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PSYCHOLOGICAL EXPERTISE AND GOVERNMENTALITY IN DEMOCRATIC SOUTH AFRICA: A TRACER STUDY OF MASTERS GRADUATES FROM UKZN

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Abstract.
Foucault (1978) proposed that scientific discourses can become objects for political practice. Following from this, Nikolas Rose has elaborated how psychological expertise is implicated in the government of conduct in liberal democracies. In this study these ideas are explored in the local South African context, paying particular attention to post-apartheid imperatives to extend psychological services to socially relevant spheres. The sample was drawn from psychologists who graduated from UKZN (University of KwaZulu-Natal) between 1993 and 2003/4. Data were collected about problems that psychologists see in their daily working environments, their causes and the practices used to solve them. Findings indicate that psychologists deal with a range of traditional psychological problems as well as diverse social/structural problems. Individualised interventions, encouraging self-regulation, dominate both these groups of problems, including interventions focussing on the community and social change. We argue that psychological expertise as a tool for government finds its limits in conditions of extreme social and economic hardship.

Key words: *governmentality, psychological expertise, relevance, self-regulation' community, developing world*

During apartheid the relevance of psychology was vigorously debated in South Africa. In the 1980s isolated voices began "to acknowledge and express their protest, anxiety and sometimes shame" about the profession's relevance (Richter et al, 1998:1). Psychological practice was criticized for "actively supporting" apartheid ideology as well as providing tacit support for the apartheid regime by its uncritical, neutral stance (Dawes, 1985); and psychology was accused of being inaccessible to the majority of South Africans. Both clinical psychologists (up to 98.5% in 1984) and their patient population (up to 92.8%) were predominantly white (Bassa & Schlebusch, 1984; Manganyi & Louw, 1986). Thus, whilst white affluent areas were well serviced, in the public sector, where 80% of the population were serviced, mental health services were found to be "lamentably inadequate" (Kriegler, 1993: 64).

In addition to criticisms about the profession's narrow demographic reach, concerns were also raised against its culturally foreign, individualistic and decontextualised approach (Holdstock, 1981). Psychology, its training and constructs were criticised for being nested in a Western worldview of the person, largely inapplicable to the African context. Post-apartheid psychology has sought to respond to these criticisms and make the profession more relevant.

De la Rey and Ipser (2004:548) claim that psychology's relevance in the post-apartheid period is evident by its responsiveness to government-led initiatives to "promote social and economic development". The race and gender representation of psychology students and practitioners has begun to change; the goals of psychological practice have been realigned in terms of post-apartheid policy imperatives (de la Rey & Ipser, 2004). Initiatives to democratize the profession have sought to extend its reach to all citizens, in particular the "historically unserved", "underserved" and "oppressed" (Duncan & Lazarus, 2001:3). Community psychology, in particular, has been valorised as a means for social and political action, for providing "culturally and contextually accessible services to marginalised and vulnerable groups" (Seedat, McKenzie & Stevens, 2004:597; Pretorius-Heuchert & Ahmed, 2001). Programmes, such as the BPsych and community service, have been promoted in terms of the relevance of psychological practice.

In this article the application of psychological expertise in the post-apartheid context is investigated. We do this by way of an analysis of the problems faced by newly graduated professionals, and the methods they use to intervene and address these problems. Whereas psychology is generally viewed as a helping discipline, we adopt a theoretical paradigm which suggests that psychology is also implicated in government. Following Rose (1990, 1996a), we propose that the profession has flourished in South Africa because its expertise has become a key tool for liberal and indirect forms of governing the conduct of citizens. However, on the basis of our investigation, we suggest that psychological expertise as a form of governmentality may find its limits in the impoverished context of the developing world.

Rose's analysis builds on the Foucauldian concept of governmentality, described as "a form of activity to shape, guide or affect the conduct of some person or persons" (Gordon, 1991:2). A central problem for government in liberal democracies is to treat people as free and autonomous agents whilst realising the ideals of "order, security, welfare, the population and submission" (Dean, 1994:185). According to Rose (1993:285), political rule installs and empowers a variety of professionals, "investing them with the authority to act as experts in the device of social rule".

Psychology provides an ethical base for governing. If government involves acting on "the relations of the individuals that constitute a population", it is dependent on knowledge of the characteristics of what is to be governed (Rose, 1990: 6). The technology of psychology, such as a psychological test or a psychodynamic theory of marriage relations, allows individuals' inner worlds to be known, predicted and managed. Human subjectivity can enter into the calculations of authorities and populations.

Psy-expertise also provides the specific techniques for governance. Technologies/ techniques of the self are "models proposed for setting up a relationship with the self" in which subjects of psychology are encouraged to scrutinise and evaluate their personal experiences, emotions and feelings in relation to psychological images, such as fulfilment and autonomy (Rose, 2000:16). This may involve attending to different parts of the self, ways for disclosing and evaluating the self or techniques for curing the self (Rose, 2000). By intervening at the level of subjectivity "the new found capacities and attributes" are exercised freely. This ethic of competent autonomous selfhood allows psychology to gain "social power" in liberal democracies as it promises to restore "citizens" without impinging on their right to autonomy and freedom, but rather encouraging citizens to govern themselves.

