

# Towards a Dialogical Decolonised Psychotherapy

## Abstract

*In the following article I will argue for a new type of therapeutic approach which I have termed “dialogical decolonised psychotherapy”, which uses similar concepts that are the foundation of Freire’s Pedagogy of Freedom (2000) and Martín-Baró’s liberation psychology (1996), and applies them to contemporary psychotherapy in South Africa. This article focuses on the practice of psychotherapy in public and private settings. In line with this, the existing models of psychotherapy which utilise exclusively westernised frameworks by practising clinicians are regarded as potentially damaging to the therapeutic relationship in South Africa. I introduce “Therapy as Dialogical” and show how this approach is preferable in terms of building a genuine therapeutic relationship where all clients and psychotherapists are considered participants in creation.*

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## Keywords

*decolonization, apartheid, psychotherapy, dialogical, South Africa, liberation psychology*

## The pervasive and persistent problem of race in psychotherapy

The relationship between psychotherapy and race is an area that has been extensively explored in the domain of psychology (Nicholas & Cooper, 2013). While racial prejudice is extensively researched, for the purposes of this paper it is important to foreground it as an unresolved area of focus in the practice of psychotherapy in South Africa. Racial prejudice can evoke strong emotions for both therapists and clients, particularly if therapists attempt to deny its pervasive influence in South Africa.

The literature indicates that white psychotherapists even in European and American contexts, working with black clients are more likely to experience subjective

discomfort when considering racial issues (Knight, 2013). Furthermore, black psychotherapists are more likely to exhibit genuine empathy towards issues of racial significance with black clients as well as white clients, whereas white psychotherapists inwardly collude on issues of race with white clients (Morgan, 2018; Dottolo & Kaschak, 2015). Therefore, a critical deconstruction is needed to break down these unconscious walls of implicit racism in psychotherapy. Kaschak (2015) states that there is resistance to change in contemporary psychotherapy and that there is still room for deconstruction of commonly-held racial (and heteronormative) assumptions. This means that it is important to see racism as an unresolved event which may show itself in subtle, and overt ways. Racialising acts are the result of inherent beliefs and discriminatory practices between racial groups and linked to forms of institutional racism as seen in the apartheid era.

This is of particular importance in South Africa when psychotherapists buy into the belief of a seemingly “right/proper” way of conducting psychotherapy. A normalisation of psychotherapeutic practice can perpetuate subtle racist discourses when psychotherapists assimilate mainstream psychotherapy theories and methods *within the South African context* (Vandeyar 2010). (The phrase “within the South African context” is italicised because it highlights the assumption that a westernised psychological framework can simply be adapted to non-western societies with the addition of this phrase). The assumption is that existing theories are infallible in approach, and one need only apply them to have successful psychotherapy outcomes (Lambert, 2013). Even as recently as 2006, evolutionary psychologists have argued that there is a correlation between low IQ and low levels of health in Sub-Saharan Africa (Kanazawa, 2006), entrenching the belief that the discipline of psychology must be diluted when applied to African contexts. This assumption is epistemically dubious as it contains value judgements about psychotherapy situations, that take on absolutist forms, rather than considering that the theories and approaches in themselves are suspect (Henriques, 2017). Hence, addressing race in psychotherapy involves a critical understanding of *context* both (1) in relation to the socio-historical space of the therapeutic encounter and (2) in relation to the history of the discipline of psychotherapy.

Context is critical for therapist and client. An action or event that carries substantial weight to one person or culture may be viewed as meaningless or entirely different to another. It is therefore of crucial expediency that the therapist is aware of the contextual factors they bring into the psychotherapy space, the context of their clients, and the result of what bringing these two contexts together may produce. The South African mental health system and its institutions operate in a context of vast racial disparities which are often reproduced in the therapeutic encounter.

