Reflexivity on medicalisation of the mind and the biomedical invasion on being human

Abstract

Clinical psychology practice is characterised by three core functions; assessment, diagnosis, and treatment. We challenge the biomedical imperative in clinical psychology through our shared personal experiences in training as clinical psychologists in South Africa. We pose that the training of clinical psychologists historically was, and continues, to be focused through a biomedical lens. Alluding to the perennial debate on the relevance of psychology and current arguments around the contemporary relevance of clinical psychologists' training; we propose clinical-community psychology as the main way forward for psychology practice in South Africa. Our position is that in South Africa, clinical psychology training and services should be appropriate and equitable in response to the needs of individuals and communities. We highlight the lack of contextual relevance that has been perpetuated in most of the clinical psychology training programmes. This misplaced historical legacy does not serve the people within the South African context.

Curwyn Mapaling

Department of Psychology, University of Johannesburg
curwynm@uj.ac.za
0000-0003-2731-9081

Thirusha Naidu

Discipline of Behavioural Medicine, University of Kwa-Zulu Natal
naidut10@ukzn.ac.za
0000-0002-8154-790X

Keywords

Introduction

Mental status examinations (MSEs) allow therapists to capture their initial assessment in the first encounter. Using *Examination* and *Extrication* as wordplays in the poem below, Naidu (2015) highlights the conflict in purpose and intention between how patients and practitioners experience this encounter. They are at odds.

> **'Mental Status Extrication (MSE)'**
> "I, poised on the edge
> of reason, sway.
> While you, weighing differentials,
> strike a diagnostic match

igniting fiery thoughts and
cogitating a multi-axial symptom overload.
I, wording my life, flounder.
Gasp, a fish on the table.
You and I fray over
shattered mirrors reflecting only
I in mine and you in yours.
You ask about my mother.
She was there, but not where
I, could find a history
In the splayed shards that
You, compose into me
With an assertive air.
Pill purveyor, dream voyeur.
I have seen izangoma [1], priests, witchdoctors.
Did they see me? I cannot know.
You a doctor of Which? When? What?
Questions to throw my bones.
To read where they lie.
To determine my status of mind.
I rise unpatient-like and cross a canyon in bare feet,
encountering you midway, adrift.
You trying to put yourself in my shoes
You still in your own feet."
Naidu (2015, p.5)

We approach this article with a view to deconstructing the biomedical imperative in clinical psychology. The three primary functions of clinical psychology are assessment, diagnosis, and treatment. The biomedical imperative here refers to the biologically-focused approach to practice, science and policy that has dominated the Western world (Deacon, 2013). The biomedical imperative views mental disorders as brain diseases and emphasises pharmacological treatment to address presumed biological abnormalities (Deacon, 2013). Before we unpack the discussion on assessment, diagnosis and treatment, we begin with an autoethnographic reflection, by looking back at our personal histories and events in various aspects of our training and experience as clinical psychologists, and people of colour, in South Africa. In our profession, we believe nascent, oppressive biomedical imperatives are shaped by events and experiences encountered during immersion in the field. Firstly, we interrogate

---

[1] South African Zulu diviners who use methods including the throwing of bone fragments to divine causes and treatments for physical, psychological and spiritual ailments (Naidu, 2015).

the way we were trained to identify and access clients (patients) according to the biomedical model. The term "clients (patients)" represents an important distinction in how mental health support is perceived and approached from a critical psychology perspective. It is common for traditional medical models to refer to these individuals as "patients", suggesting a passive role in their treatment. Clients, on the other hand, are more commonly used within humanistic and client-centered therapeutic approaches that emphasise individuals' active role in their own healing. Using the term "client" acknowledges their autonomy, agency, and capacity for self-determination. In using both terms together, "clients (patients)", we acknowledge this distinction and aim to bridge the gap between the biomedical and humanistic perspectives of psychology. There has been considerable debate regarding both terms in terms of their defense and problematisation. Different approaches may be beneficial to individuals seeking mental health support, depending on their circumstances and needs. Secondly, we discuss our feelings around our training towards the diagnoses of clients (patients) as per the diagnostic categories prescribed by the American Psychiatric Association (APA). Lastly, we propose clinical-community psychology as a way forward for psychology in South Africa. Across these three levels, we join the ongoing debate on the relevance of psychology, which has pervaded academic and professional psychology in South Africa prior to and since the dissolution of the apartheid state. Sher and Long (2012) refer to the relevance debate in psychology as the discipline's call for accessibility and social value to those who require it. The relevance debate has been reiterated by many others (de la Rey & Ipser, 2004; Kagee, 2014; Long, 2013, 2016, 2021; Macleod, 2004; Macleod & Howell, 2013; Pillay, 2017; Pretorius, 2012).

As people of colour and practising clinical psychologists, it is imperative that we contextualise the three core clinical functions mentioned previously. Our lenses, shaped by our individual journeys, memories, and interactions, offer a unique insight into these functions, grounding them in our personal realities. A deep and meaningful contextualisation is not just a scholarly exercise but is essential to truly grasp the nuances of our lived experiences. It bridges the gap between clinical terminology and the real-world implications it has on our daily lives. Our contention is fuelled by the work of Long (2021), that this unserviceable, biomedical model is seeded and rooted in oppressive dominant epistemologies. We must stop trying to heal our minds using the heads and ideas of oppressive epistemologies (Fanon, 1952; Maldonado-Torres, 2007; Muchemi, 2018). The biomedical model of mental health is based on the Western epistemic perspective of health and has been imposed or unreflectively adopted in other contexts, largely relying on pharmacological interventions (Fanon, 1952; Naidu & Abimbola, 2022). In the South African context, mental health is often intertwined with spiritual beliefs, community ties, and historical traumas, which are denied by the biomedical model. The global dominance of the biomedical model creates tension with local practices, potentially marginalising indigenous healing methods, and overlooking culturally-specific presentations of distress.

A possible resolution is a pluralistic approach, integrating local understanding and healing practices into the biomedical model, and fostering a more inclusive and culturally sensitive mental health care system in South Africa.

Our argument here is presented to draw attention to what we perceived and have experienced in our professional practice as flaws or neglect of important world views in our training. The methods, structures and systems through which we were trained do not serve us health professionals in our context nor the people we serve. Current training programmes continue to rely heavily on Western models of psychology, with a contextual relevance for Euro-American contexts. These models, while effective in their own contexts, often fail when applied to the unique socio-cultural realities of South Africa. Psychologists find themselves ill-equipped, disillusioned and demotivated when it comes to understanding the presentations and lived experiences of their clients' (patients'). For example, a client (patient) from a rural community who struggles to connect with a therapist trained predominantly in Western psychoanalytical and/or medical models, unable to incorporate or consider the client's (patient's) contextually and socially relevant understanding of their experiences and mental health (Gopalkrishnan, 2018). Such disconnects between training and context have been manifested in the low utilisation rates of psychological services, and a general sentiment of psychological services being only for the elite (Long, 2021), detached from the reality of the majority of the South African population. Training programmes should be reframed to incorporate indigenous African psychological perspectives (Dlamini, 2020; Oppong, 2022, Ratele, 2017), increase emphasis on contextual and social relevance, and encourage more experiential learning in diverse settings.