Rose's analysis has focussed almost exclusively on developed liberal democracies of the West, notably the UK and USA. South Africa is distinct both as an African country and as a newly developing liberal democracy where relations of power have shifted from a repressive undemocratic mode of functioning. This provides an opportunity to explore a contrasting case of the application of psychological expertise. Can a study of the "proliferation of practical knowledge of individual and social conduct" in South Africa help us understand "the 'nature of power' in contemporary liberal societies" (Rose, 1993:284)?

In this article we investigate how features of conduct are "constituted" as problematic and "shaped" into phenomena requiring psychological intervention. We attempt to understand how experts "act upon" psychological problems to improve them (Rose & Miller, 1994:30). Data collection thus focussed on:
1. How psychological problems are constructed as an object for intervention
2. What techniques/practices are made possible by this construction
3. Investigating the link between these practices and the Rosean argument on governmental authority.

METHOD.

Instruments.

Information was collected by means of a questionnaire about the kinds of problems that psychologists encountered in their day-to-day practice (Appendix 1). After providing demographic information (Section 1), participants were asked to describe the "two most common *problems* they face in their work context" (Section 2). In Section 3 we wanted to know how the participants themselves understand the problems. In this Section, participants were asked to discuss what they thought the "basic *cause* of each problem is"; and in Section 4 participants were asked to describe the "practices" that they use in their work to *manage* the chosen problems.

Procedure.

Questionnaires were emailed and/or posted to 224 Masters Graduates from the University of KwaZulu-Natal (UKZN) who were enrolled between 1993 and 2003/4, and who were then working in South Africa. This university was selected due to its geographical accessibility. An added advantage of selecting UKZN was that all five registration categories stipulated by the HPCSA are represented (clinical, counselling, educational, industrial and research). After an initial low response rate, participants were contacted telephonically to address any concerns they may have had with regards to the questionnaire. In total 70 questionnaires were returned, representing a response

rate of 31.25%. This response rate is not uncommon in the chosen method of data collection. It was not possible to determine whether particular gender or racial categories were proportionally more likely to respond as these characteristics were not known in the original population frame. However, there were proportionally fewer responses from those who had graduated earlier, with 70 % of respondents enrolled in the last four years (2000-2003/4) of the ten-year period.

Participants.
Fifty-seven (81.4%) participants were female and 13 (13.4%) were male; 46 (65.7%) were white, 14 (20%) were black and 10 (14.3%) were Indian. The skewed race and gender composition of the sample reflected the demographic profile of psychologists in the country as a whole (Richter & Griesel, 1999; Pillay & Kramers, 2003).

Twenty-eight participants were counselling psychologists (40%), followed by 17 (24.3%) research psychologists, 16 (22.9%) clinical psychologists, 5 (7.1%) industrial psychologist and 4 (5.7%) educational psychologists. Compared to the original population frame, there was an over-representation of research psychologists, and an under-representation of clinical psychologists. Thirty-seven (31.7%) participants worked in university settings, followed by 17.8% in government hospitals, 15.3% in business, 15.3% in NGO settings,16.1% in private practice/ mixed private practice and other settings and 4% in school settings.

DATA ANALYSIS.
The data from the questionnaires were analyzed using both quantitative (content analysis) and qualitative methodology. Holsti's (1969) method of coding was used to prepare the data for statistical analysis. By reading through the data we developed mutually exclusive and comprehensive codes for subtypes of (1) Problems, (2) Causes, and (3) Intervention strategies.

1. Psychological Problems
The units of analysis in this study are the problems presented by the participants. A total of 118 problems were identified by participants (some gave more than one problem). Each problem was assigned a number (1 to 118) for its identification.

Holsti (1969:11) suggests that before constructing categories, the researcher should "read over a sample of his data to get a 'feel' for it". We thus began the analysis by reading through the entire sample of 118 problems a number of times in order to identify themes and develop a "classification principle".

In the initial reading, three categories of problems stood out: "clinical syndromes", in which participants described psychiatric problems, "public health" issues, which consisted of health-related issues, and "social" problems, in which participants described social and economic problems. After a number of iterations we devised a way of classifying the remaining problems into the categories reported in Table 1.

Table 1. Description of Problem codes

CATEGORY	DESCRIPTION	EXAMPLE
1. Clinical Syndrome (n=22)	A psychiatric condition from a diagnostic system (predominantly the DSM IV system).	"Mood disorders" (Problem 102)
2. Public Health Issues (n=18)	The practice of protecting and improving the health of a community.	"HIV prevention" (Problem 51)
3. Social Problems (n=16)	Practical and socioeconomic problems, including problems where current disadvantage is related to apartheid legacy.	"Financial difficulties" (Problem 111)
4. Adjustment Issues (n=17)	Involves poor adjustment to the environment. A clinical syndrome should not be indicated as the primary problem.	"Academic Problems: lack of study skills, inability to manage time" (Problem 13)
5. Assessment (n=8)	The assessment of a particular capacity for the prediction of performance on another variable.	"Career choice" (Problem 41)
6. Labour/Human Relations (n=5)	Problems dealing with the internal functioning of organisations/businesses.	"Conflict Resolution" (Problem 62)
7. Specific Issue (n=10)	Specifically identified problems (there is a trigger and no mention of a clinical syndrome).	"Sexual Abuse" (Problem 106)
8. Professional Issue (n=22)	Problem refers to a professional issue.	"Poor payment for services" (Problem 65)

2. Causes.
Participants listed multiple causes for each problem. Causes were categorised by focussing on the level at which they occurred: "individual", "interpersonal", "contextual" or "social-economic" (see Table 2). In order to compare problems with broadly social and contextual causes with problems having more traditional psychological causes (individual and interpersonal), we created an additional subcategory of "systemic causes" ("contextual" + "socio-economic").

