health needs of immigrants and refugees

By definition a refugee is one who has been forced to flee their homeland because of fear of persecution on the basis of race, religion, nationality, or membership of a social or political group (UNHCR, 1951). Flight from one country to another is premised on some or other form of physical danger, which in many instanced may include the psychological experience of traumatisation or at least some form of psychological distress. Refugee flight may also be accompanied by temporary or permanent loss of family members such as children or parents, loss of material belongings including one's home, the legal and logistical challenges of obtaining refugee status in another country, as well as the practical challenges of making a life in a new environment. Various estimates indicate that SA may have as many as 5 million undocumented immigrants (Minaar, Pretorius & Wentzel, 1995), with at least 3 million from Zimbabwe.

In addition to the severe stresses of migration, in 2008 and 2015 SA witnessed a wave of xenophobic violence against foreign nationals, many of whom were economic migrants, asylum seekers, and refugees. Such challenges create specific and unique mental health needs that may be uniquely within the ambit of CP to address. If the mandate of CPs is to address problems in living among members of the general population rather than those of psychiatric patients, then the needs of refugees and displaced persons fall within this remit.

Key Articles

Watson and Fouche (2007) note that while much has been written about professional psychology in SA, very little of this is specifically about the practice of CP. Only three articles that specifically deal with CP in SA have been published since the new millennium; namely Leach et al. (2003); Watson and Fouche (2007) and Young (2013). While Leach et al. (2003) and Watson and Fouche (2007) provide critical discussions of the history and inadequacies of CP in SA, Young's (2013) article makes a particularly significant contribution towards pointing contemporary CP towards a clearer professional identity.

Conclusion

The professional practice of psychology in SA has been deeply influenced by the country's history of racial exclusion and economic exploitation. CP, by implication, has been complicit with the apartheid project. It was only in the 1980s that critical voices began to emerge calling attention to the racist and exclusionary character of the discipline which has resulted in some transformation. However, more than twenty years since SA became a democratic state, CPs are still predominantly White and still serve a mainly elite clientele. The specialty thus faces a number of challenges, which include finding ways to provide psychological interventions which are accessible, relevant, far-reaching and evidenced based. This will require a shift away from one-on-one interventions to broad-based community and public health interventions – an area where CP in SA can make a significant contribution, providing that a suitable funding model can be found and posts are created within the public health care system. In this context we note developments with the National Health Insurance scheme spearheaded by the current Minister of Health which will no doubt have an impact on the practice of CP in SA. Our position on blurring the distinction between clinical and CP warrants ongoing discussion and debate. We maintain that contestations about turf and scope of practice are unnecessary and unproductive as they perpetuate divisions in the field and prohibit services from being rendered effectively while drawing attention away from much more serious issues such as the mental health treatment gap in SA and the need for evidence based practices.

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Table 1

Racial and Gender profile of Registered Psychologists in South Africa by category of registration (as at 2nd February 2015)

	RACE	FEMALE	MALE	TOTAL
CLINICAL PSYCHOLOGY (including community service clinical psychologists)	AFRICAN	367	120	487
	COLOURED	82	27	109
	INDIAN	127	27	154
	NONE	356	235	591
	WHITE	1,155	469	1,624
Total number of clinical psychologists		**2,087**	**878**	**2,965**
COUNSELLING PSYCHOLOGY	AFRICAN	115	38	153
	COLOURED	52	16	68
	INDIAN	81	19	100
	NONE	208	109	317
	WHITE	762	252	1,014
Total number of		**1,218**	**434**	**1,652**