As outlined above, in the next section, we narrate our lived experiences.

Contextualising Our Lived Experiences

We narrate our experiences, drawing from insights seen in Ally (2020), Bell et al., (2020), and Pillay et al., (2018). Our aim is to expose the pseudo-legitimising tactics of clinical psychology. These tactics are orchestrated through borrowing from biomedical science, situating the discipline in biomedical contexts, and policing itself through statutory bodies like the Health Professions Council of South Africa (HPCSA). This is not a unique phenomenon in South Africa as similar struggles are documented in Asian (Okazaki, 2000) and Latin American psychology (Alarcón, 2003).

As authors and clinical psychologists who are people of colour, we asked ourselves the following question, "When we were growing up, would we have seen a psychologist and how would they have seen us?" Considering our background and life experiences, we question whether we would have been viewed as 'normal' or whether our emotions, thoughts, and behaviours associated with the normal human experience would have been pathologised.

CM is employed as an academic and doing research in educational psychology following his doctoral study. TN is a clinical psychologist and academic who practices in a public psychiatric setting and is currently preoccupied with decolonising global medical education.

CM

My clinical psychology story begins at the Welgevallen Community Psychology Clinic at Stellenbosch University. My frame of reference for a community clinic was a dilapidated face-brick building. Instead, to my amazement, I arrived at a beautiful colonial Dutch-styled white house with a lush green lawn where I would spend my days as a student psychologist. In our first introduction and orientation session, our lecturer not only allowed but insisted that we call him by his first name. I vividly recall him standing in class, in front of a writing board. One of the first questions posed to us, paraphrased, was, *"What are the three core functions of a clinical psychologist?"* Prompting our thinking by writing the word "assessment" on the blackboard, before that moment, I cannot recall ever spontaneously answering a question throughout my undergraduate studies. However, on that first day of class, Monday the 12th of January 2015, I felt compelled to say, "*diagnosis and treatment*". I felt conflicted after answering as I had said in my final panel interview that I wanted to be a "clinical-community psychologist" and was excited that I was going to be exposed to and taught by Prof Anthony "Tony" V. Naidoo. When I refer to 'conflict', I mean the tension I felt between my initial desire to join the programme, which had a focus on community, and the reality of my first learning experience. Surprisingly, the first lesson I encountered leaned into what Western society perceives as my primary function. This was despite the fact that I was trained within, and specifically for, the (South) African context. I wanted to be a community psychologist as I thought the profession could be the vehicle to help me pursue my civic responsibility by providing me with professional and ethical approaches to achieving greater equality and justice for all citizens of our heterogeneous society. Clinical psychology's focus on individual psychodynamics often contrasts with community psychology's emphasis on socio-cultural and economic determinants of mental health, leading to differing strategies for mental health interventions. For instance, while a clinical approach may suggest individual therapy for depression, a community approach might examine the role of poverty or social isolation. Our South African experience highlights this tension.

TN

My clinical psychology story began at the official demise of Apartheid. Its ghosts and the ghosts of its ideology continued to haunt my practice and patients for decades to come. I began my university career at a university originally for white students only, one which had recently begun to allow admission to students of colour. The university was colonial in its structures, practices, teaching, and the people it employed as lecturers. I was not seen or heard for who I was and what my history was. A modern Western psychology was

presented to me, and I took it in having been taught in my colonially designed, apartheid-assigned racially segregated school. I was determined to be a psychologist since I was 12 when I read about it in an encyclopaedia my father bought with supermarket coupons. I pestered graduate students and intern psychologists I knew for advice. One astute colleague told me that if I wanted to get into a graduate programme, I should apply to the university which was previously for black students in my province. White university professors would never give me a place in the programme. It was the best advice. I arrived there to find teachers who saw me, shared some of my history and were activists for change in the profession, well before anyone recognised there needed to be. I took courses in community psychology and social psychology based on theories developed by global revolutionaries in thought, the likes of Fanon, Marx, and Said. More than learning Western clinical psychology practice, I was taught to simultaneously question the foundations of the profession. I had the chance to work with local Zulu communities and learn how people developed their own effective ways of healing and support while dealing with the ravages of impositions such as Western health systems and apartheid. My journey in psychology has been one of flux, upheaval, and questioning. A conflicted journey in which I continue to practice in the dominions of psychology while rebelling against it.

Assessment
Arguments around the Biomedical in (Clinical) Psychology

> *"…there is widespread critique that psychiatry, and the psy-disciplines more generally, construct distress as symptomatic of 'neuropsychiatric disorders' rather than as responses to socio-politico-economic conditions of conflict, entrenched social inequality, and chronic poverty (to name but a few of the lived realities of global capitalism and liberal individualism)."*
> Mills and Fernando (2014, p.189)

What is deemed as "normal" is often what is acceptable in the social context. Behaviour is seen as pathological when one group dominates the other and describes behaviour that does not fit with the dominant ideal as pathological, especially when that behaviour is evident in someone who does not fit the dominant identity. For example, socially deemed pathological behaviour is extremely well documented in Black (Black or "Coloured" in South Africa) males. This, "misdiagnosing", proliferates even in contemporary psychology to the propensity for psychologists to pathologise a presentation in the socio-ecological as well as in the individual. Conversely, we consider the view our communities would have had of us as psychologists if ever we were to have practised in our own communities. From working in communities similar to the community I (CM) grew up in, my experience revealed that communities hold a biomedical view of psychologists. Patients consistently called me "Doctor" even after I had explained that I am not a physician and did not yet hold a PhD. Another is their

objection that I cannot prescribe medication. Given recent circumstances, I wonder if the coronavirus (COVID-19) has strengthened this biomedical ruse with so many psychologists and other allied health professionals wearing scrubs to work in hospital and clinic settings.

Too much focus has been placed on chemical imbalances rather than societal imbalances and the impact they have on the human experience (Long, 2021). From the perspective of the biomedical model, psychopathology is understood to be a biologically-induced brain disease including psychoses and mental disorders such as schizophrenia, major depressive disorder, attention deficit hyperactivity disorder (ADHD), and substance use disorders (Deacon, 2013). Oftentimes, the theory and practice of clinical psychology have been seen as a complementary paradigm or model to biomedicine (Deacon, 2013). However, we agree with Wampold (2001) who believes clinical psychology has been profoundly influenced by the biomedical model and operates less independently than commonly believed.

