As part of a growing literature on the histories of psychology in the Global South, this article outlines some historical developments in South African psychologists’ engagement with the problem of “health.” Alongside movements to formalize and professionalize a U.S.-style “health psychology” in the 1990s, there arose a parallel, eclectic, and more or less critical psychology that contested the meaning and determinants of health, transgressed disciplinary boundaries, and opposed the responsibilization of illness implicit in much health psychological theorizing and neoliberal discourse. This disciplinary bifurcation characterized South African work well into the postapartheid era, but ideological distinctions have receded in recent years under a new regime of knowledge production in thrall to the demands of the global market. The article outlines some of the historical-political roots of key trends in psychologists’ work on health in South Africa, examining the conditions that have impinged on its directions and priorities. It raises questions about the future trajectories of psychological research on health after 20 years of democracy, and argues that there currently is no “health psychology” in South Africa, and that the discipline is the better for it.

Keywords: health psychology, critical psychology, knowledge production, apartheid, South Africa

Health has become a key political term in modern industrial(izing) societies—it is seen as an unquestionable social good and means or objective of modernization, and at the same time, it has been the object of intense contestation and struggle. The rise of health psychology in the industrialized West both capitalized upon and helped to intensify the emergence of “healthism” (Crawford, 1980) or the “health society” (Kickbusch, 2006)—terms that describe the reorientation of social values, practices, and institutions around the primacy of health as a goal, and the elevation of health as a frame of reference for evaluating life choices (see Greco, 2009). Health psychological theories proffered at the time, and still prominent today, attributed healthy outcomes to the decisions of individual actors, reproducing meanings of health within a logic of personal choice (see Mol, 2008). This logic was consistent with a retreat in public health policy in the late 1980s, in many governments around the world, from a focus on universal access to health care to the individual management of risk (Schaay & Sanders, 2008).

Internalist histories attribute the emergence of health psychology in the late 1970s to the culmination of a series of challenges to the dominance of the biomedical model, mostly from psychoanalytically informed psychosomatic medicine and psychologically informed behavioral medicine (Ogden, 2012). The so-called “behavioral health zeitgeist” (Weg & Suls, 2014) gained traction in part because of widespread critiques calling into question the power of biomedicine and the medicalization of society in Europe and North America (e.g., Engel, 1977; Foucault, 1973; Murray, 2014a). Simultaneously, industrialized countries were said to be undergoing a health transition, in which infectious diseases were giving way to new epidemics of chronic and so-called lifestyle illnesses. The disciplinary moves to institutionalize a health psychology thus piggybacked on
this critical reappraisal of biomedicine, as well as the increasing concern about new epidemics of chronic illness, affording psychologists the opportunity to expand their reach into the domains of medical practice and health promotion (see Holtzman, Evans, Kennedy, & Iscoe, 1987; Matarazzo, 1980). In the more than three decades since its inception, health psychology has arguably been at the forefront of the scientifically authorized promotion of “health consciousness” and individual responsibility for health, having endorsed this view in its earliest writings:

Behavioral health is an interdisciplinary field dedicated to promoting a philosophy of health that stresses individual responsibility in the application of behavioral and biomedical science knowledge and techniques to the maintenance of health and the prevention of illness and dysfunction by a variety of self-initiated individual or shared activities. (Matarazzo, 1980, p. 813)

Such transformations of health discourse accompanied a burgeoning health industry located within a neoliberal vision of the patient-as-consumer—one in which the responsibility for well-being was shifted onto the individual, whose relation to the state was being reconfigured in the 1980s as part of the gradual dismantling of the welfare state (see Ayo, 2012; Gaffney, 2015; Mold, 2011).

Health, Apartheid, and Psychology in South Africa

Concern over the confluence of these factors is perhaps well founded in the West, where the conflation of the discourses of health promotion with those of a consumerist valorization of rational “choice” effectively masks the effects of power (Lupton, 1995). However, early proponents for comprehensive primary health care in postapartheid South Africa demonstrated an acute awareness of the political-economic dimensions of this shift. Indeed, the articulation of the meaning of health and health care provision in the 1980s was a key part of the struggle against apartheid, the legacies of which were a disastrous public health profile and a fragmented health system that were direct consequences of apartheid social policy (African National Congress [ANC], 1994). Coovadia, Jewkes, Barron, Sanders, and McIntyre (2009) summarize this legacy thus: “Racial and gender discrimination, the migrant labor system, the destruction of family life, vast income inequalities, and extreme violence have all formed part of South Africa’s troubled past, and all have inexorably affected health and health services” (p. 817).