Indeed, Carolissen et al (2010) have shown how psychology students associate public health interventions and community psychology as ‘working with African clients’. This is problematic when [white] psychotherapists are regarded as the more valued entities who need to be protected as they enter the danger zones of African “communities” (Oosthuysen, 2015). This illuminates how what I call “*discourses of danger*” (Leopeng, 2016) are reproduced in the implementation of mental health [and indeed overall public health] interventions in contemporary South Africa. It seems to be taken as an imperative that the psychotherapist, rather than providing an ethical and unprejudiced service, needs to be guarded from the client (Joseph, 2015). This has the potential to harm the client’s experience of psychotherapy, shifting responsibility and implicating blame of failed treatments to the clients themselves. In a study about investigating whether racial micro-aggressions affect therapy interactions Owen et al (2014) reported that 76% of participants experienced racial micro-aggressions in psychotherapy, and even when these were brought to the fore they were perceived to be the fault of the client rather than the fault of the therapist. In South Africa Simatele (2018) has found that the effects of these subtle variations are psychologically impacting in academic institutions as a black female- a topic discussed in fuller detail later in this article. There is also a body of literature on how black people are pathologised in psychological research privileging knowledges and approaches produced in the north while any deviations in visual/spatial abilities, verbal skills and mathematical reasoning is seen as a deficiency (Baloyi, 2008).

The question of context also includes the ideologies and assumptions underlying current forms of therapeutic practice. For instance, despite attempts to encourage more black therapists and indigenous languages, as it currently stands, psychotherapeutic practices have undergone little change beyond a westernized theoretical framework (Moodley, Gielen, & Wu, 2013; Watson & Fouche, 2007). A review on the state of psychotherapy in South Africa revealed that we may have erred in terms of our adoption of assumptions regarding the functioning of the human mind in general, and that this has implications on the provision of psychological services (Pillay, Ahmed, & Bawa, 2013) and their supposed benefit on certain communities. There is a prevailing narrative that therapy exists in an objective pure/westernised form and this model must be adapted, however inaccurately, to passive African clients. Psychology and psychotherapy suffer from ethnocentric theoretical formulations disguised as a colourblind approach (Terwilliger et al., 2013) and thus avoid addressing underlying assumptions and beliefs. In this modality the lived histories of colonialism and apartheid are brought to the fore when privileged practitioners impose a standard of so-called normalised clinical practice “adapted” to fit African communities. Even among therapists who have received multicultural training, racism often inserts itself unwittingly into the counseling process (Constantine, 2007). Racial micro-aggressions then tend to be pervasive in practice and perpetuate forms of

racial melancholia that permeate our fantasies of citizenship, assimilation, and social health (Cheng, 2000; Owen et al, 2014). Gobodo-Madikizela (2012) has written poignantly on the unexpressed pain that is a pervasive part of interracial interactions, particularly as black South Africans have to live with the former oppressors who still happen to be in socio-economic ascendancy.

What we see in psychotherapy is a trend towards a homogenised framework of practice and a misplaced sympathy towards psychotherapists who are viewed as martyrs attempting to valiantly provide benevolent assistance in trying circumstances. This misguided paradigm, far from being dialogical and interactive, is disingenuous in its intention and reproduces aspects of the colonial relationship (Constantine, 2007). Most noticeably, it mirrors the Christian missionaries attempt to civilize Southern Africa through the use of religion under the guise of clerical duty (De Gruchy, 2005). In a similar manner, psychotherapists also attempt to enforce a civilizing imperative through the use of an imposing therapy model. Any deviation from the expected outcomes of the therapeutic encounter results in the blaming of clients and the community and exonerates the oppression perpetuated by psychotherapists whose practices are seen as legitimate. Within this framework clients are taught to adhere to the traditional rules of psychotherapy, and a failure to do so will result in a perceived breakdown of the service or will somehow threaten the psychotherapeutic treatment. South African psychotherapists, applying a Westernised theoretical apparatus to the *South African context* are working within pre-determined assumptions about validity and standard practice which restrains any openness to change (Constantine, 2007; Sue et al, 2007; Terwilliger et al, 2013).