Based on our experiences we infer that there is a veiled and unspoken weight of the biomedical and Western science in psychology. From our own training, this is apparent in the pressure to have a biomedical topic for the Clinical Master's thesis or mini-dissertation that each student psychologist is required to submit before they can start the mandatory community service and, consequently qualify to write the board examination. For me (CM), I felt the pressure to conform to this unspoken rule, the unsaid tension to do something "clinical and real". I had been advised to search the departmental website to get a sense of what the current research projects and interests were amongst the staff in the department. If I had chosen to stay at my undergraduate institution, I would have continued with my research supervisor for my Bachelor of Psychology (Counselling) treatise. This supervisor, my very first main research supervisor, and I already had a tentative discussion on researching a topic within positive psychology; a branch of psychology seemingly so far removed from clinical psychology that it is often viewed as being on the opposite end of the mental health continuum.

Through positive psychology, people and society have been shifting their focus from understanding what is wrong to understanding what is working. Positive psychology has, however, received criticism for "fostering individualism, ignoring social contexts such as poverty, marginalization and violence that can seriously interfere with happiness" (Sloan & Garcia, 2011, p. 395). This criticism contradicts the critical perspective in community psychology which on the other hand, emphasises systemic injustices perpetrated through the abuse of power and social relations, which reinforce marginalisation within communities.

Despite these differences, the two fields can overlap and influence each other significantly. For instance, techniques and theories from positive psychology can

be utilised in clinical psychology to help clients build resilience, cultivate positive emotions, and enhance their overall well-being, in addition to managing their mental health disorders (Duckworth et al., 2005). This integration can lead to a more holistic approach to mental health care (Johnson & Wood, 2017). At the same time, clinical psychology can contribute to positive psychology by providing insights into how people cope with adversity, mental illness, and other challenges, as well as how interventions can be developed to alleviate distress and improve well-being. Therefore, integrating individual clinical interventions with systemic community strategies could yield a more comprehensive, culturally appropriate mental health care model for South Africa. This integration is supported by research demonstrating the effectiveness of such approaches (Carolissen et al., 2010; Naidoo, 1996, 2000; Pillay, 2017; Seedat & Suffla, 2017).

Interestingly enough, I (CM), until recently, found myself in my first academic post lecturing at a South African university which is known for its teaching and research in positive psychology, with some of its previous departmental chairs being the national proponents in this field. I never imagined that it would take me six years to return to a space which not only accepts but also advocates for the kind of research which had initially sparked my interest. Nonetheless, when pursuing my Master's degree in clinical psychology and community counselling at Stellenbosch University, I selected a clinical topic which best resonated with my personal life at the time, *suicide*, specifically related to young men. I never knew my grandfather but I heard from my father at an early age that he had taken his own life by suicide in his thirties when my father was only 11 years old. Growing up, there were also speculations about a paternal uncle and a close neighbour. All these instances had to some degree sparked enough curiosity to approach my supervisor, who was recognised as a national and international expert in this field, to be my Master's research supervisor. Here again, with my budding research interest, I felt the tension of how we were trained to assess, diagnose and treat and I found that it did not really work with para-suicide or deliberate self-harm. During my community service year, a senior psychologist challenged us to view psychology as the study of the psyche, while the study of medicine involves diagnosing, treating, and preventing disease in the body. He further derived the word "soul" from the Greek roots of the word "psyche". The crux of his argument was to challenge us to view our role as psychologists as those who must honour the soul and not the body. But even this is contentious if we begin to think about how we understand 'the soul' from secular and theistic positions. Therefore, and this might seem highly contentious, we could argue that we should not impose our biomedical values to keep people alive against their will. This particular point of reflection was also shared by Sonja Pasche (Pasche, 2020), who completed her doctorate on adolescent self-harm, when she said, "I also started to question the implicit expectation that mental health professionals were responsible for preventing adolescent suicide, and the pressure this placed on clinicians" (Pasche, 2020, p. 1). It's notable that the expectation for psychologists to prioritise life preservation,

particularly in cases of expressed suicidal intent, is not explicitly stated in the Scope of Profession of Psychology document (South African Department of Health, 2008). This expectation, while often an unspoken assumption in our field, is more closely associated with the medical profession, which operates within the biomedical model. However, the challenges and complexities of this expectation become apparent when one considers the context-specific realities of the South African lived experience. Indeed, the principle of life preservation assumes a one-size-fits-all approach that may not fully account for the unique socio-cultural, economic, and political factors shaping mental health in South Africa. Our training in clinical psychology has often followed a decontextualised model, one that struggles to address the realities of our clients' (patients') lived experiences effectively. In dealing with a client (patient) who expresses suicidal thoughts, for instance, the focus on life preservation can sometimes overshadow a thorough exploration of the complex realities that led to such despair. The debate here revolves around how we, as psychologists, can balance our ethical responsibilities to protect life with our commitment to understanding and addressing the complex realities of our clients' (patients') lived experiences. This is not a call to abandon the principle of life preservation, but rather to broaden our understanding of what it means to preserve life in a context like South Africa. Perhaps, instead of a blinkered perspective on preventing the act of suicide, a more contextually appropriate approach could involve working with the client (patient) to address the root causes of their despair, be it their socio-economic hardship, systemic inequality, or other factors. Such an approach would align more closely with a bio-psycho-social-spiritual model of mental health (Saad et al., 2017), one that sees the 'preservation of life' as not merely preventing death but enhancing quality of life. This could potentially represent a more contextually appropriate, ethical, and effective approach to mental health care in the South African context. This shift in perspective is a challenging one, requiring a critical reassessment of our training, our ethical guidelines, and our practices.

Given the aforementioned tensions and contradictions in the application of traditional clinical psychology models within diverse South African contexts, there emerges a critical need to scrutinise the broader implications of our practices. As Mills and Fernando (2014, p. 188) observe, "serious questions are being asked about the utility and validity of psychiatric diagnoses". This particularly pertains to the exportation of Western mental health models and diagnoses to contexts with differing cultural, socio-economic, and historical landscapes. These concerns bring us to the core of a far-reaching debate in global mental health. When we apply Western mental health models to diverse contexts, are we facilitating a valuable exchange of knowledge and resources, thereby globalising mental health? Or are we instead imposing an ill-fitting framework onto the Global South, potentially overlooking or undermining local understandings and approaches to mental health? In other words, are we "Globalising Mental Health or Pathologising the Global South?" (Mills & Fernando, 2014).