As such, by 1994, the year of South Africa’s democratic transition, it was recognized that the country faced four “colliding epidemics”: (a) diseases of poverty, including infectious diseases, maternal and neonatal death and malnutrition; (b) HIV/AIDS and tuberculosis; (c) injury and violence; and (d) chronic illness and mental health problems (Mayosi et al., 2012). It is within this critical health context that psychologists directed their attention to health issues in South Africa, and in which mainstream health psychology appeared most starkly to be politically and ideologically problematic. South African psychologists did not have any illusions about the immensity of the public health crises that required their attention, but perhaps the spectacle of the apparently miraculous political transition to the “rainbow nation” and the warmth with which they were welcomed back into the international fold left them ill-prepared—as Neville Alexander had warned in 1993—for the persistence of “racial capitalism given the ‘new world order’ and the hegemonic consolidation of reformist strategies among formerly anti-apartheid social forces” (Alexander, 1993, p. 7). It is now unclear the extent to which the resulting recruitment and deployment of psychologists to senior positions in “science councils, tertiary institutions, research institutes, policy units and directorates within government departments, the private sector and organized psychology itself” (Suffla & Seedat, 2004, p. 514) has strengthened or neutralized the critical potential that the discipline had envisioned in the 1980s (see Painter, Kiguwa, & Böhmke, 2013; Seedat, 2010). Once characterized by a more or less explicit activist and oppositional agenda, South African psychologists have withdrawn slowly into the academic enterprise while embracing (not unequivocally) the role of consultants for circumscribed health problems (see Palmary & Barnes, 2015). Through a roughly periodized narrative, this article analyzes some of the changing conditions of psychological knowledge production and intervention into health in South Africa. It details some of the significant ways in which
South African psychologists have both courted and resisted “mainstream” health psychology under apartheid and through the democratic transition to the present. It concludes with reflections on the future trajectories of psychological research on health in South Africa.

Notes on Method

The historical narrative I offer here is based on bibliographic analysis of published literature, but it is also informed by oral history interviews conducted with South African psychologists active in the broad domain of health since the late 1970s. The analysis of the literature covers articles published between 1970 and 2015 in South African journals, such as the South African Journal of Psychology, as well as international social science, health psychology, and public health publications. Oral history interviews were conducted over the course of 2014 and 2015 with 12 psychologists, two of whom have also published on the history of South African psychology. The interviewees included both mid-career as well as senior psychologists, many of whom now chair academic departments and/or hold senior positions in South African government and research organizations. The current article does not present any of these interviews in detail but is informed by them; a full analysis of these interviews will appear in an upcoming article as part of a comparative collection of international histories of health psychology (see Yen & Vaccarino, 2016).

In constructing this account, I have intentionally refused the category “health psychology” as a starting point for analysis, for both analytic and historical reasons (see Danziger, 1997). Analytically, I adopt a perspective on the social sciences that views their subdisciplinary specialization as the outcome of historically specific sociopolitical forces, rather than of necessity as reflections of an increasingly sophisticated knowledge of the “natural world” (e.g., Staeuble, 2006; Wolf, 2010). Furthermore, what is traditionally understood to constitute “health psychology” does not do justice to the diverse, interdisciplinary, and critical work that has made up South African psychological intervention in health issues, some of which is notable for contesting the very meanings of both “health” and “psychology.” Though the work I have included in this account concentrates loosely on issues of physical health, many strands of it overlap with mental health, and, in some cases, questions the biomedical assumptions that treat the two domains as separate.1 Finally, in contrast to its Anglo-American centers of origin, there is today very little institutional representation of health psychology in South Africa, apart from a number of eponymous undergraduate courses, a few clinical psychology internships with an emphasis on “medical psychology,” and two special issues on health psychology in the South African Journal of Psychology. There are, at the time of writing, no graduate or professional training programs in South African universities, and no professional practice category, as there is in the United Kingdom. Health psychology, in this sense, does not exist in South Africa.

Psychology in South Africa: Colonialism and the Indigenization of Psychology

The historiography of psychology in the margins provides an important lens through which to understand the cultural-political shaping of the discipline, not only because it throws into sharp relief the particularities of European and North American psychology, but also because it highlights the interplay between local and global dynamics of psychological knowledge production. As Staeuble (2006) has pointed out, the export of psychology to the global margins must be understood in the context of colonialism and “indigenization,” which have structured relations of knowledge production in terms of center and periphery. However, the exchange has been far from uniform or unidirectional. Psychology in the margins has both mimicked its Northern practices and priorities, and worked to subvert them (see, e.g., Adams, Dobles, Gómez, Kurtis, & Molina, 2015). As this article will demonstrate, a straightforward characterization of South African psychology in these terms is not possible.

Although institutionalized psychology had existed around the world prior to the Second World War, mostly in academic departments established by those who had originally been trained in England, Europe, or the United States

---

1 For a fuller discussion of the critique of health psychology, including the ubiquitous “biopsychosocial” approach, see Murray (2014b) and Stam (2014).
(e.g., in India and South Africa), it was only after the war that the discipline received a major boost. Following its spectacular successes in aiding the war effort in the United States, the export and internationalization of psychology was heavily shaped by the geopolitical realignments associated with the Cold War. The modernization of the emerging nations of the Third World was seen as integral to the extension of Western influence to these countries, and the social sciences, a key means by which this could be achieved (Pickren, 2009).

