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Black Students' Experiences of Training at a 'White' Institution

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One of the challenges for transformation in the mental health field in South Africa is to train more black psychologists in order to meet the growing need for accessible and appropriate services for all people. Under apartheid, white people benefited from a fairly well established health infrastructure, while black people had little access to a whole range of services including mental health. Not surprisingly this pattern was duplicated in the access of black people to psychological training. In 1989, there were fewer than 20 black registered clinical psychologists in South Africa, in spite of the fact that over 80 per cent of the population is black. Numbers of black clinical psychologists who are currently registered are not available but many training institutions report an under-representation of black people amongst their students. In this chapter, we discuss our experiences as black clinical psychology trainees at a formerly white university. The issues surrounding the training of black clinical psychologists in a historically 'white' environment are multiple and complex (Kleintjes & Swartz, 1996; Mokutu, 1998). We focus here on issues from our personal experiences of transformation in a changing institution against the background of broader changes in psychology and in the society as a whole.

We were asked at the end of our first year of training if we would write a paper outlining our experiences and impressions of being black in a clinical psychology training programme. The purpose was to explore and document some of the issues that might affect other students in our situation. It is now

three years since we wrote the paper and, in currently reviewing and thinking about it, we were astonished to notice a major oversight in our thinking at the time. Perhaps the formulation of the topic itself and our acceptance of it reflected as much about our experiences as did the issues we ended up writing about. We were three students who were all broadly classified as being black and we wrote the paper without considering the very significant differences between us and the ways in which these differences had impacted upon our training experiences. For example, apart from any differences which we have in terms of personality, there are broad differences in life experience. Two of us grew up in South Africa and one of us, born of South African parents, grew up in exile. One of us speaks English as a first language, one of us Afrikaans and the other Sotho. Two of us, in terms of apartheid legislation, were classified 'Black', one of us was classified 'Coloured'. One of us is male, two are female. We have different religious and class backgrounds, and differ moreover as to whether we had rural or urban upbringings.

Why, then, did we so readily (and unconsciously) agree to being labelled 'the black students', and why, by implication, did our lecturers label us in this way? In order to answer this question we need to consider some South African history. The apartheid system resulted in the formalisation of difference at the most absurd levels. In fact, what may be termed the 'manufacture' of difference was crucial to the ideological underpinnings of the system (Kottler, 1996). For example, black South Africans of African origin were classified into different 'tribes' regardless of whether they saw these tribes as meaningful in their own self-classification. What this ensured though was that in most cases the individual black 'tribes' were numerically smaller than the white population – the ideal basis for a 'divide and rule' situation. Under the terms of the *Population Registration Act* – a cornerstone of apartheid – people of mixed or Eastern origin were classified under the general rubric of 'Coloured', with various subclassifications including the infamous 'Other Coloured' – for people who could not fit into another category. There were no such divisions amongst whites in spite of the fact that whites in South Africa are of diverse origins in themselves, the most notable divide being between English speakers and Afrikaans speakers.

In response to this strategy of division and control, movements such as the African National Congress (the current ruling party) emphasised commonalities amongst oppressed groups in an attempt to create a united opposition. At the height of the struggle against apartheid, many disenfranchised people resisted the apartheid classifications and described themselves as generically 'black', thereby implicitly forging common political purpose. The term 'coloured', in particular, came to be rejected in progressive circles, and it was common to hear of people being referred to as 'so-called coloured'.

Interestingly, now that South Africa is a democracy, there is greater freedom to explore both the similarities and differences between people, which in the past seemed to be a dangerous kind of conservatism. There are debates about differences, and especially about the question of coloured identity. We began professional training in clinical psychology in 1996, at a time when the ideology of nation building after a traumatic past was very strong (Nuttall &

Coetzee, 1998). Three years later we have sufficient distance from apartheid to allow ourselves to admit that the thread of 'blackness' which held us together – necessary and important though it was in the broader process of transforming South African psychology – may be more frayed than we had assumed.