Existing Arguments on the Relevance of Psychology Training and Internships

"In continuing to crack this edifice, I propose an initial agenda of five areas that require an urgent decolonial orientation with new forms of practice—Curriculum, Research, Selections, Interventions, and Attitudes"
Pillay (2017, p. 139)

The relevance debate is imperative in understanding the transformation of training in clinical psychology. In South Africa, community psychology emerged as a response to help shape the scope of South African psychology as a result of the discipline's past failure to address issues such as racial oppression and social inequality (Kessi & Kiguwa, 2015). Thus, the majority of professional psychology training programmes have included components of community psychology in their training at a theoretical or practical level, or both (Kessi & Kiguwa, 2015).

Reflecting on Cheryl de la Ray's work on relevance unfolding in successive iterations influenced by the social and political climate in South Africa, we recognise that this is not a new story (de la Rey & Ipser, 2004). Notably, in 2004, 10 years into democracy others were grappling with similar questions of relevance (Ahmed & Pillay, 2004; Macleod, 2004; Suffla & Seedat, 2004). Shortly before the 20-year mark, we see more publications on the relevance debate (Long, 2013; Macleod & Howell, 2013; Painter et al., 2013; Pillay et al., 2013). The contention of the relevance problem continued for the 20-year anniversary of the South African democracy (Kagee, 2014; Pillay & Kramers-Olsen, 2014). What remains absent, however, from the previous work over the last nearly three decades is an explicit consideration of the biomedical thread founded in Western scientific epistemology.

It's been ten years since Pretorius (2012) pleaded for the re-definition of the Scope of Practice in South Africa. The Scope of Practice is a document that defines the acts of practice that can be performed by each of the registration categories in South Africa. There have been only five recognised registration categories for psychologists for many years: clinical, counselling, educational, research, and industrial psychology A recent addition includes neuropsychology, with forensic psychology to follow as a formal category in the future. However, the consensus on public platforms and online engagements hosted by the Psychological Society of South Africa (PsySSA) is that a generic category of 'psychologist' would better serve the South African communities in dire need of psychological services, and that specialisation should follow at the doctoral level as opposed to master's level. Yet, the HPCSA's newly proposed changes introduce a generalist category but, paradoxically, continue to perpetuate the biomedical model by retaining the same categories at the specialist level. This raises questions about the alignment of the regulatory framework with the evolving needs and aspirations of the South African psychological community.

In the past, the biomedical model strongly influenced the research and dissemination of psychotherapy; different methods, including drug trials, have been employed by clinical scientists to study the effectiveness of psychological treatments in psychotherapy research (Deacon, 2013). It should come as no surprise then that Pillay contemplated "whether our research dissertations ever actually create real change for the populations studied, or merely provide us a ticket into the profession" (2017, p. 135). The populations we study belong to and are situated in various communities. In their editorial Seedat and Suffla (2017) offer an apt summary of the contributions being made by the existing work toward decolonising community psychology.

> "Irrespective of the historical, geographical, and socio-political context, particularities and issues, it would seem that critical work within the discipline was patently focused on producing knowledge to resist and expose dominant methodological, epistemic, and intervention traditions; support transformative and social justice ideals, and advance human welfare and liberatory-oriented theories."
> Seedat and Suffla (2017, p. 422)

In South Africa, the recruitment of students for clinical psychology programmes is challenging due to the demand for professional training outweighing the availability of these programmes. Institutions make use of indices such as academic performance, life experience, community involvement, self-awareness and introspection to recruit the most suitable candidates for the professional training of becoming a practising, HPCSA registered, clinical psychologist. This emphasis on community elements within the field of psychology has increased the acceptance of psychologists taking on a less traditional role in the South African context (Ahmed & Pillay, 2004; Leach et al., 2003). Additionally, this may allow for opportunities for transforming clinical psychology.

Within the field of community psychology, health promotion and preventative measures remain central. Notably, preventative measures may extend into policy work. Psychologists are influential and have a valuable role in contributing to the development of our national mental health policy. This is inclusive of research conducted on mental health care and national plans for managing the human components of major disasters and trauma. The current parameters of clinical training can accommodate the shifts accorded by community psychology within South Africa. In recent years clinical psychology internships have transitioned from hospital settings to community-based settings (Pillay & Johnston, 2011).

The needs met by clinical psychology have developed from the common individualistic one-on-one approaches to approaches that meet the preventative and developmental needs of groups within communities, schools, prisons, and non-governmental organisations (NGOs) (Lazarus, et al. 2009). The need for brief psychological interventions aimed at alleviating symptoms of distress is highlighted in many poor African

communities (Patel et al., 2007). Despite the general inclusion of psychotic disorders in clinical psychology training programmes, there is a pronounced bias in psychiatry toward pharmacological interventions, which disfavours the development of adjunctive psychosocial interventions (Pillay et al., 2013). In this light, short-term modalities are inclusive in psychology training with some institutions expanding their input on evidence-based methods.

As we have seen, the need for contextually responsive, equitable, and inclusive clinical psychology training and services in South Africa is paramount. We must move beyond traditional models that may not fully encompass the realities of those less privileged or living in resource-constrained contexts. Multidisciplinary teams (MDTs) hold enormous potential for meeting these needs, especially when they include not only the typical assortment of health professionals but also traditional healers and religious leaders (Campbell-Hall et al., 2010; Ennion & Rhoda, 2016; Liberman et al., 2001). Despite their potential, however, there can be confusion about the roles of different professionals within these teams and the wider community. In this light, we find ourselves confronting an important question. How can we ensure that our clinical psychology training, practices, and MDT collaborations truly align with the lived realities of South Africans, rather than imposing a potentially ill-fitting framework onto these diverse communities? This brings us to a critical point in our discussion. As we look to the future of clinical psychology in South Africa, there is a pressing need to decolonise the knowledge taught in our academic institutions, particularly within the Global South (Kessi & Kiguwa 2015; Mbembe, 2015; Pillay, 2017).

Through decolonisation, we are calling for a shift in our academic curricula and clinical practices - a shift that acknowledges and addresses the historical, cultural, and socio-political contexts that shape mental health in South Africa. This entails questioning and challenging dominant Western paradigms, and instead fostering a more pluralistic understanding of mental health that incorporates local knowledge, beliefs, and practices. In doing so, we can ensure our services are truly meeting the needs of all South Africans, not just those who fit within a particular model or framework.

Diagnosis

How do we put a name to what we see in front of us? In this section we speak to empathy and how it relates to feelings of disenchantment around how we were trained to, sometimes, unjustly and within limits (diagnostic categories prescribed by the APA), name, term, define and diagnose the presentation in front of us.