It is important to note that I am also advocating against a binary discourse of so-called “westernised” models versus “indigenous knowledge systems” (Matoane, 2012). Although Matshepo Matoane (2012) has rightly called for a reconceptualisation of South African psychology, one must not fall into the trap that there is a common understanding of psychology in the first instance. By localising, or contextualising psychology within indigenous frameworks we reify an absolutist notion of psychological theory, rather than seeing the multiplicity of contextual factors which form our understandings of the human mind. Instead, I am advocating a dialogical decolonized psychotherapy that draws on multiple knowledges and practices but with an emphasis on contextual relevance.

## **Aims and key principles of a Dialogical Decolonised Psychotherapy**

### **1. A Decolonial Framework**

The decolonisation aspect of this proposed therapy framework is crucial to the development of a dialogical framework. One of the most well-known works on

the psychological aspect of decolonisation is *Decolonising the Mind: the Politics of Language in African Literature* (1992) written by Ngũgĩ wa Thiong'o. Resisting the imperialism of knowledge is a central theme. Wa Thiong'o (1992) writes about the "quest for relevance" in which the politics of language enable a search for self-definition, our positionality in the universe, and [what is most important for the present critique], our relations with each other. Along similar lines, South American liberation psychologist Martín-Baró argued that the psychologist ought to address, in acts of solidarity and compassion, the sources of oppression and injustice that suffocated the possibility of genuine flourishing for the majority of people (Martín-Baró, 1996). I am proposing that the therapy experience must draw on these ideas and promote a dialogical method that is cognizant of the sources of oppression, in other words, the socio-political and economic determinants of people's lived realities rather than a mainstream Western psychology that tends to primarily psychologise experience and seeks solution from within the individual. I believe that an understanding of these complexities will provoke a critical re-evaluation of established modes of practice. Furthermore, such an approach would have to highlight the complexities in the relationship between the therapist and the client in South Africa, given the racialized context of psychotherapy described previously. A more relevant [broader] methodology of psychotherapeutic practice should include the immediate social factors affecting people's lives, the historical antecedents, and the impact on the current interaction between therapist and client. Such an approach could have a bearing on psychological tools, such as assessment and diagnostic systems that serve as guideposts in courts of law, prisons, schools, and medical venues. These are largely Eurocentric and make assumptions of universality without qualifying the race and social circumstances of the populations they speak to (Laher & Cockcroft, 2017). A more productive and responsible approach is one which is endorsed by Laher and Cockcroft (2017: 115) who assert that [in relation to assessment tools] South African psychotherapists would need to be involved in the "...development of emic (culturally and linguistically specific to a particular context) measures, rather than relying on adaptations of existing tests developed for other contexts and communities". An emic methodology is preferable as it demonstrates that there is a possibility of going further than what has already been established, the erstwhile model being fraught with systemic and ideological flaws, towards a systemic approach that considers qualitative, quantitative, and constructivist measures when interpreting results (Laher & Cockcroft, 2017). The constructivist measure is important as 'objective' ways of knowing and understanding human behaviour and subjectivity will be less rigid on a specific construct, and rather interpret results in a more fluid manner.

## **2. A Dialogical Approach**

### *Therapy as Dialogical*

In a decolonised model, the emphasis on dialogue in psychotherapy should extend beyond the traditional modality of talking [by the client] and interpretively responding [by the therapist]. It should be seen as a mutual way to create knowledge as well as a way we learn about each other in the therapy context. As participants in a dynamically-oriented reality both psychotherapists and clients raise awareness about relations in society at large, establishing a collaborative process to deconstruct various elements of hegemonic culture, and to act upon these. This process is situated in the thought, language, aspirations, and conditions of the clients whilst the psychotherapist activates the role of healthcare professional, a politician, a fallible human being and an artist instilling creativity and generating new ideas. Shor and Freire state that:

*“...dialogue must be understood as something taking part in the very historical nature of human beings. It is part of our historical progress in becoming human beings. That is, dialogue is a kind of necessary posture to the extent that humans have become more and more critically communicative beings. Dialogue is a moment where humans meet to reflect on their reality as they make and remake it”*

(Shor and Freire, 1987: 13).