Thus, the growth of psychology in the global periphery accompanied, in many cases, programs of socioeconomic modernization and the discourse of liberal individualism. In the same ways that psychology capitalized on the need for both a technology of social management, as well as a secularized, scientific discourse on human subjectivity in the modernizing societies of 19th-century Europe and North America (G. Richards, 2010), so, too, did it ride the wave of liberal modernization theory in the former colonies of Africa, Latin America, South Asia, and the Far East.

Prior to the Second World War, in places such as South Africa or India, psychology functioned in large part as a colonial science. In South Africa specifically, the discourse and technologies of psychology were imbricated with the objectives of the imperial project, contributing to scientific racism—primarily through its techniques of mental testing—and, later, lending theoretical support to anxieties about “cultural contact” that fueled the apartheid ideology of separate racial development (see Long, 2014; Tilley, 2011).

The gradual overthrowing of European colonial rule after the war was accompanied by widespread moves to adapt or indigenize psychology in the Third World. When indigenous psychologists have taken issue with the concepts of Western psychology, they have tended to offer alternatives that have simply replaced these with “indigenous,” culturalized ones, leaving the particular ideology and ontology of psychological discourse—that erases the socio-political and material conditions of existence from view—largely unexamined (e.g., Pe-Pua & Protacio-Marcelino, 2000).

In places like Latin America and South Africa, the “indigenization” of psychology took on more explicitly critical and political forms (e.g., Anonymous, 1986; Martín-Baró, 1994; Seedat, 1997), foregrounding the problematic nature of psychological praxis and the contradictory position of academics and experts in the context of political change (Parker, 2014). The pervasive racism and violence in the final years of the apartheid regime in South Africa had forced a sharp ideological divide among psychologists, separating those with a more progressive and transformational politics from those who were more reformist in their views.

The Changing Face of “Health” in South African Psychology

The account of psychologists’ engagement with health is divided into three periods, comparisons of which reveal changes in the ways in which health has been constituted as a problem in South African psychology and health care more generally. Changes are evident not only in whose health is targeted for research and intervention, but also in very meanings of health, ill health, and health care.

1930s–1970s: Pursuing Professionalization and the Health of the Elite

It is perhaps little known that community-oriented primary care (COPC) originated in South Africa in the 1940s. The model, developed at the small, rural Pholela Health Centre, was highly innovative for its time, combining curative and preventive services with a focus on family and community—rather than individual—health. Also unique was its emphasis on community participation in health care delivery, as well as the reliance on social and epidemiological data to adapt services to the specific needs of a community (Kautzky & Tollman, 2008). Attempts to leverage the insights gained from Pholela into the creation of a new integrated national health system—envisioned in the 1944 Gluckman Commission report—were ultimately thwarted by the election to power in 1948 of the National Party. The resultant rise of segregationist rhetoric and social policies, as well as the indifference of a medical profession determined to establish a private health sector and hold onto its high salaries, were the death knell for COPC and progressive health care in South Africa (Freund, 2012). The key proponents of primary health care, including the
Karks and the Sussers, emigrated to Israel, the United States, and a number of African countries, helping to transform health care in those countries. Tragically, “health care and systems development in South Africa in the coming decades would focus on hospitals and an exclusivist private sector, with disastrous effect for the health of the country’s citizenry” (Kautzky & Tollman, 2008, p. 20).

In the context of health and health services, South African psychology during this period was a relatively insignificant discipline and profession in relation to medicine, and remained so well into the 1970s (Louw et al., 1995). Even so, it is worth noting that South African psychologists, as elsewhere, were eager to throw their lot in with those in power. They were centrally involved in early interventions to improve the plight of “poor whites” marginalized in the rapid industrialization of the South African economy in the first decades of the 20th century. White poverty and ill health were perceived to be scandalous and threatening to a society based on racial stratification (Posel, 2010). It was thus that the first Carnegie Commission studies of the “poor white question” in the 1930s would boost the careers of some of the key protagonists of apartheid social policy (e.g., R. W. Wilcocks and E. G. Malherbe), demonstrating the “usefulness” of psychology to national concerns, as well as shaping the ideological contours of the future discipline of psychology that apparently would not have any qualms about privileging the concerns and needs of whites over those of blacks; that is, a discipline that would not have any qualms in advancing the fundamentally racist social order in which it was located. (Duncan, Stevens, & Bowman, 2004, p. 277)

In the decades that followed, clinical psychologists would pursue the professionalization of their discipline and make small inroads into the domain of the health professions. Psychological themes began to appear in the general medical literature, and there are indications in the South African Medical Journal that as early as the 1940s, general practitioners and a small number of psychologists had begun to focus on the psychological aspects of physical diseases. By the mid-1950s, some of the language of the currently dominant “biopsychosocial” model was already making an appearance in the medical literature in relation to hospital treatment (Louw et al., 1995). However, the majority of psychologists would confine themselves to the understanding and treatment of psychopathology as their main contribution to medical practice.