The process of reworking this chapter for publication, therefore, has been interesting in that it has enabled us to focus both on what is common in our experience and on what divides us. The tension between these will be seen throughout, but particularly in a fundamental issue facing black trainees at our university. It is with this issue – that of 'merit' – that we start our discussion.

Selection for training – merit or obligation?

The university at which we trained is vocal about its commitment to contributing to changing the racial profile of psychologists in South Africa. This commitment immediately raises the question for all black trainees of whether they were accepted on merit or to fulfil an implicit racial quota. In this context, it is a generic 'blackness' which may be valued, not particular qualities of individuals. Though the trainers are clear that they do not accept people whom they regard as unsuitable for training, the experience for trainees is – as it was for us – inevitably one of questioning the motivation for their being selected. In our experience, there is something of a contradiction between the university staff's referring frequently to the fact that they are pleased to be training so many black students, and their insistence to us that we were selected on our own merits. Though it may be true both that selection is conducted on merit and that there is pride in the number of black students selected, the reluctance amongst staff to talk openly with students about the precise impact of these issues on the selection process has helped to fuel fantasies on our part. These fantasies are of not being good enough, of not standing on our own merits, and of being 'tokens' in an organisation's attempts to transform itself.

Fantasies such as these are inevitably elaborations of the fantasies experienced by all trainees in the mental health field (Kleintjes & Swartz, 1996). Becoming a clinical psychologist often seems to involve a process of increasing awareness of areas of lack of skill (Kottler, 2000). For very successful people accepted into training through a highly competitive selection process, this experience of not being skilled may be very difficult to tolerate and may fuel feelings of incompetence. For black trainees these fantasies are filtered through our racial socialisation, and through our lived experience of racism.

We all felt that having been accepted into the course was part of a blanket affirmative-action policy. Rationally, we could see that, for example, one of us was the most experienced of all the trainees (regardless of colour) in the mental health field, having extensive experience as a social worker. Another of us had had the unique experience of teaching handicapped children, and the third had experience of trauma, exile and return – key mental health issues in contemporary South Africa. Notwithstanding this, there was constant internal pressure to perform well – to prove to staff and ourselves that we were worthy of being chosen. This

experience is similar to that described by a participant in a research study into the experiences of black students undertaken by one of us (Mokutu, 1998, p.47):

> *I think there's always that thing there, ehm, you don't want to be perceived as a good black... instead it makes you to have more of a drive to work harder... people see that you are competent – you did not get there because you are black.*

Kleintjes, in her study of black trainees in clinical psychology, found that, though some black trainees felt that they were accepted into the course on the basis of merit, many others felt 'not good enough' (Kleintjes & Swartz, 1996). In terms of coping with these feelings some black trainees found it useful to discuss the issue with an empathic supervisor. They also found that when they began working as psychologists and seeing satisfactory results in their efforts with clients they began to develop more confidence in their abilities.

A further complication in black trainees' experiences of themselves in the course is that they still, at this stage, constitute a minority in the discipline of clinical psychology – and often within the university itself. This, together with the fact that there is such a strong desire on the part of the institution to change the racial balance of psychologists, means that each black student seems to attract a disproportional weight of attention. To some extent every black student comes to symbolise black students in general. Everything that is done, be it good or bad, by a black trainee, cannot but be scrutinised through a racial lens. In this context, it can become difficult for students to hold their successes and their failures, and even their opinions, as uniquely their own. This is clearly an issue important for supervision, to which we turn in the next section.

The racial dynamics of supervision

Because there is an historical backlog of trained black clinicians, the majority of supervisors of black trainees are white, though this should change with time. As Kleintjes (1991) notes, supervision may play a role in ameliorating some of the trainees' doubts about their place in the organisation. Supervision potentially provides an important forum for trainees to be able to discuss racial issues in a matter-of-fact way (Kleintjes & Swartz, 1996). This forum can subvert the traditional hierarchies of knowledge between supervisor and trainee, as a respondent to Mokutu's (1998, p.53) study shows when black trainees are asked to fill in the gaps in the cultural and experiential knowledge of white supervisors:

> *... but I think in terms of knowledge of some of the dynamics, that I felt that in most cases I was the one who enlightened the supervisor in terms of saying that this does not work in this context, and fortunately I had people who were quite open.*

Sometimes, however, racial and other issues of power can be inadequately taken into account by supervisors. During our training, a black male client who was seeing one of us expressed doubts about the clinician's competence and demanded to see his 'superior'. The supervisor,

a very experienced and eminent white male clinician, agreed to meet with the client. In introducing himself he made clear his status position as supervisor. The trainee clinician felt that this further undermined the client's perception of him. In any situation the interference of a supervisor in this kind of way might produce more difficulties than it resolves. In this case the particular experience was overlaid by racial dynamics that created discomfort for the trainee. In spite of the fact that the client was also black, it felt for the trainee as though the elderly white supervisor's intervention highlighted his relative immaturity and repeated the hierarchy of white in relation to black under apartheid. The issue of this supervisor's using his power in this particular way is not, of course, solely about questions of race. Had all the players in the scenario been white (or black) there could still be questions raised about whether the supervisor's power was being used appropriately. The context of racial politics in a changing South Africa does, however, demand extra attention to these issues in all the teaching hierarchies.

Racial dynamics within the clinical team

When trainees and supervisors work together in community and consultation work, the clinical teams are commonly racially mixed. As this form of work usually brings together a number of clinicians on a single project, racial dynamics within the team itself, as well as with the clients, are highlighted. For instance, we found that even black staff from non-governmental organisations tended to direct conversations towards our white colleagues or supervisors. This may be indicative of assumptions around who has power, authority and knowledge or may express an envious dismissal of the contribution of another black person. It would be too easy, though, to ascribe all these difficulties simply to issues on the part of clients. Van der Walt (this volume) has discussed the ways in which clinicians may seek to distance themselves from clients they see as similar to themselves – she terms this phenomenon 'too close for comfort'. It is possible that we ourselves communicated some discomfort to the clients, or were implicitly portraying the lack of confidence in ourselves which we discussed earlier. Equally, though, what we observed could be an artefact of the personality dynamics amongst us and our colleagues, with race in this case being secondary or even irrelevant. Because of the political dimensions of the racially changing mental health scene in South Africa, however, it is almost impossible to ignore the way in which race colours our experiences and perceptions of clinical work.

Language

It is hardly surprising that in a divided society such as South Africa, language, as a concrete manifestation of difference, has assumed both political and emotional weight. In the interests of making services as accessible as possible to the public, black trainees are often assigned black clients who speak the same language. This issue, however, introduces its own complexity. One of us (who is Afrikaans-speaking – the predominant language amongst the coloured community in the Western Cape) had the experience of an initial telephone interaction with a coloured family whose first language was Afrikaans but who

lived in an English-dominated suburb in Cape Town. They were experiencing obvious difficulty communicating in English over the telephone but were offended when the trainee offered to communicate in Afrikaans. Their refusal to speak Afrikaans, which was clearly their home language, made communication extremely difficult and hampered the intervention. To make matters more complex, the child's difficulty with English was part of the presenting problem. It seems that the parents were prepared to struggle with English. This may have been based upon a desire to portray to the clinic a particular image of themselves – English is considered the highest status language in South Africa amongst some groups. The clients may also have felt that they needed to present themselves as English-speaking in order to receive help from a historically English-medium institution.

Complexity around language and race was also illustrated when Xhosa-speaking clients commonly assumed that black clinicians would invariably be able to speak their language. Xhosa is the dominant African language in the Western Cape, but the university draws its students from the entire country and from many speech communities. One of the authors grew up in exile and speaks English as a first language. She is also fluent in Tswana but not in Xhosa. This situation led to her Xhosa-speaking client asking questions about where the trainee came from and where the trainee's parents lived. The trainee felt forced to explain her situation in order to avert the client's potential criticism that she was trying to distance herself from her culture – a politically loaded action. The trainee also found herself making an attempt to speak Xhosa whenever she could so that she would be seen to be making an effort and not trying to be too 'English'. This, together with her answering questions about her origins and letting her clients know that she did speak another African language, seemed to make her clients feel more at ease. The issues of exile and return are especially painful for many South Africans, including those who did not go into exile, and who may experience returnees as having both benefited from living elsewhere and having abandoned their African identity (Rankoe, 1999).