Empathy: A theoretical construct or a lived experience?

> *"But what is empathy other than the deeply imaginative effort of walking in another person's shoes, of seeing the world through their eyes?"*
> Long (2021, p. 177)

We sometimes find it hard to see or recognise what we are taught about ourselves and the human condition outside the lecture hall. Sometimes this is because the knowledge was created without us, even when it was about us. Nyamnjoh (2012) captures this when he writes, "[e]thnographic representations of Africa are often blindly crafted and served as delicacies without rigorous, systematic dialogue with the Africans in question" (p. 67).

When training as a psychologist, you are constantly being evaluated by a panel of experts who believe that they really know you…until they don't. It's perhaps not surprising then that my (CM) therapist at the time referred to the dynamics at a previous internship site as a "psychodynamic circus". Psychodynamic psychology is the modality which emerged from psychoanalysis, which was developed by the biomedical, medically trained, forefathers of psychology in the West. If we look to the East, Vietnamese Buddhist monk Thich Nhat Hanh captured the essence of empathy I had expected to experience:

> "When you plant lettuce, if it does not grow well, you do not blame the lettuce. You look for reasons it is not doing well. It may need fertilizer, or more water, or less sun. You never blame the lettuce. Yet, if we have problems with our friends or family, we blame the other person. But if we know how to take care of them, they will grow well, like the lettuce. Blaming has no positive effect at all, nor does trying to persuade using reason and argument. That is my experience. No blame, no reasoning, no argument, just understanding, if you understand, and you show that you understand, you can love, and the situation will change."

My experience was that the teaching staff had adopted the biomedical model in how they related to us. It is not clear from the training if they are training us to be so-called "cold", "blank slate" clinical or warm and empathetic therapists. Is the training intended to make us both? Or neither?

It is fitting then that Long (2021) chose to base the concluding chapter of '*Nation on the Couch*' on the act of empathy as the basis for the "Golden Rule". He makes the necessary distinction between empathy and seeing empathy in practice, the latter being an act and not merely a concept taught to budding therapists. I would have appreciated, during my training, being treated how they (my seniors and supervisors) would have liked to be treated. Long (2021) asserts that empathy is so central to the therapeutic alliance that the "helping relationship is no longer a helping relationship" without it. It is surprising then that empathy is not the 4th core function of clinical psychologists, or are we being taught to believe that clinicians do not show empathy? Is it only a "hat" we wear in private practice and not in ward rounds?

Sadly, this perception is held by others outside of our discipline as well, as close as the profession we share many of our undergraduate classes with–social work. Recently

a social work colleague of mine (CM) stated that "you clinical psychologists are too clinical." Here lies another tension as a colleague who prides himself in perpetuating a famous line, "maybe I'm just too clinical."

Disenchanted, disillusioned, and deluded

"The process of becoming a psychologist, which is filled with uncertainty and growth, resonates with the eventual dynamics psychologists must grapple with in training and in practice."
Booysen and Naidoo (2016, p. 23)

In his inaugural lecture as a Professor of Community Psychology at Stellenbosch University, Anthony Naidoo reflects on the progression of his studies from social work to psychology, "[d]isenchanted with social work, I went on to pursue graduate studies in my other major subject, psychology" (Naidoo, 2000, p. 3). The word disenchanted is often used synonymously with disillusioned. Similarly, Long in '*A history of 'relevance' in psychology'* reflects on the depth of his disillusionment when he describes requesting that the Professional Board for Psychology have his name removed from the professional register. For Long, "[t]he trouble was that 12 months of visiting community health centres in the most impoverished areas of the Western Cape had left me feeling disillusioned about the social value of the profession" (Long, 2016, p. 1).

Reflecting on my own experiences and the narratives of these two senior academics I wonder if 'going to the desert' is yet another rite of passage in psychology. The process of becoming a psychologist was previously described as a "rite of passage" (Kottler & Swarts, 2004, p. 1). Then for us that have already felt disenchanted and disillusioned; the next time we go to the desert, we should not go alone. There are a few ways in which one could interpret this, we offer two: (i) reflect on yourself and your purpose by removing yourself from the current context or (ii) because the dominant structures in the context oppress your ideas and beliefs about your lived reality, it is necessary to escape an oppressive context. This signifies the importance of sharing our experiences in this article so that the next generation of psychologists are better equipped for life in the desert.

I (CM) too felt disillusioned with psychology, and I am sure there are many others out there. I find myself constantly returning to a contemplative space where I wondered if I wanted to be associated with the profession, how it emerged historically and what it stood for. I contemplated whether my training prepared me to work with people and problems I felt compelled to work with. Although this questioning had started before I received acceptance in the Master's programme, it became a bigger question mark during my M1 (first year of Master's) and M2 (internship) years. If it was not every one of my lecturers commenting on how quiet I was in class, then it was the critique of being

the youngest in the class from the external lecturers, or I was being told that I need to change my tone of voice. Yet, there was no course in M1 or M2 on how to not be a "quiet" therapist nor drama lessons on how to speak in a manner that would be perceived as "therapeutic". I remember all three of my internship placements and the feelings that came with them, most notably feeling disabled by what I had learned about how to assess, diagnose, and treat what was sitting across from me.

Just when the windstorm of disenchantment and disillusion wanes, we are expected to register with the HPCSA. The HPCSA polices the biomedical in clinical psychology with an unrelenting and frustrating fervour by alternately dangling the legitimate carrot of registration and pulling it away at every milestone on the way from student psychologist to independent practitioner. In your first year of master's in clinical psychology, you are a student psychologist (also referred to as your M1 year), thereafter you must complete an internship as an intern psychologist (also referred to as M2). Upon completing your HPCSA accredited internship and the research component of your M1, you will need proof from your HPCSA accredited university that you have successfully met all the academic requirements and that your degree will be conferred. Only thereafter will you be able to register for and write the HPCSA national board examination which is only written three times a year, in February, June and October. Bearing in mind that registration for the board exam closes two months prior to the exam date. Through these years, you are paying increasing registration fees for each of these levels. In addition, you are assessed, not only on the content but also on your self-awareness and other aspects of your personality functioning. Should you be found to not yet be competent at any stage, you can be mandated to repeat a few months of M1 or M2. After passing the board exam, you can start community service, provided you have applied for a post using the online centralised system. During community service, you are registered independently, although still under supervision at most sites (whether placed at the Department of Correctional Services, or Department of Health) and only after being signed off at the end of community service, can you apply and register as an independent practitioner. Accreditation of training and internship programmes is another exemplar, for instance, the expectation to have a test library of assessments and to use original testing material and not photocopies. If back in 1997 already, Foxcroft described the process of psychological test development as "haphazard, [and in an] uncoordinated manner" (p. 234) and in the same year Claassen urged that test scores cannot "be interpreted without taking note of and understanding the context in which the score was obtained" (p.306). Why are both instances still taking place today? We engage in self-deception about the testing (psychometric assessment) based on tests developed in other contexts, irrelevant norms developed on people vastly different from our own and in counties far removed from ours. At resource-constrained institutions, there is a not-so-secretive use of photocopies of original test material when original copies are meant to be