Through concerted effort, and emphasizing their specialization in psychometrics, psychologists were able to secure their status as auxiliary health professionals under the auspices of the South African Medical and Dental Council (SAMDC) in 1955 (Louw et al., 1995). Then, partly in concert with international trends toward professionalization, but spurred by government action to manage “the dangerous individual” in response to the assassination of Prime Minister Hendrik Verwoerd in 1966, psychologists formed their own regulatory body and were granted license to practice independently in 1974. Psychology was seen “not only as a means of modernizing health provision, but also as a means of helping to identify and control a potentially destabilizing sector of the population that was not yet being optimally managed” (Laurenson & Swartz, 2011, p. 261). Clinical psychology grew rapidly as a result, and many clinicians found themselves working in support of medical practitioners in general hospitals.

1980s–1990s: Political Crisis and Renewal

The 1980s were some of the most violent and repressive years of the apartheid regime. Responding to a renewal of organized mass political resistance, the government imposed two States of Emergency, under which tens of thousands of people were detained, and many tortured and murdered, by state security forces. Many historical accounts of South African psychology locate the emergence of critical reappraisals of psychological theory and praxis in this period, when politically active academics began to confront the complicity of the largely conservative psychological establishment (e.g., Foster, 2008; Hayes, 2000; Yen, 2008). These reappraisals were oriented primarily toward situating psychology within the social and historical context of apartheid, and the scale and violence of events in the 1980s appeared to force psychologists to “take sides” in relation to apartheid. For a discipline that had historically traded on its pretensions to scientific and professional neutrality, this could indeed be seen as
a watershed moment (see Hayes, 2014; Painter & Terre Blanche, 2004). Still, one would have been hard-pressed at this time to find any psychologist who was overtly supportive of apartheid, perhaps reflecting the reformist tenor of the times, and also in part because of the desire to maintain relations with international psychological associations (Dumont & Louw, 2001). However, for the most part, psychologists continued to work as they had done before, oriented toward professional concerns, independent practice, scientific neutrality, and disciplinary developments in the north.

With an eye, no doubt, on the success of efforts to establish health psychology in the United States and United Kingdom, the new field of medical psychology would declare itself, in 1985 in South Africa, as the result of efforts to include clinical psychologists as valuable members of medical teams (see Schlebusch, 1987). Then, in 1989, the (now defunct) Division of Health Psychology was established in the main professional organization of the time, the Psychological Association of South Africa (see Schlebusch, 1996), which had itself been the result of wrangling over guild interests (see Dumont & Louw, 2001).

Article analyses of the flagship national journal, the *South African Journal of Psychology* corroborate characterizations of the mainstream discipline as politically aloof during this critical time (see, e.g., Durrheim & Mokeki, 1997). The psychological problematization of “health” seen in South African research between 1979 and 1990 evidences few exceptions to this. Some examples of health-related research published at the time include studies of the mental strategies of marathon runners (Schomer, 1986), stress levels of white executives (Strümpfer, 1989), cultural perspectives on parasuicide (A. L. Pillay & Schlebusch, 1987), and the relationship between ambient temperature and collective violence (Tyson & Turnbull, 1990). Although, in different times, these might have been important health-related topics in their own right, it is difficult not to see some of them as particularly egregious cases of fiddling while Rome burns.

In parallel to this work, a growing and increasingly vocal group of psychologists began to organize in opposition to apartheid, chiefly through the provision of psychological services to survivors of heightened state violence, detention, and repression. Joining with doctors, nurses and social services workers, they formed alternative, progressive organizations such as the Organisation for Appropriate Social Services in South Africa, the Psychology and Apartheid Committee, the Progressive Primary Health Care Network, and the National Medical and Dental Association. Psychological work that developed out of these movements matured into several lines of critique and praxis that were broadly aligned with a heightened politicization in South Africa of health care and of health itself. Attempts by the health authorities to cover up the torture and murders of Steve Biko in 1977 and Neil Aggett in 1982 while in police detention served to seriously discredit the SAMDC (under which psychologists had only recently been licensed to practice as health professionals; Kautzky & Tollman, 2008). A number of important analyses of South African health care were written in the middle of the 1980s, highlighting the links between apartheid ideologies, their implementation, and the (ill) health of South Africans. These reports detailed the health consequences of apartheid society (Andersson & Marks, 1988), the reproduction of apartheid class structure in the health care system itself (Price, 1986), political and human rights abuses of medicine (Zwi, 1987), and the health effects of the close associations between the state and industry affecting migrant workers in the country’s mines (Tsampiras, 2012). These writings helped to historicize and contextualize the severely racially stratified health burdens of South African society as direct consequences of colonialism and policies of racial capitalism. The understanding of health in these analyses, as integral to a vision of social justice itself, stood in stark contrast to the biopsychosocial concept of individualized health that was being promulgated in the new health psychology (see Schlebusch, 1996).