Employing this psychotherapeutically entails a shift in the mode of communication often employed. In the traditional application mentioned above therapist involvement is often kept at a minimum level adhering to stifling norms of engagement. Within a dialogical framework this is replaced by the contribution of the therapist as a unique human being with cultural, religious, and political affiliations that either mirror or are opposed to those of the client or a combination of both. In a phenomenological sense the therapist is ‘exposed’ to the client rather than shielded behind a wall of interpretation. The affective and political engagement of the therapist in the encounter increases the capacity of co-creative catharsis. In the classic clinical setting, the therapist would limit themselves from co-sharing, relying only on what the client says, but in a dialogical decolonised psychotherapy model the therapist would reveal their own experience; thus, revealing their humanity. This newer understanding of emotional regulation draws on ideas of emotional interdependence (Rimé, 2009) and is in line with a dialogical decolonised psychotherapy methodology. If we draw from Freire or Fanon who both state that critical consciousness is a collective process, then it is clear that one cannot become critically conscious in isolation. What does this mean for affect in the therapeutic relationship? It implies that there is mutual recognition in this deeper way of relating. Both therapist and client are influencers of this emotional interdependence as a state of being concurrent with contextual dimensions.

### *Conscientisation*

The dialogical aspect of the therapeutic encounter should also draw on ideas of conscientization. Freire (1974) uses the notion of conscientization as an active process of reflection and action upon oppressive structures- and Martín-Baró hails this as the 'horizon for psychology's work' (1996: 41). A dialogical decolonised psychotherapy combines this active process of reflection in engagement not only of the self but the self in relation to a colonial environment. It is hoped that individuals will then come to locate themselves and their struggles in a broader historical context and identify the need for social change at an ideological level. The two concepts are inextricably linked: social change can influence critical reflection, yet at the same time critical reflection can bring about social change. I am motivated by this need for practice, and for applying theories in a pragmatic manner ideally shaped by continuous changing circumstances. It is critical that collaboration is essential for breaking down the hierarchies that exist between teacher and student, client and psychologist, and all other forms of hierarchical pedagogy (Freire, 1974).

### *Client-led theories*

A dialogical therapy must also include a move away from psychotherapist-centred to client-centred practice. About two decades ago, patient-focused research (PFR) was introduced as a new concept in psychotherapy (Lutz, De Jong, & Rubel, 2015). This line of research has had a substantial impact on national and international policy decisions and research collaborations in countries such as Germany, Australia, and the USA. The potential for more effective treatments is a burgeoning and necessary field, yet there is currently no widespread method like this in South Africa. Dialogical decolonised psychotherapy, with the emphasis on collaboration, has the goal of ensuring that psychotherapists and clients are both engaged in a continuous feedback dialogue; particularly, focusing on the client's expectations, as well as a review of the process. From research to treatment to supervision of students in psychotherapy training, these represent different aspects of psychotherapy practice. Supervision and feedback still generally follow a model where the opinions of the supervisors are more likely to be counted, rather than a system which favours the judgments of the clients themselves in psychotherapy (Falvey, 2002). In Corey's (1991) view 'a preoccupation with using techniques is seen as depersonalizing the relationship' therefore the voice of the client becomes critical in determining the successful therapeutic outcome. Falender (2014) has also criticised the current model of supervision as it is based on supervisee disclosure, meaning that it is based on what the supervisee is willing to share in feedback, unless video and audio recordings are utilised, which is only necessary in training psychology graduates. Yet, I would strongly argue, that even this alternative places an enforced narrow perspective on the solutions to be considered- rather than focusing on the systematic procedure which attempts to employ methods

in an attempt to address faulty assumptions there needs to be an acknowledgement that these biases are disproportionately *systemic*. A systemic approach such as the dialogical decolonised psychotherapy model suggested in this article will focus on factors taking place at the session/assessment moment. This allows contextualized conditions and the moment-to-moment interaction, to be observed. A dialogical decolonised psychotherapy approach does more than acknowledge the historical precedents as peripheral; it centralizes the active pervasive role that these systemic factors play in the psychotherapy experience; assessment and diagnostic tools also being a part of informing psychological theory.