In some instances, even where there was language commonality between clinician and client, the implicit language bias of the biggest body of psychological knowledge created difficulties for black trainees. One of us who is Sotho-speaking found working with Sotho-speaking clients difficult at times because he could not always find words in that language to describe particular psychological phenomena, even though he found it more comfortable to work in his native language. For instance, the trainee could not find a Sotho word synonymous with sexuality and had to replace this with English terminology.

The area of language highlighted for us a particular example of the issues we raised at the outset of this chapter. Just as there have been unwarranted assumptions about the sameness of all black trainees, so it could be erroneously assumed that tensions around language disappear when there is a matching of client and clinician by race and language. In fact, the issue of language is complex and painful everywhere, but especially so given South Africa's political history (Swartz & Drennan, 2000).

Cultural conventions and the ambiguities of identification with black clients

Psychological practice, even in South Africa, is primarily a Western product with certain conventions and ways of understanding individuals, society and professional expertise. Many notions held dear by psychotherapy – for example, those of individual autonomy and choice – are not universal, and are not necessarily familiar to all African people (Swartz, 1998). Similarly, Western culture fosters the idea that clinical expertise may exist apart from other knowledge, such as the gaining of wisdom through experience. Psychology, thus, allows for a situation in which a younger person may act as a healer and advisor to an older person by virtue of their specific training. This contrasts strongly with many African indigenous views whereby it is the elders who dispense wisdom and advice. Similarly, the boundaries which psychologists set around their work, which may be foreign even to other professionals in Western culture, may appear more bizarre to people accustomed to emotional healing taking place in a public context.

In therapy with a middle-aged black woman, one of the authors was perceived by her client to be a younger daughter, and was initially addressed as '*nono*' (baby). On a number of occasions, the client, going against clinical convention, invited the trainee to her home for a meal. The client had longed for a daughter but had not had one, and this exacerbated the trainee's dilemma about how to respond sensitively to the client's perception of her. The trainee felt unsure as to whether she should maintain her therapeutic stance or show respect and appreciation for an older person as would be expected in her own and her client's culture. With the help of supervision, the trainee decided to adhere to her therapeutic stance and she communicated to the client her reasons for maintaining boundaries. Later in the therapeutic relationship, the client ceased to address the trainee as '*nono*', and also stopped dinner invitations. In this later phase of the treatment, the client became more open and was able to discuss sexual matters which would usually not be discussed across age boundaries. As the therapy developed, and either in spite of or because of the fact that the trainee had broken 'traditional' rules, the client came to develop pride in the fact that the therapist was African. She also felt able to discuss issues which she felt white people would not be able to understand – such as traditional healing rites.

Many black clients seemed to identify with their black clinicians, particularly around issues of feeling marginal in a white-dominated context. An adult black female client asked one of us to turn off the tape recorder (routinely used for supervision purposes) when she spoke of certain traditional healing methods that she had undergone in childhood. She did not want the trainee's white colleagues to hear her speak about these healing methods as she felt that they would not understand and would look down on her because of her beliefs. This kind of situation creates conflict for the clinician in balancing the patient's interests against that of her supervision.

Identification between client and clinician can be used in many ways, including defensively. A black male client would repeatedly say to one of us, 'You know what it is like – you have

also experienced oppression'. In this case, it seemed to the therapist that race was being used by the client to project blame onto white people and to deflect from his own responsibility for his difficulties. In the post-apartheid context, with racial issues a source of pain for most South Africans, there is something particularly attractive to a black clinician in participating in a collusion with a client when the primary issue is racial. Sensitive supervision is important for trainees to help them not to be drawn into this.