used. This is part of a broader performative compliance by universities and tertiary training hospitals which results as we scramble unthinkingly to enforce and perpetuate colonially established methods. Although, it is highly likely that no institution would ever admit to complying for the sake of complying at an HPCSA audit. An HPCSA audit, which could be equated to a child getting a visit from the Bogeyman, in this instance refers to when the HPCSA visits an accredited university or training institution which trains psychologists-in-training (M1 and M2) to assess whether the master's programme is compliant and adhering to the relevant legislation. HPCSA audits of this nature take place every four years.

Laher and Cockcroft (2013, pp. 535-536), South African experts on psychological assessment, remind us of the following:

> "The Health Professions Council of South Africa (HPCSA) has a Psychometrics Committee under the Professional Board for Psychology. The Psychometrics Committee has a mandate to evaluate tests to determine whether they are reliable, valid, and fair before registering them for use in the country. However, there is currently no legislation indicating that only HPCSA-registered tests may be used."

In many ways, the HPCSA is a statutory body upholding the biomedical façade nowhere more clearly than in the Professional Board for Psychology which strives unreflectively for legitimacy in the colonial corridors of Western biomedical science. This view has been publicised as far as the editor of the South African Medical Journal wrote an editorial in 2009 entitled, "HPCSA: a mess in the health department's pocket" (van Niekerk, 2009, p.1). Others might argue, and within their right, that the HPCSA helps regulate fraud, corruption, and uneven practices within the various health professions. Beyond their existing role of regulating fees and continuing professional development (CPD) points, as well as ensuring public safety, it is crucial that the HPCSA expands its function to actively support and assist practitioners. This could involve providing resources, training, and support mechanisms to help practitioners navigate the complexities of mental health care within diverse South African communities, thus enhancing their professional competency and resilience.

Treatment
The Not-so-new Kid on the Block: Clinical-Community Psychology
> "Social justice and a focus on the needs of the marginalized are seen as central to community psychology."
> Carolissen et al. (2010, p. 496)

A Special Issue on 'Liberatory and critical voices in decolonising community psychologies', which was edited by Seedat and Suffla (2017) recognises that the

prevailing knowledge economy in community psychologies has been "largely shaped by imperialism; colonialism and coloniality; neo-colonialism; globalisation; and Euro-American ethnocentrism" (p. 422). This special issue was indeed a huge feat for community psychology as a discipline especially if we consider that just three decades ago Tony Naidoo and Shaun Whitaker chose to publish their seminal text (Anonymous, 1986) anonymously (Naidoo, 2000). Their paper, entitled "*Some thoughts on a more relevant or indigenous counselling psychology: Discovering the socio-political context of the oppressed*" was arguably one of the earliest calls for a relevant and socially just psychology. When asked why they chose to publish their paper anonymously, Tony Naidoo had the following to say and is quoted below with permission:

> "*That's a very good question and a complicated question. In short, it was co-authored with a colleague of mine, Shaun Whitaker. Shaun is now a prominent clinical psychologist in Namibia and has been for many years. Both of us were relatively junior in the psychology ranks at that stage as interns at the Centre for Student Counselling at UWC [University of the Western Cape]. The paper was quite, what should I call it… radical, challenging the status quo of the time, which was still deeply entrenched in the apartheid context, there were deep contentions fomenting at the time, with students calling for the relevance and a politically responsive psychology while there were people who were still holding onto an apartheid psychology ideology. For these reasons, we opted to say what we needed to say but safeguarded ourselves by remaining anonymous as we were still in training, and still needed to be registered.*"
> A. V. Naidoo (personal communication, June 2, 2022)

Just a few years following the paper by Anonymous (1986), Butchart and Seedat (1990) problematise the notion of community within our context in South Africa, "'[c]ommunities' (whether real or imagined), are socially constructed and exist within, not above, history and ideology." (p. 1096). For this reason, the definition is continually evolving through various critiques and contexts.

Another instance where I (CM) experienced this tension is in me, myself as a newly trained psychologist 20+ years after 1994, the psychology I was trained in was still a colonial psychology. A colonial psychology that I am compelled to practice in the assessment, diagnosis and treatment phases. What makes this all the more puzzling is that academics and mental health professionals such as Frantz Fanon have been critiquing and challenging Eurocentric psychology from as early as 1952 (Fanon, 1970). However, it is important to acknowledge that, while there were criticisms of psychology even before 1952, it was Fanon's seminal work that truly anchored these critiques within a framework of decolonisation. Therefore, even more alarming is that I now stand in front of a class and continue to teach the very Eurocentric psychology that we critique in this

article. Furthermore, in training and supervision of psychologists, I concede and leave it to the "kind of clinical psychologist we're supposedly supposed to be training". Feeling that because I do not yet meet the statutory HPCSA requirements to supervise (three years of registration as an independent practitioner), I do not have the legitimacy (in a technical sense) to give honest, reflective, input. Whereas Carolissen et al. (2010) assert that *subjugated knowledges* (Foucault, 2004) and *critical pedagogies* (Freire, 1993) ought to be integrated into the curriculum in order for all kinds of knowledge to be recognised and valued.

We believe that clinical community psychology is what should be happening in psychology training.

Conclusion

"O my body, make of me always a man who questions!"
Fanon (1952)

The critique of the biomedical in psychology may not be mainstream but is very well-argued and articulated within certain circles as being complex and nuanced. The biomedical deep narrative in psychology is that clinical psychology has a science behind it. A legitimacy which is deeply implicit and almost unquestioned when in fact it's a pseudo-legitimacy. It is a borrowed legitimacy from science; it has no place in psychology. In other words, biomedicine would like to claim that psychology's (scientific) legitimacy is situated within the science of biomedicine while decolonial psychology would refute this claim, not only as untrue but also irrelevant. In fact, this claim may even lead to oppressive practices.