Table 2. Description of Causes codes

CATEGORY	%	DESCRIPTION	EXAMPLE
Individual	41.5%	Located within the individual	"poor study skills"
Interpersonal	25.4%	Causes originating in the interpersonal interaction: interactions between individuals	"poor social relationships"
Contextual	56.7%	Environmental factors	"poor-person environment fit"
Socio/economic	53.3%	Broader socioeconomic causes	"apartheid legacy"
Systemic	88.1%	Contextual + socio/economic causes	

Note: Percentage adds up to >100 because each problem had an average of 2.38 causes.

3. Interventions.
Multiple interventions were listed for each problem. At a first level of differentiation, we developed different codes for the target of the intervention, distinguishing interventions aimed at individuals (for example "therapy") and those aimed at systemic change (for example "train managers to better manage conflict"). Thereafter "individual" and "systemic" interventions were subcategorised by the types of intervention described in Table 3. Examples of therapeutic interventions are "exploration of the clients intra- and interpersonal personality dynamics" (Problem 109) or "encouraging the client to talk about an experience", such as a hijacking (Problem 2). In these interventions, the client is encouraged to focus on an aspect of their subjective experience. "Directive" interventions focussed on developing an attribute in the self, such as "teaching social skills" or "anger management". These "therapeutic" and "directive" interventions reflect psychologists' use of technologies of the self as discussed in the introduction. Alongside these individual interventions, the category "social change" was of especial interest to us. These strategies were defined as interventions that aimed to eradicate the effects of apartheid, and included interventions falling under the umbrella of community psychology.

Table 3. Description of Intervention codes

LEVEL	CATEGORY	DESCRIPTION	EXAMPLE
INDIVIDUAL (N=77) **(63.5%)**	Therapeutic (n=52)	Some therapeutic modality or the importance of the therapeutic relationship	"psychodynamic therapy"
	Directive (n=44)	Mentions specific skill or information	"teach problem solving skills"
	Assessment (n=12)	Assessment of problem	"intake and assessment"
	Practical (n=4)	Practical assistance given	"lend money out of an 'emergency fund'"
SYSTEMMIC (N=65) **55.1%**	Referral (n=21)	Referral to another profession system	"refer to legal aid"
	Professional (n= 21)	Focuses on a professional issue	"obtain supervision from other psychologists"
	Social change (n=16)	Addresses previous disadvantage	"empowerment of individuals in the community"
	Systemic therapeutic (n=16)	An intervention aimed at changing the system	"establishment of an Employee Assistance scheme"
	Research (n=4)	Research as part of the intervention	"research to generate knowledge"

Note: the total number of interventions is >118 and %> 100 as each problem had an average of 2.15 interventions

Reliability.

Once the coding was completed and all codes defined, a second coder was trained to use the coding scheme. Fifteen randomly selected problems were then coded independently by the two coders. The findings were compared and deviations discussed. These discussions and deviations identified ambiguous categories and served to refine the coding scheme.

To test coding reliability, a second set of 23 randomly selected problems (20% of the sample) were coded independently by the two coders. Cohen's Kappa statistics were computed to estimate inter-rater agreement (see Table 4). Holsti (1969) argues that there is no universal standard of adequate reliability. Nonetheless, the reliability for problems and interventions was acceptable, but the low coding reliability for causes was concerning. Not only did respondents identify multiple causes per problem, but they described them on complex, overlapping ways. The coders experienced difficulties in sifting through quite complex and often contradictory explanations to identify and label

singular causes. We have taken this lack of reliability into account by focusing our analyses mainly on problems and interventions; whereas the causes are analysed primarily by qualitative means.

Table 4. Cohen's Kappa statistics

CATEGORY	*COHEN'S KAPPA*
Problem	**0.74**
Causes	
Individual	0.23
Interpersonal	0.17
Contextual	0.38
Socio/economic	0.55
Individual interventions	**0.89**
Systemic interventions	**0.82**

Note: Since causes were not mutually exclusive we could not compute overall Kappa, but computed separate statistics for each subcategory, treating them as binary variables (code present or not).

DATA ANALYSIS AND RESULTS

Chi-square analyses were conducted to examine associations between the categories; and adjusted standardised residuals were generated to identify the associated codes. A residual of greater than 1.96 (or less than -1.96) is considered significant at the level $\alpha = .05$. Low frequency counts and the rule of independence of observation prevented any analyses testing association between problem types and particular participant characteristics, such as gender or registration categories. Qualitative analysis was conducted to elaborate the relationships that emerged from the quantitative analysis and to explore "the finer nuances of meaning not captured by the coding system" (Terre Blanche, Durrheim & Kelly, 1999:326).

Problem categories and causes.

Table 2 shows that 53.3% of problems had "socio/economic" causes, 41.5% had "individual" causes, and 25.4% had "interpersonal" causes. An overwhelming number of problems (88.1%) were described as having some type of systemic cause. Four separate Chi-square analyses – one for each kind of cause – were conducted to determine whether the causes were more likely to be associated with some problems rather than others. The eight problem categories were mutually exclusive and each level of cause was treated separately as a binary category. The findings of the analysis are summarised in Table 5, each column representing a separate Chi-square analysis.