By the early 1990s, a series of scathing critiques of the basic ontological and epistemological assumptions of psychological theory had been published in the critical journal *Psychology in Society* (or *PINS*; Foster, 2014). *PINS* was to provide a vital forum for progressive voices in South African psychology. Drawing on a range of resources, including Marxian theory, poststructuralism, liberation, and community psychology, psychologists attacked the discipline’s complicity with apartheid, highlighting the ideological functions of psychology’s individualistic
modes of analysis and intervention, as well as its pretense to objectivity and neutrality. Indeed, the 1980s and 1990s appear now to have been the heyday of critical theoretical and practical renewal in South African psychology. The published critical work of the time conveyed a great sense of both crisis and possibility as the country teetered on the brink of civil war, and as the inevitability of apartheid’s demise became clearer, many applied themselves to reimagining more democratic forms of psychological practice within the context of postapartheid social reconstruction (e.g., Freeman, 1991; Krieger, 1993; Y. Pillay, 1994). These developments were accompanied by a great deal of reflection on the problematics of professionalization (e.g., Isemonger, 1994), psychology’s troubled relations with biomedicine (e.g., Miller & Swartz, 1990; Seedar & Nell, 1992), and the recognition of indigenous healing traditions in a new health care system (e.g., Freeman & Motsei, 1992). For many, progressive work necessarily entailed an effacement of the identity, status, and disciplinary boundaries of “psychologist” (Parker, 2014).

As the country transitioned to democratic rule in the 1990s, intellectual and political movements that had organized in opposition to apartheid now had to reorient themselves in relation to a new democratic society and the majority ANC government (Hayes, 2014). Many progressive psychologists now found themselves working with, rather than against, the structures of power, contributing, for example, to the formulation of the ANC’s National Health Plan (ANC, 1994). Spurred by a vision of “health for all,” the National Health Plan was an ambitious program for the fundamental restructuration of the health system based on the premises of the primary health care approach (Kautzky & Tollman, 2008). Having inherited a highly fragmented and inefficient health care system that was predominantly privatized, racially segregated and oriented toward high-cost tertiary care, progressive psychologists faced the challenge of restructuring the discipline in more equitable, accessible ways (Parker, 2014).

It was around this time that many psychologists turned their attention to addressing the urgent health care needs arising directly or indirectly from human rights abuses under apartheid. Although some attended to the much-needed reform of clinical service provision within a primary health care model, there was a significant shift toward frameworks for prevention and health promotion drawn from community psychology and public health, as well as policy-oriented research, particularly in relation to what was beginning to be recognized as the country’s quadruple burden of health (see Coo-vadia et al., 2009).

It is arguably these characteristics of the sociopolitical context of the end of apartheid that shaped the direction that South African psychological research on health issues would take in the decades that followed. Research and intervention on the country’s four colliding health epidemics has since developed into substantial fields of research and intervention, involving the creation of a variety of research programs and/or research institutes, attracting considerable funding, and engaging communities and government in long-term relationships. In many cases, these have entailed significant departures from the theory and methods associated with health psychology à la Matarazzo (1980). A few outstanding examples will serve to illustrate their transdisciplinary, reflexive, and—in some instances—politicized character.

Psychology in public health. Universal and equitable access to health care was a key component of social and political transformation envisaged in the new South Africa (ANC, 1994), and included the integration of mental health care into primary care services as a major objective (e.g., Foster, Freeman, & Pillay, 1997). For many psychologists, confronting the complexities of this task meant abandoning, or at the very least, reconceptualizing, entrenched assumptions about the nature of psychological care and of psychological inquiry. Theory and methods in community psychology, medical anthropology, public health, and epidemiology became integral to innovative work in rural primary care (e.g., the Mamre Community Health Project—see Katzenellenbogen, Swartz, & Hoffman, 1995; Reynolds & Swartz, 1993), alcohol and substance abuse (e.g., Parry & Ben-
netts, 1998), and maternal and perinatal health (e.g., Tomlinson, 1999).