We feel that psychology is not and should not be regarded as a biomedical science (Nguyen, 2019), but rather situated within psychology as a discipline in its own right. Philosophers of science can validate the claim that psychology is a priori inclusive of biomedical aspects, plus a great deal more. On the other hand, it cannot be said the same for the other way around; for instance, biomedical science cannot include psychology's science and paradigms. We could point out that the workaround and working in the gaps (curriculum, research, selections, interventions, and attitudes (Pillay, 2017)) happen on a constant and daily basis in psychology in public service practice and in private psychology practice in South Africa. Here psychologists realised that when biomedically-based psychology is taught in university, it does not serve the people they work with and so they deploy decolonial practice supported by subjugated knowledge. Thus, we are dealing with double colonisation (Ahmed, 2019) here: (i) psychology being reduced to a biomedical paradigm only within the broader discourse and context of health care, and (ii) the way and content of psychology teaching at universities have also been hijacked by biomedical reductionism. There is not a universal, one size fits all

psychology for everywhere. Therefore, we believe that psychology is a discipline in its own right that has inherent tools to:

a) Not only work in a contextually responsive way with people to whom it renders service to, but also,

b) Draw on subjugated knowledge to counter biomedicine's epistemically arrogant, colonial, foundationalist, and attenuating assumptions about the whole of a person's psychological being - trying to reduce it to physiology etc. - while the discipline of psychology is so much more than that.

As practitioners, we know this occurs and practitioners either deny that they do it, frame it in other ways, or like Long (2016) and Naidoo (2000) attempted to do: opt-out or/and reject formal psychology practice. Many would never acknowledge rejecting formal psychology practice for fear of having their HPCSA registration and access to income threatened. However, we suggest that the argument about decolonial practices is an area worth exploring primarily to find ways to subvert biomedical practices that are oppressive to those with non-dominant identities. At a broader level, this kind of ethnographic and grounded theory type research would contribute significantly towards discovering the kind of psychology and the kinds of psychology lenses (beyond their reverence for/fixation on the biomedical) that work in the lived experience of psychologists who practice in the real world.

References

Ahmed, S. M. (2019). Double colonization: A postcolonial feminist study of sia figiel's where we once belonged. *Scholaria: Jurnal Pendidikan Dan Kebudayaan*, *9*(1), 1–10.

Ahmed, R. & Pillay, A. L. (2004). Reviewing clinical psychology training in the post-apartheid period: Have we made any progress? *South African Journal of Psychology, 34*(4), 630-656.

Alarcón, R. D. (2003). Mental health and mental health care in Latin America. *World psychiatry: official journal of the World Psychiatric Association (WPA), 2*(1), 54-56.

Ally, Yaseen. (2020). Autoethnographic methodology and its applicability to psychological research and practitioners. *Psychology in Society, (60)*, 31-40.

Bell, D., Canham, H., Dutta, U., & Fernández, J. S. (2020). Retrospective autoethnographies: A call for decolonial imaginings for the new university. *Qualitative Inquiry, 26*(7), 849-859.

Booysen, D. D., & Naidoo, A. V. (2016). On becoming a psychologist: The experiences of the unsuccessful applicant. *New Voices in Psychology, 12*(1), 23-39.

Butchart, A. & Seedat, M. (1990). Within and without: Images of community and implications for South African psychology. *Social Science & Medicine, 31*(10), 1093-1102.

Campbell-Hall, V., Petersen, I., Bhana, A., Mjadu, S., Hosegood, V., Flisher, A. J., & MHaPP Research Programme Consortium. (2010). Collaboration between traditional practitioners and primary health care staff in South Africa: Developing a workable partnership for community mental health services. *Transcultural Psychiatry, 47*(4), 610-628.

Carolissen, R., Rohleder, P., Bozalek, V., Swartz, L., & Leibowitz, B. (2010). "Community Psychology is for Poor, Black People": Pedagogy and teaching of community psychology in South Africa. *Equity & Excellence in Education, 43*(4), 495-510.

Claassen, N. C. W. (1997). Cultural differences, politics and test bias in South Africa. *European Review of Applied Psychology, 47*(4), 297–307.

Deacon, B. J. (2013). The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research. *Clinical Psychology Review, 33*(7), 846-861.

de la Rey, C., & Ipser, J. (2004). The call for relevance: South African psychology ten years into democracy. *South African Journal of Psychology, 34*(4), 544-552.

Dlamini, S. S. (2020). *(Re)centring Africa in the training of counselling and clinical psychologists* (Doctoral thesis, University of South Africa). UNISA Institutional Repository. http://hdl.handle.net/10500/27614

Duckworth, A. L., Steen, T. A., Seligman, M. E. (2005). Positive psychology in clinical practice. *Annual Review of Clinical Psychology, 1*, 629-651.

Ennion, L., & Rhoda, A. (2016). Roles and challenges of the multidisciplinary team involved in prosthetic rehabilitation, in a rural district in South Africa. *Journal of Multidisciplinary Healthcare, 9*, 565.

Fanon, F. (1952). *Black skin, white masks.* Grove Press.

Foucault, M. (2004). *Society must be defended: Lectures at the College de France, 1975–76*. Penguin.

Foxcroft, C. D. (1997). Psychological testing in South Africa: Perspectives regarding ethical and fair practices. *European Journal of Psychological Assessment, 13*(3), 229–235.

Freire, P. (1993). *Pedagogy of the oppressed. Revised ed.* Penguin Books.

Gopalkrishnan, N. (2018). Cultural diversity and mental health: Considerations for policy and practice. *Frontiers in Public Health*, *6, 1-7.*

Gregorian, C. (2005). A career in hospital social work: Do you have what it takes?. *Social Work in Health Care, 40*(3), 1-14.

Hays, P. A. (2008). *Addressing cultural complexities in practice: Assessment, diagnosis, and therapy (Vol. 10, pp. 11650-000)*. American Psychological Association.

Johnson, J., & Wood, A. M. (2017). Integrating positive and clinical psychology: Viewing human functioning as continua from positive to negative can benefit clinical assessment, interventions and understandings of resilience. *Cognitive Therapy and Research, 41*(3), 335-349.

Kagee, A. (2014). South African psychology after 20 years of democracy: Criticality, social development, and relevance. *South African Journal of Psychology, 44*(3), 350–363.

Kessi, S., & Kiguwa, P. (2015). Social psychology and social change: Beyond Western perspectives. *Papers on Social Representations, 24*(1), 1-11.

Kottler, A., & Swartz, S. (2004). Rites of passage: Identity and the training of clinical psychologists in the South African context. *South African Journal of Psychology, 34*(1), 55-71.

Laher, S., & Cockcroft, K. (2013). Current and future trends in psychological assessment in South Africa: Challenges and opportunities, In S. Laher & K. Cockcroft (Eds.). Psychological Assessment in South Africa: Research and applications (pp. 535–552). Wits University Press.