Table 5. Association between problem categories and causes

	Individual		**I/personal**		**Contextual**		**Socio/ec**		**TOTAL**
χ^2	12.223		55.484		17.236		15.193		
p	0.093		<0.0001		0.016		0.034		
df	7		7		7		7		
Cramer's V	0.322		0.686		0.382		0.359		
	N	(residual)	N	(residual)	N	(residual)	N	(residual)	
Clinical Syn	14	**(2.3)**	18	**(6.7)**	11	(-.7)	10	(-.8)	**23**
P Health	6	(-.8)	1	**(-2.1)**	9	(-.6)	11	(.7)	**19**
Social Pr	7	(.2)	0	**(-2.5)**	5	**(-2.2)**	14	**(2.9)**	**16**
Prof I	5	**(-2.0)**	2	**(-2.0)**	15	(1.2)	8	(-1.8)	**21**
Adjustment	10	(1.6)	7	(1.6)	7	(-1.4)	9	(.0)	**16**
Assesm	3	(-.2)	0	(-1.7)	8	***(2.6)***	3	(-.9)	**9**
Org/lab	2	(-.1)	1	(-.3)	4	(1.1)	1	(-1.5)	**5**
Specific	2	(-1.4)	1	(-1.2)	8	(1.5)	7	(1.1)	**9**
TOTAL:	**49**		**30**		**67**		**63**		**118**

Note: each **column** represents a **different** χ^2 testing the relationship between a level of cause and problem categories
Note: residuals shown in brackets

"Interpersonal" and "contextual" causes are treated with caution (and consequently not discussed) as expected frequencies were not large enough to satisfy statistical requirements (Lachenicht, 2002).

No significant association was found between problem categories and "individual" causes (Column 1), although "clinical syndromes" (residual = 2.3) and "adjustment" issues tended to have more "individual" causes. A high proportion of "social" (43.7%) and "public health" issues (31.6%) also had "individual" causes. A significant relationship was found between "socio/economic" causes and problem categories (Column 2). Not surprisingly, "social" problems were significantly more likely to report "socio/economic" causes. Interestingly, 43.5% of "clinical syndromes" and 56.3% of "adjustment" issues were also found to have "socio/economic" causes. Problem 72 is an example of a clinical syndrome with socio/economic (and individual) causes:
*"Depression … common issues related to their depressed mood are **poverty, unemployment** and **abusive partners** … often in **powerless** positions … dependent financially on their abusive partners … **Gender inequality** and **high levels of unemployment** … They often resign themselves to **a sense of helplessness**, which presents as symptoms of depression" (Problem 72, Depression)*.

This extract shows how a clinical problem could have causes located in the clients' socio/economic context. It would be interesting to note how interventions are constructed for problems with such multiple causes.

Problems and interventions.
Chi-square analyses were conducted to determine whether there was an association between problem type and intervention type (see Table 6). Interventions (Table 3) that did not have sufficiently large frequencies to satisfy statistical requirements were not included in the analysis.

Table 6. Association between problem categories and interventions

	INDIVIDUAL		**Therapeutic**		**Directive**		**SYSTEMIC**		**TOTAL**
χ^2	46.117		47.778		15.753		17.593		
p	<0.0001		<0.0001		0.027		.014		
df	7		7		7		7		
Cramer's V	0.642		0.653		0.375		0.396		
	N	(residual)	N	(residual)	N	(residual)	N	(residual)	
Clinical syn	21	**(3.0)**	20	**(5.5)**	13	(1.3)	10	(-1.3)	**22**
P Health	5	**(-3.5)**	2	**(-2.4)**	4	(-1.9)	13	**(2.0)**	**16**
Socio/ec pr	12	(1.0)	6	(.1)	7	(.0)	9	(.2)	**15**
Prof I	5	**(-4.7)**	0	**(4.0)**	5	**(-2.1)**	16	**(2.2)**	**20**
Adjustment	15	**(2.3)**	6	(-.2)	11	(1.9)	4	(**-2.9)**	**16**
Assesm	5	(-.4)	2	(-.9)	2	(-1.3)	4	(-.5)	**8**
Org/lab	4	(.6)	1	(-.9)	4	(1.5)	4	(1.0)	**5**
Specific	10	**(2.2)**	7	**(2.1)**	6	(.9)	5	(-.5)	**10**
	77		**44**		**52**		**65**		**112**

Note: n is < 118 as some participants did not complete this section of the questionnaire
Note: each **column** represents a **different** χ^2 testing the relationship between a type of intervention and a problem category.
Note: residuals shown in brackets

A relationship was found between problems and interventions targeted at an individual level (Column 1). Although 25% of the cells had an expected count of less than 5, the data satisfied Wicken's rule (Lachenicht, 2002). "Clinical syndromes" were significantly more likely to have "individual" interventions (residual = 3.0), as were "adjustment" (residual = 2.0) and "specific" problems (residual = 2.2). This is not surprising as these categories also tended to have more individual causes. "Public health" and

"professional" problems had significantly lower proportions of "individual" interventions (residual = -3.5, -4.7). Although no association was found between "individual" interventions and "social" problems, 75% of "social" problems had interventions targeted at an individual level.