Violence. As the large-scale forms of political violence that had been characteristic of life under apartheid began to recede over the course of the decade, psychologists played a critical role in reconceptualizing violence as a public health issue. Psychologists who had focused on trauma treatment and support for survivors of violence began to apply themselves to its prevention, but did so with a political and historical sensibility that attempted to avoid the narrow criminalization of violence or its psychologization as “aggression” (e.g., Seedat, 1999), as well as drawing attention to its gendered dimensions (e.g., C. Campbell, 1992). This reformulation allowed for intersectoral and interdisciplinary cooperation among a diverse range of stakeholders, including politicians, civil society, academics, and practitioners committed to its prevention (Bowman, Stevens, Eagle, & Matzopoulos, 2015). The vital work of organizations such as the Health Psychology Research Unit at the University of South Africa, which differed a great deal from “traditional” health psychology, included community and public health approaches to violence prevention (Butchart, Hamber, Terre Blanche, & Seedat, 1998), Foucauldian genealogies of South African clinical medicine (Butchart, 1997), and political analyses of mental health care (Nell, 1994). The Centre for the Study of Violence and Reconciliation in Johannesburg was similarly important in its attempts to make sense of violence and influence policy in the early years of South African democracy (e.g., Hamber, 2000; Vogelman & Eagle, 1991).

HIV and AIDS. Although HIV and AIDS were recognized relatively early in South Africa (Zwi & Bachmayer, 1990), the issue has been largely a postapartheid problem (Posel, 2005). The epidemic has lagged about 15 to 20 years behind that in other African countries, and as late as 1990, the prevalence was estimated to be about 1% (Marks, 2002), but this has since ballooned to almost 20% (UNAIDS, 2014). Despite some early warnings of an impending crisis, political and public health responses were muted because of a number of factors. Most notably, the silence about HIV/AIDS under the Mandela government was replaced by the “denialism” of Thabo Mbeki. Mbeki famously and publically denied the severity of the epidemic as well as calling into question the science of HIV transmission, resulting in heated national debate and controversy, inciting an intensified politicization of sexuality, and mobilizing a number of important and vibrant activist NGOs (Posel, 2005), such as the Treatment Action Campaign. Thus, coordinated action was mired in political controversy.

Social scientific and public health researchers were also taken by surprise by the HIV/AIDS epidemic. In South Africa, as in the United States, denial of an impending epidemic was facilitated by the construction of, and preoccupation with, “high-risk” groups—those in the so-called “Four-H Club”: homosexuals, heroin addicts, Haitians, and hemophiliacs—which diverted attention away from the vulnerability of the “average person” (see Tsampiras, 2012). Additionally, the migrant labor system that provided a cheap supply of workers for the country’s mines caused profound disruptions in family life, facilitating “the spread of STDs through casual sex, prostitution and ‘situational’ homosexuality” (Zwi & Bachmayer, 1990, p. 319). Not only were early government reactions to HIV seropositivity punitive (e.g., migrant workers found to be HIV-positive were deported or “released” from service), but there was a broad mistrust of family planning services, which had long been seen as a strategy to suppress the size of the Black population. Finally, the fragmentation and duplication of health services across South Africa’s homelands (the equivalent of “native reserves”) prevented a comprehensive and coordinated response from being mounted (Zwi & Cabral, 1991).

The first South African psychological research on HIV/AIDS appeared in the early 1990s and drew on social psychological theory and methods to assess knowledge, attitudes, beliefs, and practices about HIV/AIDS (e.g., Perkel, Strebelt, & Joubert, 1991; Schlebusch, Bedford, Bosch, & Du Preez, 1991). This approach reflected both what was readily available, theoretically and methodologically, to psychologists, and the dominant construction of HIV/AIDS as an educational and behavioral

---

4 This is now the Institute for Social and Health Sciences.
5 For an insightful analysis of the conjunctions of race, class, and the politics of nation building in Mbeki’s arguments, see Posel (2005).
problem (see Kippax & Crawford, 1993) in South Africa and abroad (e.g., Van Dyk, 1991). Thus, although many analyses of the causes of the epidemic had identified structural, cultural, and economic factors, psychological research and intervention remained confined to an individualistic understanding of “sexuality [as] a range of discrete behaviors that fall under individual control, such as using condoms or practicing anal sex” (C. M. Campbell & Williams, 1996, p. 58), that could be changed by providing information about sexual health risks. The work of Catherine Campbell and her colleagues would come to exemplify a psychological approach to HIV/AIDS prevention that recognized its sociohistorical and epidemiological complexity. In an early study, C. Campbell (1997) had identified South Africa’s mining industry and, specifically, the hostels in which migrant workers were living as a key context for the transmission of the virus. This early work highlighted the ways in which migrancy and masculine identity put mine workers at increased risk of infection, and was an important contribution to critical perspectives on the epidemic.

Institutional contexts in political transition.

