INTRODUCTION

Ashraf Kagee was born in Cape Town in 1965 and matriculated from Harold Cressy High School in 1982. He spent his undergraduate years at the University of Cape Town, where he completed a Bachelor of Arts degree in Psychology and Political Studies and a Higher Diploma in Education. He was awarded the Christine Reis Scholarship to study at the University of Portland in Oregon, USA, and completed a Master of Arts degree in Psychology in 1991. After returning to South Africa in 1993 he registered as a psychologist with the South African Medical and Dental Council. Between 1993 and 1995 he worked as a programme officer at the Centre for Student Counselling and as a lecturer in the Department of Psychology at the University of the Western Cape. He returned to the USA for doctoral studies and completed a PhD in Counselling Psychology at Ball State University in Indiana in 1999. Ashraf then began a postdoctoral fellowship in the Department of Psychiatry at the University of Pennsylvania School of Medicine, which he completed in 2001. He was awarded a research fellowship by the Solomon Asch Center for the Study of Ethnopolitical Violence at the University of Pennsylvania in 2002, and spent that year as a researcher at Stellenbosch University. Ashraf joined the Department of Psychology at Stellenbosch University as Associate Professor in 2003 and was promoted to Professor in 2004. He also completed a Master of Public Health degree at the University of Cape Town in 2005.

Professor Kagee's general field of research is Health Psychology. Within this area he has focused on stress and trauma, treatment adherence in primary care, and the behavioural aspects of HIV and AIDS. He is the recipient of research grants from the Lyell Bussell Foundation, the Harry Frank Guggenheim Foundation, the United States Institute of Peace, the South African Medical Research Council, and the National Research Foundation (NRF). In 2003 he received an NRF rating as a promising young researcher and is the author of numerous single- and joint-authored publications of various kinds. He is a member of the editorial boards of the *South African Journal of Psychology* and *The Counselling Psychologist* and regularly reviews material for a number of other local and international journals.

Professor Kagee is Associate Director of the Socio-Behavioural Research Group of the South African AIDS Vaccine Initiative, a member of the Board of Trustees of the Trauma Centre for Survivors of Violence and Torture, and chairperson of Positive Muslims, a faith-based organisation that does HIV-related community work. His current research projects include:

- Treatment adherence among patients with hypertension and diabetes attending primary health care clinics;
- HIV risk among South African adolescents;
- Factors affecting willingness to participate in HIV vaccine trials;
- Stress and coping in traumatised South African populations.

Professor Kagee is married to Dr Sa'diyya Shaikh, an Islamic Studies scholar, who has done pioneering work on feminist understandings of Islam. Their daughter, Nuriyya, is nearly three years old.

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I am very grateful to Prof Hennie Kotzé, the dean of our Faculty, Prof Andre Moller, the chair of our Department, Prof Leslie Swartz, Prof Tony Naidoo and my other colleagues in the Department of Psychology for their support over the past few years. I also thank my friends and family for their ongoing encouragement throughout my career. To Sa'diyya and Nuriyya: thank you for your love and support.

EPISTEMOLOGY, SOCIAL RELEVANCE AND HEALTH PSYCHOLOGY RESEARCH

INTRODUCTION

This lecture focuses on the imperative for critical and relevant scholarship in behavioural science, with a specific emphasis on health psychology. I have structured my presentation in three parts. First, I would like to locate my work within an epistemological paradigm and examine some of the questions around this paradigm. Second, I would like to discuss social relevance. Our department and our faculty have taken the question of social relevance very seriously as it applies to our teaching, research and community service. This matter has implications not only for psychology, but for all disciplines within academia. I would like to focus on the role of interdisciplinary research collaborations in contributing to social relevance in the field of health psychology. Third, I would like to share some of my own work and demonstrate the manner in which health psychology research might work to advance social development both in South Africa and in other developing countries. In this section of the lecture I focus specifically on my work on post-traumatic stress disorder, treatment adherence in primary care, and the behavioural aspects of HIV and AIDS.

AN EPISTEMOLOGICAL FRAMEWORK FOR HEALTH PSYCHOLOGY RESEARCH

There is great diversity in modern psychology, in terms of its content, perspectives and epistemological assumptions. While this diversity is potentially a strength, it can also limit the coherence and internal consistency of the discipline. A prominent psychologist, Henry Gleitman, suggested that psychology is a loosely federated intellectual empire that stretches from the domains of the biological sciences on one border to those of the social sciences on the other border (Gleitman, 1981). In a similar manner, then, psychology represents a diversity of epistemological traditions that informs the various theories and heuristics that constitute the discipline. These epistemological traditions extend, for example, from the psychoanalytic school that is rich in theory but perhaps less rich in terms of empirical data (Freud, 1900/1968; 1905/1962), to what has been called crude empiricism, with an emphasis primarily on what can be observed and measured (Skinner, 1938; 1953).