Therapeutic interventions were differentially distributed across problem categories (Column 2). "Clinical syndromes" (residual = 5.5) and "specific issues" (residual = 2.1) were more likely to have therapeutic interventions. The relationship between problem categories and "directive" interventions was significant (Column 3). "Professional" problems had proportionally fewer "directive" interventions. "Clinical syndromes" (residual = 1.3) and "adjustment issues" (residual = 1.9) were more likely to have "directive" interventions. The relationship between problem categories and "systemic" interventions was significant (Column 4). "Public health" problems (residual = 2.0) and "professional" problems (residual = 2.2) were more likely to have systemic interventions whereas "adjustment" problems were underrepresented (residual = - 2.9). It is noteworthy that 40% of "social" problems did not have systemic interventions.

In sum, the quantitative analysis has shown that even though problems were typically described as having multiple causes, interventions predominately target individual change, with 63.5% of problems having individual interventions. This pattern of individual intervention was common both for traditional psychological problems ("clinical syndromes", "adjustment" issues, and "specific" issues), as well as "social" and "public health" problems. "Therapeutic" and "directive" interventions predominated among these "individual" interventions.

Individual interventions.
Qualitative analysis involved a close reading of responses with a view to seeing how the problems were constructed, particularly how problems were constructed as amenable to one form of intervention or another.

Earlier we showed how Problem 72 (Depression) was constructed as having multiple social ("poverty"), interpersonal ("abusive partners") and individual factors ("powerlessness"). See now how this participant describes the intervention in individualized terms:
*"**Individual psychotherapy** … **Supportive therapy, empathic** relationship. **Exploring** the various **options** available to deal with social problems and change the current situation. **Cognitive therapy** aimed at gently **challenging perceived powerlessness and blame**" (Problem 72, Depression)*.

With support and empathy, clients are encouraged to challenge their cognitions and sense of powerlessness which interferes with their ability to function. The intervention targets a subjective attribute (the client's cognitions around "perceived powerlessness and blame"), and the aim of the intervention is to mobilise the client to effect change in whatever "social problems" are present. In other words, the intervention encourages the client to become active in managing his/her situation.

A similar strategy is evident in Problem 29, constructed as a "lack of financial skill":
*"**Financial life skills**: Employees who **overextend themselves financially** … Common **financial needs** are as follows: School fees, Transport, housing, medical …" (Problem 29, Financial life skills)*.

The causes are described as follows:
"Employees living outside their means: ***Psychological issues*** *relating to financial wellbeing. Blue collar workers -* ***lack of financial education*** *and background …* ***culture*** *within which they live sustains their financial position …* ***Are the employers remunerating their employees fair****?" (Problem 29, Financial life skills)*.

Financial difficulties are constructed as the clients' lacking "financial education". The problem is framed from the perspective of the individual thus allowing the problem to become a psychological/subjective issue requiring attention. Although "culture" and unfair remuneration are also suggested as causes, the intervention is focused on the individual:
"Individual ***counsellin****g …* ***training*** *that addresses the* ***psychological issues*** *related to financial life skills ...* ***Practical training*** *with regards to methods of getting out of debt and budgeting" (Problem 29, Financial life skills)*.

The problem is framed in a way that makes "practical training" seem like a necessary solution. Talk of a "*lack* of financial skill(s)" and "employees who over-extend themselves" locates responsibility for change within the individual, who must be helped to manage their own affairs. As was the case in Problem 72, the target of the intervention is a psychological deficit – "perceived powerless and blame" – for which the individual must take responsibility. The goal of psychological intervention is to help the individual cope so that they can function autonomously. This goal of autonomy is illustrated clearly in the account of therapeutic success:
"… once employees have addressed their immediate crisis and overcome the resistance they begin to ***plan for the future*** *and some have started to make headway in reaching for* ***financial freedom****"* (*Problem 29, Financial life skills)*.

The intervention – which is coded as a directive individual intervention – encourages the participant to take ownership and responsibility of their problems by developing the necessary skills to "self-manage". The discourse of responsibility and the autonomous self is evident; clients need to "plan for the future" and obtain "financial freedom".
The concepts, theories and technologies of psy-expertise allow for problems to be "framed" in terms of subjectivity. In the above examples, poverty, unemployment and abuse (Problem 72), and financial problems of poverty and debt (Problem 29) are reframed as problems of depression, powerlessness, and blame, and problems with financial planning. As such, the problems demand psychological intervention to help individuals manage their lives. This formulation of problems legitimates interventions that do not intrude on the client's freedom or rights, but aim to restore the client as a fulfilled, happy and autonomous citizen. Psychological expertise allows individual selves to become objects of the subtle and indirect management that Rose terms self-governance.

A high proportion of social problems (75%) and public health problems (31%) were the targets of individual interventions. We now examine how a public health problem with socio-economic causes is rendered manageable by psy-expertise.
*"****Respiratory health problems*** *… caused by the indoor burning of polluting fuels such as wood, coal, cow dung and paraffin has been causally linked to respiratory health problems ... in children less than five years old. Due to* ***widespread poverty****, over half of South African dwellings are reliant on polluting fuels that are burnt in open gas fires*

or poorly maintained stoves … resulting in poor levels of indoor air quality" (Problem 52, Respiratory health problems).