### *Examples from practice*

In South Africa the living apartheid dynamic represents a shared emotional interaction. As Vice (2010) states, the former oppressors now live among the formerly oppressed and must somehow live harmoniously in a democratic South Africa. However, the perception and affection of this past will invariably differ from individual-to-individual and have significant cultural implications. As a self-identified African psychotherapist I raise these issues, not as a way of being confrontational, but to make therapy an interactive space when [white] clients hold views and enact practices, opinions, and beliefs that differ in principle from my own. An example involves a 44-year-old white male who presented with feelings of depression and anxiety. He came to see me after having a breakdown involving suicidal ideation. He was unhappy with his job as a dental technician and felt regret for not pursuing a degree in dentistry at university. He revealed that during the time when he was a student (in the 1980s), there was political unrest in South Africa. Incidentally, his father was a military officer who was mandated to “shoot the blacks”. As a result, my client grew up in a hostile family environment and ended up adopting some of the stereotypical prejudices against black people as his father had. In the course of deconstructing his racial prejudices he shared that being able to share his vulnerabilities with a black man helped him to form a romantic relationship with a black woman but was still afraid to tell his father about any of us. As we worked to eradicate his prejudices I admitted to him how hurt I felt about some of his beliefs, but also pointed out that by bringing both our respective feelings in a dialogical space, we were able to make the process more dynamically beneficial for us both. The experience was transformational as it gave me the chance to confront some of my own beliefs and interpretations of what people, in general, can say contrary to my own views. It shattered the blank mirror I had been trained to convey in psychotherapy and instead showed how the therapeutic relationship and can be a co-healing space. In turn, my client also learned that what he believed to be seemingly innocuous views about people of other races were impacting his behaviour towards these ‘others’. He also admitted some of his latent resentment at having to now deal with these issues with a younger, more qualified African therapist but this



ultimately benefited him in his relationship by causing him to release some of his authoritative control which was based on a latent belief of the inferiority of African people. Classically the psychotherapist would be guarded or at the very least exhibit diplomatic restraint when addressing these topics, however in the dialogical model these issues are laid bare at the outset as a means to simultaneous understanding, healing, and catharsis. It is especially detrimental in contemporary South Africa to divorce politics in the psychosocial analysis from the interactions in the therapy space. To do so would only weaken the therapeutic engagement and produce practices of psychotherapy which are in accord with the prevailing value system of the society. My conscious identification as an African is inherently indicative of political identifications, and can sometimes cause [internal and external] conflict in a society where racial politics inevitably establishes the “Other” as a counter-position. As seen in the above case example there was a coming together of differences that was only achieved through direct engagement in the therapy process, beyond the interpretative level. Although my client and I may have each seen the “Other” from a socio-political standpoint, we became co-creators in an interactive space by resolving to address the set of South Africa’s complex issues.