For psychologists and social scientists, the sweeping institutional changes that accompanied political transition in the 1990s were incredibly important. Much of the public and community health work that began to appear in this decade was enabled by an influx of international funding and the lifting of international academic boycotts in the early 1990s. The Human Sciences Research Council and the Medical Research Council (MRC) of South Africa—both science councils that were formerly part of the parastatal machinery of scientific backing for apartheid policy, began to channel donor funds to employ psychologists in an increasing number of public health and health systems research projects (see Benatar, 2004; Pouris, 2012; Whitworth et al., 2008). For many international funders and academics, postapartheid South Africa and its myriad social and health problems had become the flavour of the month, having been the dominant morality tale to which they had hitched their wagons in the wake of the Cold War (Hyslop, Vally, & Hassim, 2006). To be fair, the large influx of resources enabled research and intervention to take place on several critical health problems, as detailed in the preceding sections. In the meantime, the new ANC government, which had historically been committed to Marxist-informed economic stance of wealth redistribution and poverty reduction, quickly abandoned it in favor of neoliberal principles of economic growth that left the capitalist order largely intact. Such policies were designed to promote privatization, favor global market integration, and attract much needed foreign investment (Peet, 2002). In the decades since, the lot of those in dire poverty has worsened (Leibbrandt, Woolard, Finn, & Argent, 2010) amid a growing trend toward conspicuous consumption, aspirations to which have to a large extent been conflated with the objectives of political emancipation (see Posel, 2010).

2000s–2010s: Growth and Institutionalization

To a great extent, developments in psychology in the last 15 years reflect the fruits of two decades of positive but uneven political transformation, as well as South Africa’s integration into global markets and its opening up to global health programs, funding sources, and academic practices.

On the one hand, this has meant a maturing and scaling up of psychologically informed health promotion and prevention projects, many of which have been the direct result of the successes of psychologists in securing large international grants, and collaborating with international aid agencies, the World Health Organization, government, social justice and public health NGOs, grassroots community organizations, and independent government agencies. These interventions, however, have had mixed outcomes (see, e.g., C. Campbell, 2003), and came in a period characterized by controversy over the South African government’s handling of public health, epitomized by its inaction on HIV/AIDS. Sustained political activism by the Treatment Action Campaign effectively forced the government, in 2003, to institute a national program for public rollout of antiretroviral (ARV) drugs, highlighting, once again, the necessity for public mobilization and an oppositional politics (Heywood, 2009). The resultant program for ARV provision ushered in the “age of ARVs.” HIV vaccine trials have also gained momentum in recent years. This has resulted in new programs of research on ARV adherence.
(e.g., Kagee, Steel, & Coetzee, 2014), as well as the psychosocial and ethical aspects of vaccine trials (e.g., Moorhouse, Slack, Quayle, Essack, & Lindeger, 2014). More nuanced understandings of the social context of HIV have emerged, detailing, for example, the relations between gendered power inequities, intimate partner violence and HIV (e.g., Jewkes, Dunkle, Nduna, & Shai, 2010), and the importance of the history and materiality of intimate relationships and sexuality in South Africa (e.g., Brouard & Crewe, 2012).

Research and intervention on the problem of violence, some of the most notable of which has come from the team at the Institute for Social and Health Sciences at University of South Africa and the MRC, has also attracted significant financial and resource support, and has contributed to psychologically informed analyses of the structural, social, and cultural dynamics of violence in South Africa. Others have turned their attention to the direct links between the material conditions of poverty and health in South Africa (e.g., Barnes, 2007).

Recent work on disabilities (e.g., Watermeyer, 2012), chronic illness (R. Richards, 2008), and the ethics of care (Swartz, 2015), using autoethnography and departing from the standard academic idiom, is a refreshing development, as is the emerging reflection on the contradictions and compromises of working with government agencies and sources of funding, and balancing the need to intervene with the imperative for critique (e.g., Barnes, 2007; Seedat, 2010; van Niekerk, Ratele, Seedat, & Suffla, 2014). In all of this work, there has been a more or less explicit rejection of the responsibility “healthist” implications of health psychological theories.

On the other hand, however, and despite the scale or innovation of these important projects, to a large extent, their impact has been diluted by political inaction, the steady deterioration of public governance, and the collusion of government with market demands (see Coovadia et al., 2009). This period has also seen many of the once-transgressive movements to address health under apartheid, which also incorporated forms of critical self-reflection on psychological practice and professional power, being absorbed into the mainstream of South African academe (see Painter et al., 2013). Indeed, the language of critical analysis has now become a part of “establishment speak” in postapartheid South African psychology, a kind of shorthand to signify the relevance of one’s work to the social agendas of the day, but with little connection to the kinds of mobilization and activism through which social change is effected in civil society. This is due, in part, and paradoxically, to the successes of the critical psychology project in South Africa.