Lazarus, S., Baptiste, D., & Seedat, M. (2009). Community counselling in African contexts. *Journal of Psychology in Africa, 19*(4), 463-469.

Leach, M. M., Akhurst, J., & Basson, C. (2003). Counseling psychology in South Africa: Current political and professional challenges and future promise. *The Counseling Psychologist, 31*(5), 619-640.

Liberman, R. P., Hilty, D. M., Drake, R. E., & Tsang, H. W. (2001). Requirements for multidisciplinary teamwork in psychiatric rehabilitation. *Psychiatric Services, 52*(10), 1331-1342.

Long, W. (2013). "Market relevance", "social relevance", and psychology in South Africa. *South African Journal of Psychology, 43*(4), 434-444.

Long, W. (2016). *A history of 'relevance' in psychology*. Palgrave Macmillan.

Long, W. (2021). *Nation on the couch: Inside South Africa's mind*. Melinda Ferguson Books.

Macleod, C. (2004). South African psychology and 'relevance': Continuing challenges. *South African Journal of Psychology, 34*(4), 613–29.

Macleod, C., & Howell, S. (2013). Reflecting on South African psychology: Published research, "relevance" and social issues. *South African Journal of Psychology, 43*(2), 222-237.

Maldonado-Torres, N. (2007). On the coloniality of being. *Cultural Studies, 21*(2-3), 240-270.

Mbembe, A. (2015). Decolonizing knowledge and the question of the archive. [Lecture transcript].

Mills, C., & Fernando, S. (2014). Globalising mental health or pathologising the Global South? Mapping the ethics, theory and practice of global mental health. *Disability and the Global South, 1*(2), 188-202.

Muchemi, S. K. (2018). *Embodiment, Power, Fear, and the Other: Dimensions of Spirituality in (Sub-Saharan) African Psychology.* Fuller Theological Seminary, School of Psychology.

Naidoo, A. V. (1996). Challenging the hegemony of Eurocentric psychology. *Journal of Community and Health Sciences, 2*(2), 9-16.

Naidoo, A. V. (2000). Community Psychology: Constructing Community, Reconstruction Psychology in South Africa. Inaugural Lecture. University of Stellenbosch.

Naidu, T. (2015). Mental status extrication (MSE). *Medical Humanities, 41*(1), 5.

Naidu, T., & Abimbola S. (2022). How medical education holds back health equity. *Lancet, 400*(10352), 556-557.

Nguyen, D. (2019). Mapping knowledge domains of non-biomedical modalities: A large-scale co-word analysis of literature 1987–2017. *Social Science & Medicine*, *233*, 1-12.

Nyamnjoh, F. B. (2012). Blinded by sight: Divining the future of anthropology in Africa. *Africa Spectrum, 47*(2/3), 63-92.

Okazaki, S. (2000). Assessing and treating Asian Americans: Recent advances, In I. Cuéllar & F. A. Paniagua (Eds.), *Handbook of multicultural mental health* (pp. 171–193). Academic Press.

Oppong, S. (2022). Indigenous psychology in Africa: Centrality of culture, misunderstandings, and global positioning. *Theory & Psychology, 32*(6), 953–973.

Painter, D., Kiguwa, P., & Böhmke, W. (2013). Contexts, continuities and conundrums: Reflections on the current state of critical psychology in South Africa. *Annual Review of Critical Psychology, 13*, 849-869.

Pasche, S. C. (2020). *Attempted suicide among South African adolescents living in a low resource environment: Contested meanings, lived experience, and expressed support needs* (Doctoral dissertation, Stellenbosch University). SUNScholar. http://hdl.handle.net/10019.1/109223

Patel, V., Araya, R., Chatterjee, S., Chisholm, D., Cohen, A., Silva, M. D., Hosman, C., McGuire, H., Rojas, G., & van Ommeren, M. (2007). Treatment and prevention of mental disorders in low-income and middle-income countries. *Lancet, 370*(9591), 991-1005.

Pillay, A. L., Ahmed, R., & Bawa, U. (2013). Clinical psychology training in South Africa: A call to action. *South African Journal of Psychology, 43*(1), 46–58.

Pillay, A. L., & Johnston, E. R. (2011). Intern clinical psychologists' experiences of their training and internship placements. *South African Journal of Psychology, 41*(1), 74–82.

Pillay, A., & Kramers-Olsen, A. (2014). The changing face of clinical psychology intern training: A 30-year analysis of a programme in KwaZulu-Natal, South Africa. *South African Journal of Psychology, 44*(3), 364–374.

Pillay, A. L. (2017). Advancing community psychology: a Special Issue of the South African Journal of Psychology. *South African Journal of Psychology, 47*(4), 419-420.

Pillay, S. R. (2017). Cracking the fortress: Can we really decolonize psychology? *South African Journal of Psychology, 47*(2), 135-140.

Pillay, S. R., Naidu, T., & Geils, C. (2018). Re-imaging our careers in post-apartheid public psychology: A collaborative autoethnography. *Psychology in Society, 57*, 181-98.

Pretorius, G. (2012). Reflections on the scope of practice in the South African profession of psychology: A moral plea for relevance and a future vision. *South African Journal of Psychology, 42*(4), 509–521.

Ratele, K. (2017). Four (African) psychologies. *Theory & Psychology*, *27*(3), 313–327.

Rochat, P. (2006). What does it mean to be human? *Journal of Anthropological Psychology, 17*, 48-51.

Saad, M., de Medeiros, R., Mosini, A. C. (2017). Are we ready for a true biopsychosocial-spiritual model? The many meanings of "Spiritual". *Medicines (Basel), 4*(4), 79.

Seedat, M., & Suffla, S. (2017) Community psychology and its (dis)contents, archival legacies and decolonisation. *South African Journal of Psychology, 47*(4), 421–431.

Sher, D, & Long, W. (2012) Historicising the relevance debate: South African and American psychology in context. *South African Journal of Psychology, 42*(4), 564-575.

Sloan, T., & Garcia, M. (2018). Pleasure as a form of liberatory practice. In N.J.L. Brown, T. Lomas, & F. J. Eiroa-Orosa (Eds.), The Routledge international handbook of critical positive psychology (pp. 395–404). Routledge.

South African Department of Health. (2008). *Health Professions Act, 1974: Regulations defining the scope of the profession of psychology*.

Suffla, S., & Seedat, M. (2004). How has psychology fared over ten years of democracy? Achievements, challenges and questions. *South African Journal of Psychology, 34*(4), 513–519.

Van Niekerk, J. P. (2009). HPCSA: A mess in the Health Department's pocket. *South African Medical Journal, 99*(4), 203.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings.* Routledge.