The second example involves a third-year white female university student who was dealing with general life issues and feeling pressure to do well after failing her third year, and now having to repeat. Being in her early twenties she grew up in the so-called “born-free” generation of post-apartheid children (Mattes, 2012). Having attended a former model c school, her racial integration was more diverse than the first client mentioned in this article. She confessed to mostly staying in the company of black friends, and her familiarity with them led her to use the same terms and vernacular they were using including the word “nigga”. After we established rapport she began to use this term more frequently, even in reference to me, being comfortable with our proximity in age and social contexts. Shortly after I told her of the pejorative use of the term and how African Americans use it as a method of re-appropriation to reclaim power, dignity, and self-identity (Croom, 2011). I explained that by her freely using the term she was ignoring the painful racial history in which the term progressed from “negro” to “nigger” and finally “nigga” (Kennedy, 2008). She admitted her ignorance while stating that she also wanted to “fit in” being the only white person in a group of black people. We resolved to establish a more respectable dialogue between us. Here again, I was brought into an awareness of that my own feelings, interpretations, and beliefs can alter the course of the therapy relationship. Although there are many black people who use the word I choose not to, and I had to admit that it was not only about white people using the word but even other black people offended me when using the term. The dynamic between us was also affected by her relating to me as somebody in her own generational upbringing and she admitted that she assumed that referring to

me by that term would lead to a more familial relationship. Although I had associated the term with racism and violence, she associated it with friendship and congeniality. It helped us to both, respectively, set a stronger foundation for future engagements on racial topics.

When other viewpoints are made manifest in the clients presented in this paper there ensues a set of complexes that should be brought to the fore. Being able to engage with dialogical approach geared towards reciprocal conscientization demonstrate the capacity for this methodology in producing meaningful change, but as each person differs the approach must be flexible and sensitive to this. This article shows the trend of evolution with the Dialogical Decolonised Psychotherapy method by offering it as a dynamic approach rather than a static, deeply ensconced [illusory] infallible technique.

### **An African-centred dialogical decolonized psychotherapy?**

*“The therapy room is a patch of waste ground, and the therapist’s couch a wooden bench under a tree. The therapist is an elderly Zimbabwean woman, in a long brown dress and headscarf”.*

This quote is taken from an online article written in the guardian by Mberi in 2017. The article goes on to describe how “untrained”<sup>1</sup> elderly Zimbabwean women conduct a new form of therapy in the treatment of a wide range of symptoms such as depression, outside on park benches. What this example shows is (1) an alternative to westernised psychotherapy models and aetiology, (2) a therapeutic approach from a purely emic position. Such an example should inform the research and training of a new generation of psychotherapists in South Africa. Indeed, Gentz and Durrheim (2009) found that clinical psychology graduates from the University of KwaZulu-Natal reported a disconnect between what was gained during their university training as inadequate for real-life application in the public health sector. This is especially poignant regarding the state of mental healthcare in South Africa, as well as the scope of the African continent. Furthermore, the example demonstrates the unique African approaches that are being used to address mental healthcare in innovative ways. Feminist approaches to psychology would argue that women are seen as nurturing and caring rather than as ‘professional therapist’, although in this case it does not diminish the importance of simply having a trustful person to help with emotional challenges. The communal archetype of the venerable matriarch expresses itself as caring and holding, rather than the mistrustful and dispassionate sterility of colonially constructed ‘therapeutic’ spaces. These include areas such as hospital rooms, university consultation offices, and

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<sup>1</sup> I like to think of *this* term in *this* context less pejoratively as using it implies that the current models of psychology training are infallible. The course of this article has shown this to be categorically and conceptually false, hence the suggestion of the term *non-trained* as a distinguishing factor as that which is counter-normative.

private practice office parks. The former two are historical in their make-up and their enforced antiquity may signal a conforming to westernised civility in individualising psychological experience, rather than considering that it is possible that social sharing is actually shown to improve aspects of holistic well-being outside of standard clinical practice (Rimé, 2009; Martín-Baró, 1996), while the latter setting alludes to the neo-liberal capitalist commodification of psychotherapy, with the exorbitant fees associated with seeing a psychologist in private practice. This has presented in such ways that medicalisation (Szasz, 1961) as a treatment canon depletes the capacity for empathy and the destigmatisation of conditions such as depression, anxiety, and other day-to-day life challenges. Medication and hospitalisation are integral components of psychological treatment within a biomedical framework, and can offer treatment in acute and severe situations. This being noted, the disparity appears when the total make-up of an individual is based on what is pathologically diagnosed almost immediately in lieu of differential and psychosocial factors. One of these is the fact that human beings are social beings who benefit psychologically from shared empathy, the building of communal values, and expressions of gratitude and love (Breggin, 1991). Sitting side-by-side adds the element of dialogical equality rather than didactic expertise, influencing the closeness in our therapeutic encounters and intimacy of emotional bonding. These therapeutic encounters centered on relationship building and strengthening have been a motivating factor for me in beginning to develop a dialogical decolonised psychotherapy model. As seen in the case study examples provided in this article being able to honestly express my feelings towards clients based on my own experience of the content of our interactions i.e. whatever is raised in the moment, has allowed for a more freely flowing method of healing parts of ourselves that have been affected by prejudice, racism, and other social factors.