The aim of psychological research is to design a behavioural intervention:
*"A **behavioural intervention** to reduce childhood exposure to indoor air pollution", parents/caregivers are trained in these interventions "until more technical solutions become available" (Problem 52, Respiratory health problems).*

The intervention aims to modify parental behaviour thereby reducing the child's risk of respiratory disease. The object of management for the psychologist is the individual subject who must be encouraged to take responsibility, to change his/her behaviour, and to act in responsible ways. What is left out of the picture is the economic reality of poverty, the lack of services, and the struggle for survival. This translation of material and economic problems into psychological ones is often explicit:
*"The type of clients I see present with serious social problems and my training enables me to conceptualise how these social factors can lead to … **psychological difficulties**" (Problem 72, Depression)*.

In the context of social and economic issues the above problems are not inherently psychological problems, as understood in the conventional sense. They are social or economic problems reframed in a way that makes them manageable by practices of psychology.

Systemic interventions.
Systemic level interventions were deemed important by our sample, with 55% of problems having systemic interventions, 13.6% of these being social change interventions targeted at the eradication of historical disadvantage. Many of these social change interventions were informed by the ideals of community psychology. Consider the following "social" problem which has a systemic intervention targeting social change:
*"**Rural development** - … the problems are many and equally important - access to land, water, sanitation, schools, healthcare facilities, recreational facilities, food security, work, finance for entrepreneurs, information, etc" (Problem 59, Rural development)*.

The participant describes multiple systemic, especially socio-economic, causes:
*"**Post-colonial chaos** in African countries … huge problems once Europeans are overthrown – like **lack of infrastructure, skills, education, health facilities, land** etc" (Problem 59, Rural development)*.

Now consider the intervention:
*"I try to get the people affected by programmes to **take ownership of the process**, be **more empowered** to say yes we do want your money, but we want to use it in a way that best suites us - not you (the donor). … I use **M&E skills and training** to set up mechanisms for communities affected by funding programmes to **self-manage** and be **self-accountable** for funds and progress with programmes. **If they don't own it - it falls on its face the minute the donor is gone**" (Problem 59, Rural development)*.

This systemic, community-based intervention aims to address the consequences of apartheid. The psychologist is self-consciously acting as an agent of change in a post-colonial context. Notice though the similarities that the intervention has with interventions targeted at the individual. The aim of the psychologist is to encourage

community members to "take ownership" of and to "self-manage" their problems. They are encouraged to be "self-accountable" for the use of funds and the progress of programmes. Emphasis is placed on self-governance and responsibility at a community level ("If they don't own it – it falls on its face the minute the donor is gone").

This theme of responsibility and ownership is also apparent in the following social problem, which involves assisting orphans and vulnerable children (OVC):
*"Due to unemployment and death there are a lot of OVC who live in **poverty** … (we) provide **training** (to the caregivers), they get to realise **they can do things for themselves**, they also get to know about the resources … **our duty is to educate the public to about steps to take** in order to assist such children and their families" (Problem 74, OVC)*.

Members of the community are trained and taught to identify and assist vulnerable children. In both of these community-based interventions, the aim is to get individual community members to take responsibility for community problems, by taking "ownership" of the problems and developing solutions. Individual community members are constructed as active agents who are held responsible for the well-being of the community to which they belong, and who have a duty to act responsibly with donor funds (Problem 59) or in relation to vulnerable children (Problem 74). Techniques, such as empowerment and training, not only activate the community members awareness of themselves and their responsibilities to manage their communities, but also provide them with the skills to achieve this.

The limits of psy-expertise.
A number of participants expressed concern about the relevance of their training for problems encountered in their professional work. In particular, they argued that the practices of psychology do not fit the demands of problems encountered in contexts of extreme social upheaval and economic deprivation. Problem 39 (HIV intervention) and Problem 1 (Depression) are instances of such challenges:
*"… it becomes **increasingly** difficult to **provide therapy** to clients who come from **disempowered/impoverished** backgrounds as their first priority is basic survival" (Problem 39, HIV intervention)*.

*"Depression is hard to heal completely because it is so often inextricably linked to the client's **external circumstances**. **Empowering and supporting** the client is beneficial, but their sadness may not disappear until their **circumstances improve**" (Problem 1, Depression)*.

In both cases the psychologist reflects on the value of interventions that target individual change – through "therapy" or "empowering and supporting" – in a context where the broader systemic causes of the problems cannot be addressed. Such circumstances present limitations for interventions that focuses on the self and call for interventions of other kinds. In some cases the psychologist can find legitimate practical solutions. For example, one psychologist, who works with students who are depressed due to financial concerns, mentions "developing more of a practical focus" which includes referring students to financial aid (Problem 32, Financial impoverishment). Government grants are another legitimate way that psychologists in our sample assist the poor practically:
"Poverty is a huge problem I have to deal with on a daily basis. The people in the areas we live in are extremely poverty stricken. Most guardians/ parents are unemployed and

are not receiving government grants … and ask us regularly to help them. I try to help them as much as I can by liaising with the Home Affairs and Social Welfare Department, but most times to no avail" (Problem 5, HIV orphans).

However this system is not without its limitations, as reflected by the following comments:
"social workers, lately refer almost every community member they come across for psychological services. ***Some are just poor, they need financial support*** *and the social worker thinks they must go to the Psychology clinic to get a Government grant … they feel the psychologist is cruel, why couldn't she just write the 'letter' to the department of pension (welfare) that recommends a disability grant" (Problem 118, Professional issue with social workers)*.

Clearly people are accessing psychological services in certain sectors of the population for completely different reasons; one that the psychologist above is not equipped to deal with. This participant recognises the limits of the intervention as "some are just poor, they need financial support".