Power and identity in work with white clients

The dynamics of black trainees working with white clients are also complex, partly because of the subversion of the expected power relationships between black and white people still prevalent in post-apartheid South Africa. The clinic does not have a policy of racial matching of clients and clinicians, though there are attempts at linguistic matching where possible. The clinic also has a policy not to allow clients to choose clinicians on the basis of race. Interestingly, there has, in fact, been little need to refer back to this kind of policy. By and large, race has seldom been placed overtly on the agenda by a client. The only time during our training that a client overtly complained about the race of a clinician was when a black woman client refused to see a black male clinician as she had experienced abuse at the hands of black men. This particular example probably has more to do with localised gender politics than with race in itself.

There are many possible reasons why white clients have seldom refused to see black clinicians (or why, within the divisions of black South Africa which we discussed earlier, coloured patients have not refused to see African clinicians or African patients to see coloured clinicians). One important factor is the scarcity of affordable child mental health services (the clinic charges according to client income and is often far cheaper than even the cheapest state service). It may also be that it is not politically acceptable for clients to object to clinicians on racial grounds – for a South African to be accused of racism at this historical time would be especially shameful.

Racial feelings of white clients towards black people will of course surface in the work in indirect ways. During our training, one of us, the only coloured, Afrikaans-speaking woman on the course, had an interaction with a white man who had brought his child to the clinic. He seemed quietly angry and resistant to taking help from the clinician. The man was acutely aware of his being a white working-class male having to accept help from a middle-class black woman, and the work required both sensitivity to his position and an awareness of the possible impact of racial countertransference feelings.

Many people who seek psychological help feel vulnerable, powerless and at the margins of mainstream society. On occasions white clients have mentioned to us that they feel more comfortable seeing black clinicians because they assume we understand, as black South Africans, what it means to feel marginal and powerless. Though there are obvious advantages to this perception in that some clients immediately feel more comfortable with us, there are complexities too. For example, these clients may feel that by working

with black clinicians they can avoid confronting the difficulties they may have with authority figures. There may also be an implicit perception of the black clinician as damaged, which has implications for how robustly the client is able to engage, especially with the negative and more painful aspects of the transference and also within the work more generally.

Liminality and licence in interactions with white trainees

The training environment is a transitional space where new identities are assumed and integrated (Kottler, 2000). It was this liminal space, perhaps, which enabled the exploration of racial and other differences in our first year of training. Mostly, these issues were explored through play and humour. For instance, our racially mixed class developed a light-hearted game whereby persons of one race could assume 'honorary status' as a person of another race. Racial jokes, which might in many contexts be viewed as offensive, were commonplace and generated much amusement. It is, of course, possible that the use of play and humour were not only a way of safely exploring and acknowledging difference but were also a way of defending against the very painful feelings associated with that difference. There were also jokes amongst the black students about class differences, and about the rural-urban divide.

In a serious conversation with one of our white colleagues at the end of our first year of training, in which we talked and asked questions about experiences and differences based on race, we wondered why it was that serious talk about such issues had only been possible at the end of the year. This might provide us with a clue as to the protective function of humour and play.

Conclusion

The experience of being a black psychologist in a historically white training programme is clearly going to be different for each individual and each group setting. However, what is clear is that the dynamics of race in whatever form they take are a constant feature of psychological work in post-apartheid South Africa. Psychology has not always taken sufficient cognisance of these kinds of issues in clinical work. However, if we do not deal with racism, it operates below the surface as a powerful and even dangerous influence on our relationships with our clients and our colleagues. As Young puts it in relation to the enterprise of psychoanalysis specifically:

> *We come into the world and into psychoanalysis full of horrid feelings, and the task of the parent, therapist, group, or political movement is not to pretend that they are not there or to provide a corrective emotional experience, but to feel with them, to suffer the truth, to contain and detoxify them and to move from love and hate to knowledge.*
> *(1999, p.2)*

The only way through this is to create a space in which these difficult issues can be spoken about. In order to achieve this we need to acknowledge our painful past and the way in which this still lives on in each one of us. Psychological training always involves thinking about emotional experience. It is, however, important that our discomfort in dealing with these things does not compel us to screen out the political roots of much of what constitutes our emotional worlds.

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