Ultimately, the implementation of an innovative emic methodology should prioritise the involvement of more African practitioners and clients. African experts with deep knowledge of local conditions and a phenomenological history of all forms of racism should be engaged in teaching and directing the development course of dialogical decolonised psychotherapy towards a profound liberation. Only then can psychotherapy overcome the critical challenge of providing a service that is relevant to South African praxis. Mental healthcare practitioners need to devise far more inventive solutions than adapting an existing methodology to tackle the unequal nature of our psychotherapy.

Any policies that follow from this must also consider the following points:

- Firstly, a decolonised epistemology must be integrated across all levels of public and private psychotherapy systems and training programmes. This is in line with the overall project of decolonisation that was a prevalent theme in the 2015

#FeesmustFall protests, and allows us to change the system itself rather than conforming to an existing framework (Pillay, 2017).

- Secondly, these changes must continuously challenge the status quo and inherent biases that are present therein, and recognise human development and its cultural value. This is particularly crucial for an African psychological liberation in order to promote activism and advocacy for equality and justice in the South African landscape as a path toward self-identity, social cohesion, and political engagement.
- Thirdly, decolonised dialogical psychotherapy development should be encouraged via appropriate investments across all levels, including contributing to research and development. In this manner, researchers and health professionals can contribute to building a conducive model and one subject to continuous engagement.

## Conclusion

This article provided a critique of the current state of psychotherapy practice in contemporary South Africa by exposing how implicit racist assumptions and westernised epistemic positions pervade therapeutic spaces. The clients in these encounters become passive recipients of a malfunctioning service. In psychotherapy things are seldom what they appear to be; even if, a client expresses grievances about the course of therapy or complains to their therapist, their concerns are only seriously taken into account upon submission of a written complaint to an official body such as the Health Professions Council of South Africa (HPCSA). Martin and Durrheim (2006) confirm this claim with direct reference to the continued function of implicit racism in contemporary South Africa offering insight into the conservation of racial advantage in the context of radical socio-political change. The point being made is that when racial assumptions become presuppositions in theory and practice there is the creation of a self-serving discourse that normalises erroneous cultural beliefs such as needing to adapt an approach to certain populations of people. Clearly, these errors must be eradicated in favour of a more effective way of dealing with our present socio-political situation.

I have argued against such assumptions by incorporating tenets of Freire's dialogical praxis (2000) and Martín-Baró's (1996) liberation psychology concomitant with real-life implications for the development of a conceptual methodology in South Africa. It is hoped that the topics discussed continue to be debated further with the goal of improving understanding and providing the most ethical recourse for mental healthcare. This is a call for psychotherapists to pose profound questions that will most likely feel uncomfortable to ask but enable them to be more accountable. These questions include facets about social positioning and practical application that are equitably responsive to local communities.

It is clear that a dialogical decolonised psychotherapy approach must pay attention to an emic methodological development as a route to generating uniquely South African Psychotherapy epistemology, that is not considered ‘alternative’ or ‘within the South African context’, but is a standalone methodology in and of itself. Although it seeks to deconstruct existing beliefs, the dialectical nature of dialogical decolonised psychotherapy means that it establishes no firm position per se, but a model that is fluid, open to critique, and a constant process of refinement and revision.

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