These problems require practical solutions which are often outside the individual and subjective focus of psychologists. In such situations psychologists struggle to develop solutions. Consider the following account where severe economic hardship leads the psychologist to set aside the edicts of his/her training as he/she transgresses professional boundaries by providing practical assistance:
"Many of the students I see … battle financially … when a student comes to me without food and transport money … I feel like I should give them money in some instances, but ***I also have to draw boundaries*** *… if I give them money I do so out of a 'fund' so they know its official and they have to return the money. But in actual fact the money is from my purse … psychologists are trained to be fairly* ***neutral*** *and* ***non-practically involved helpers*** *…* ***we are supposed to empower our patients with the impetus to change in a positive sense and also to manage their lives more effectively****. In my work environment the student's need outweigh(s) the 'how do you feel about that?' option … I'll be quite active in helping the student resolve an issue and become more like a 'problem consultant'. Although I always try and* ***get them to find solutions*** *to their problems before I make any suggestions." (Problem 75, Financial Aid)*.

This psychologist struggles with the requirement of psy-expertise to be neutral and non-practically involved helpers whose *modus operandi* is to help their clients reflect: "the 'how do you feel about that?' option". The aim of psychological practice in traditional terms is to change the client, not the situation: "empowering our patients with the impetus to change… and manage their lives more effectively". The goal is to foster a sense of autonomy among clients, to help them take responsibility for managing their lives. However, in this context, the aims of producing an autonomous responsible individual presents a tension with more immediate concerns, that of not having basic needs met, in this case, money for transport or food. Due to the "neutral" stance of psychologists, this participant finds him/herself in a difficult position on how to address this issue without interfering with the participant's autonomy. Psychology's authority depends on its efforts to produce competent and autonomous citizens by its promises to "sustain (and) restore selfhood to the citizens" (Rose, 1996:100). Providing practical assistance is in sharp contradiction to this "ethic of autonomous selfhood", but not doing so would be to ignore the clients' material needs.

The intervention is described as follows:
*"I usually try to get a **full understanding** of the problem (i.e. financial aid/ student housing) … Frequently I will make phone calls to Student Housing and Financial Aid…It is important to **empathise**...i.e. to realize that they might be **feeling scared/angry and allow them to vent**. I … build a team – working together mentality when dealing with practical problems so the students feel supported but **realize they also need to do their part**. The money situation is tricky: if I lend money I always try and **make it seem official** … I do what I can but ultimately the student needs to **take responsibility** for his situation. I don't regret lending money … students nearly always pay one back." (Problem 75, Financial Aid)*.

In such situations of extreme economic hardship, the lack of resources becomes a barrier to using psy-practices, such as interventions focussing on the self. This psychologist provided a mixture of practical assistance along with more traditional therapeutic interventions, which encouraged the client to take responsibility for his/her situation at the same time as realizing that he/she is in a disempowered, untenable situation. The difficulty of working as a psychologist with clients in situations of socio-economic hardships is further illustrated by the following comments:
*"**Systemic issues** disempower the client, therefore making it hard to work in **therapy** ... how can you make someone feel in control when they are not?" (Problem 39, HIV/AIDS)*.

"It (therapy) does not work. Poverty is poverty" (Problem 33, Financial impoverishment).

*"Perceived control over a situation often leads to an external locus of control, which can be **paralysing** for the client, when there is **insufficient resources to empower** the client to attain an internal locus of control … The societal structures/systems often disempowers clients and therapy … It is often a great challenge to empower clients in **attaining a state of mastery** over their circumstances" (Problem 40, Trauma debriefing)*.

DISCUSSION.
The relevance of psychological practice remains a central concern in the post-apartheid context. In this article we have considered how the technology of psychology can be employed, as Rose suggests, as a strategy of government. By way of conclusion, we discuss three emergent findings.

First, the recently trained psychologists we studied, continued to deal with a range of conventional therapeutic problems ("clinical syndromes", "adjustment" issues, "specific issues"). Interestingly, while these problems were depicted as having predominantly individual causes, many were said to have "socio/economic" causes (43.5% of "clinical syndromes" and 56.3% of "adjustment issues"). This high proportion of traditional problems having socio/economic causes could be indicative of the complexity and widespread social deprivation of the contexts within which psychologists work in South Africa.

The high proportion of interventions focussing on traditional "individualistic" approaches, suggest that this group of problems is easily rendered into the psychological gaze. This is consistent with the Rosean suggestion that psychologists frame "problems of living"

as amenable to therapeutic and psychological intervention and our analyses have shown how these individualising "techniques of the self" encourage self-regulation.

Second, our analyses suggest that social/structural problems are managed by means of individualising interventions. The psychologists in our sample reported dealing with many social/structural problems (such as poverty and HIV/AIDS) or issues related to social disadvantage and the legacy of colonialism and apartheid. In fact, excluding problems that relate to the profession ("professional" problems), 36.4 % of problems described in this study were depicted either as "socio/economic" or "public health" problems; and 53% of all problems were described as having socio-economic causes. The dominant strategy for working with these social/structural problems mirrors the approach used by the conventional therapeutic problems. Clients are subject to individualising interventions, where the object of intervention is to foster ways in which individuals manage themselves as autonomous and self-regulating agents. Even community-based interventions were individualising in this sense. They aimed to heighten community members' sense of responsibility for their community, thereby promoting a sense of duty and appropriate action. The goal is to produce self-managing and responsible communities who, for example, manage funds responsibly and assist vulnerable children appropriately. Individuals' sense of collective social responsibility and obligation to their communities is encouraged by the application of psy-expertise (Rose, 1996b).