As mentioned previously, it is significant that many of the psychologists who pioneered the dissident work of the 1980s and 1990s went on to assume more senior academic and managerial positions in universities and government departments and agencies as part of broad attempts to transform the profession, higher education, and health institutions in the country. This has, undoubtedly, helped to open and direct resources into spaces for critical thought and innovative psychological research, training, and intervention. Some of these psychologists have shaped, and continue to contribute to national health policy development (e.g., Mahomed, Asmall, & Freeman, 2014), and others have been successful in securing the guild interests of the profession (e.g., Cooper, 2014). Although once their work had been oriented in opposition to the establishment, these psychologists now find themselves working within it, leading to a number of unavoidable tensions and compromises, making ever more salient the need to understand “how particular formulations of scientific and social relevance function to marginalize criticality and critical scholarship” (Seedat, 2010, p. 193). As the research surveyed in the preceding paragraphs attests, many of these psychologists are at the forefront of important new directions of inquiry, and have been able to maintain a critical and self-reflexive orientation to their work. However, some have admitted that it is becoming increasingly difficult to do truly creative and transgressive work in South African academia (see Yen & Vaccarino, 2016). Indeed, arguments for a criticality tempered by the need for a psychological “evidence base”—particularly as it relates to health issues—are becoming increasingly influential in tying together the fates of the discipline with those of the developmental state (e.g., see the debate between Swartz, 2006, and Kagee, 2006; see also Kagee, 2014).

The often-ignored but crucial backdrop to these currents stems from substantive changes
to the South African political economy of knowledge production over the last three decades. Science policy discussions beginning in the mid-1990s identified the need for South African research to become “globally competitive” as part of the country’s economic development strategy (see Department of Arts, Culture, Science and Technology, 1996). These discussions resulted in institutional and policy instruments that would ultimately facilitate the processes of neoliberal rationalization now sweeping through South African universities (as they are in many other parts of the world; Pouris, 2012). Of particular relevance to psychologists was the incorporation of the social sciences into the National Research Foundation’s research assessment system in 2001 and the introduction of a new research funding framework in 2004 that funnels direct financial reward to researchers for research outputs (Inegi-Lotz & Pouris, 2011; Pouris, 2012). Additionally, under this system, South African researchers are encouraged to pursue and apply for a research rating, which functions in the credentialing of individuals and institutions for resource allocation in the broader global knowledge economy (National Research Foundation, n.d.). Thus, despite ambitious attempts to restructure South African higher education, universities and psychology departments around the country have become drawn inexorably into the metrics of “excellence” and productivity that are closely tied to the global market for scientific capital. Industrious psychologists have fared exceptionally well under these conditions of knowledge production, which favor single-author, high-impact journal publications and narrow disciplinary specialization, and the interests of the Anglophone heartland of psychology, rather than engagement, transgressive inquiry, and the promotion of a truly postcolonial scholarship (for a parallel analysis in South African human geography, see Visser, 2007).

**Conclusion**

The foregoing narrative has identified some of the main currents in South African psychologists’ engagement with health in the recent past. In doing so, it has also highlighted the ways in which what we might regard as uniquely South African forms of contemporary psychological practice have been the result of critical engagements with the discipline under specific historical and geopolitical conditions. In consequence, and as I have suggested throughout this article, “health psychology,” as it tends to be understood and manifest in its centers of origin, does not currently exist in South Africa. For the most part, South African psychologists have instead focused on health in relation to its social, structural, and material determinants, whereas psychological theory has been predisposed to conceptualize it narrowly in terms of discrete behaviors under individual control. Perhaps we can conclude, then, that the absence of health psychology proper in South Africa has been a good thing. Its marginalization has been the direct result of psychological work on health that has had entirely more progressive and politicized roots. Thirty years later, however, the tensions between a South African psychology for “health for all” and the epistemic values of its distal but parent discipline are ever more present in the new, globalized order of academic capitalism. Outside of the health domain, calls for structural and material change are being gradually eclipsed by calls for psychological change in a discourse of individualism and personal responsibility (see Barnes & Milovanovic, 2015). Indeed, as the discipline that embodies par excellence the epistemic aspirations of the modern subject (De Vos, 2012), the psychologization of South African public life is proceeding apace.6

What of the “health society”? Among the relatively small but growing middle class, the wellness revolution has surely set in. It has taken the form of health consumerism, driven largely by the market, and manifest in a preoccupation with such things as healthy eating, new diets, and the latest exercise regimens (see Kickbusch, 2006; Rowe & Moodley, 2013). The recent controversy surrounding the high-profile public promotion of the low-carbohydrate, high-fat, or so-called “Banting,” diet is a case in point. More broadly, calls to intervene in an impending epidemic of obesity, diabetes, and cardiovascular disease (see Bateman, 2015) will only provide further spaces and opportunities

---

6 See, for example, Swartz and Drennan’s (2000) analysis of the Truth and Reconciliation Commission, and, more recently, Barnes and Milovanovic’s (2015) study of public discourse on development and good citizenship in South Africa.
for a traditional health psychology to take root. Given that health now constitutes a significant part of economic growth and productivity in modern societies, it is very likely that health psychology is yet to have its day in South Africa.

References


on primary health care in South Africa. In P. Barron & J. Roma-Reardon (Eds.), *South African health review* (pp. 17–30). Durban, South Africa: Health Systems Trust.


Received September 22, 2015
Revision received January 5, 2016
Accepted January 6, 2016