To conceptualise the application of psy-expertise in conditions of social and economic deprivation and its links to governmentality, Rose's (1996b) differentiation between "affiliated" and "marginalised" citizens may be of use. According to Rose (1996b) "affiliated" members have the means (financial, educational and moral) to execute their roles as active and responsible citizens of a community, as parents, in employment and in consumption. The "marginalized", however, are unable (and sometimes unwilling) to pass as active citizens of a liberal democracy. Although they may seek to fulfil these roles, they do not have the necessary means or capacities to do so (for example, financial management or parenting skills). Rose (1996b) suggests that these communities have to be reframed and re-unified ethically and spatially. The project of relevance and the discourses of psychology, particularly community psychology, provide the means to achieve this reframing. Within these discourses, communities are reframed as "disadvantaged" and "underserved" subjects and society is obligated to intervene.

The discussion above has focussed on two ways psychological expertise operates as a form of government in both conventional types of psychological problems and social/ structural problems. Our analyses also show, thirdly, that psy-expertise finds its limits as a form of government that focuses on self-regulation in contexts of extreme socio-economic hardship. Certain social/structural problems are not easily rendered into an individualising frame or gaze. Within these contexts non-psychological interventions, such as a referral for a government grant or practical help, become the method of intervention. Psychologists are faced with the limitations of their practices when faced with a subject who lacks the economic means to achieve an autonomous life, or is in a situation of extreme powerlessness. Some of our respondents working in such contexts reported high levels of frustration and ambivalence about the value of their work. Some felt misplaced or unacknowledged, and a number commented that these issues needed to be addressed in training. These issues have been raised by other authors, in

particular Gibson & Swartz (2001) and more recently Pillay & Kometsi (2007), who looked at issues facing psychologists working in non-urban settings.

Certainly, our study had a number of limitations. The sample was relatively small and the response rate was low; we struggled to classify causes in a reliable way; and the psychologists were all graduates of training institutions in KwaZulu-Natal. The generalizability of our findings is thus questionable. Nonetheless, our findings resonate with other analyses of the application of psychology in South Africa. Louw (2002), for example, argues that psychology is not only "Westocentric" or "Eurocentric", as suggested by critics such as Bulhan (1985, as cited in Louw, 2002:3), but that the very subject matter of psychology, human subjectivity, with "its vocabulary and its frameworks have been historically constituted in the Western world". Why then is there an imperative to export psychology outside its original cultural contexts, especially to contexts where the construction of subjectivity is dissimilar to Western constructions of self?

Rose's writings on governmentality may provide a useful framework for critically reflecting on the application of psychology in South Africa. Psy-expertise operates by means of a serviceable construction of self and domain of subjectivity, which is not only calculable but also manageable, constructing as it does a framework for identifying normality and deviance. The techniques of psychology incite autonomy and self-regulation, and so the individualising practices of psy-expertise have become tactics in governing conduct in democratic South Africa.

The aims of a relevant psychology are to extend mental health services to previously underserved areas and, as Louw (2002) points out, these are "positive objectives" (p.3). However, governmentality theory illustrates how psy-expertise also ties citizens to new "micro-networks of disciplinary power" (Louw, 2002). Although practitioners are often unaware of this, our analysis suggests that they struggle to apply psychological methods in contexts of deprivation, ongoing structural inequality and poverty. We recommend that further research be conduced to critically examining how psychology is practiced "on the ground" in South Africa.

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APPENDIX 1: QUESTIONNAIRE

Section 1
Demographic information of participants.

Section 2
In this section we would like you to think about problems and/or issues that arise in your workplace or in society more generally that you are called on to address or "work with" in the course of your working life. ***Please list and then provide a description of the two most common problems or issues that you deal with in your daily practice.***

For example, if you are in private practice and treat mostly eating disordered patients, you could list eating disorders, and then describe the difficulties patients report. If you work in a Human Resource Department in an organizational setting, doing personnel selection, you may list "personal selection", and then describe the difficulties you/the company face in selecting staff. Alternatively, if you work in a research setting, studying the effects of HIV on communities, you may say list "HIV/AIDS", and then describe the problems that you have observed your research communities to face.

Please list ***specific problems*** (for example, eating disorders not individual mental health, personnel selection, not human resource management, and HIV/AIDS not health).

Problem/issue 1 *(Name the problem/issue):*
Description*:*

Problem/issue 2 *(Name the problem/issue):*
Description:

Section 3 – Understanding the problems.
In the section above you have described how the problems or issues that you manage present themselves to you. We are now interested in ***how you understand these problems***. What do you think is the ***basic cause*** of each the problem/issue? Please think broadly and discuss these causes in detail.

Problem/issue 1 *(Name the problem/issue):*
Your understanding of the causes:

Problem/issue 2 *(Name the problem/issue):*
Your understanding of the causes:

How has your training in psychological methods (for example theory, assessment techniques, research method etc.) aided your *understanding* of the problems and issues you face?

Section 4 – Managing the problems.
What do you do manage these problems/issues? Please describe your actual practice.

Problem/issue 1 *(Name the problem/issue):*
Practices to manage the problem:

Problem/issue 2 *(Name the problem/issue):*
Practices to manage the problem:

Do you think what you do helps? Why? How?