An important epistemological tenet that underpins my own work is the criterion of falsification. Falsification requires that scientific theories should generate research hypotheses that can be tested. If testing indicates support for a hypothesis then the theory receives some degree of corroboration. On the other hand, if testing falsifies a theoretical postulation, then this postulation must be either rejected or altered in some way (Popper, 1959; 1963). For this to happen, of course, psychological theories should then have a predictive component.

Rather than being able to explain psychological phenomena in retrospect, theoretical formulations that have credible and accurate predictive power are of greater utility in behavioural science. To a large extent psychodynamic theory specifically has been slower than most to subject itself to empirical testing and thereby make itself vulnerable to falsification (Hook, 1959; Nagel, 1959; Notturno & McHugh, 1986). In my view theories that make an attempt at prediction and thereby expose themselves to falsification have greater epistemic utility than those that are only a rich source of post-hoc explanation.

Scholarly claims that rest on meagre or non-existent data and those that are based on epistemologies that invoke authority, tradition or heuristic dogma are untenable in informing research agendas or clinical practice compared to those that are based on the criterion of evidence. Thus treatments, interventions, methods of assessment and social policy that are informed only by theoretical speculation, rather than data, deserve to be met with scepticism. Some scholars (e.g. Blocher, 1987) have suggested that psychological theories are not true scientific theories in that they do not exist to focus and guide empirical inquiry and are not fundamentally refined through the accumulation of research findings. Instead, many of our so-called theories in psychologies are in reality better described as heuristics. They are devices designed to offer practitioners a cognitive map or a process model for how to go about conceptualising their interventions with patients (Blocher, 1987).

Our society requires evidence-based and data-driven methods of assessments, interventions and policy development rather than those that are solely theoretical, speculative and hypothetical in nature. Research findings that demonstrate measurable outcomes and can serve to guide practitioners by identifying best practice guide-

lines and inform public policy are more useful in addressing the needs of contemporary South African society. I argue here in favour of an evidence-based approach to rendering psychological services. Clinical decisions based only on intuition, theoretical doctrine or the enduring legacy of professional training programmes are likely to have only limited effectiveness (Dawes, 1994). At the heart of evidence-based practice is the belief that basing decisions on an explicit use of the best available research data achieves superior outcomes for patients and clients (McCabe, 2004).

The hypothetico-deductive paradigm with its emphasis on data and evidence is of course not without its problems. When researchers focus only on the technical aspects of research methodology without examining the wider social context in which knowledge is produced, de-contextualised data may result, which are inherently limited in applicability and utility (Terreblanche & Durheim, 1999). Therefore, to revisit the epistemological assumptions of the research enterprise is vital to the production of new knowledge and as such forms part of an agenda of social relevance. To this extent, the hermeneutic, post-modern and social constructionist critiques and challenges to positivism need to be acknowledged and engaged. Part of the quest for social relevance then is to deliberately, regularly, and consistently examine the epistemological assumptions that inform the research enterprise.

The whole question of epistemology is central to what a university is about. An important component of the business of our institution is to contribute toward the scientific, technological and intellectual capacity of our continent (University of Stellenbosch, 2005). It is true the world over and certainly in South Africa that research is conducted in a political context. Our role as researchers therefore has to be very clearly defined and demarcated from that of advocates and politicians. To this extent, part of our role is to ask questions that may in some instances be unpopular, despite what the prevailing political mood may be. The role of the researcher is not to endorse conventional wisdom, but to challenge it when necessary and call attention to instances of mismatch between conventional wisdom and empirical observations.

THE QUEST FOR SOCIAL RELEVANCE

There has been a great deal of discussion and debate about the obligation of university departments to make their work plainly pertinent to the needs of our country and our continent. Our institution's stated commitment is to rethink its interaction with the broader community as a core process alongside research and teaching and as a catalyst for redress, renewal and development (University of Stellenbosch, 2000).

The charge is sometimes levelled at psychology that as a discipline and a profession it is only tangentially relevant to the needs of developing countries. This is especially true in a society such as ours with problems that stem from a history of colonialism and racial segregation (Dawes, 1985). South African psychology's complicity with apartheid means that our profession has a highly reactionary history (Nicholas, 1990). Prominent psychologists such as Hendrik Verwoerd and RW Wilcocks contributed significantly to the intellectual tradition in South African psychology by perpetuating the myths of racial superiority and by justifying racial segregation and oppression (Bulhan, 1985).

At the same time our discipline has also had a liberatory potential. The heuristics and applications of psychology has helped to understand and intervene in areas such as stereotyping and discrimination (Foster, 1991; Foster & Nel, 1991), provided the basis for the treatment of political detainees who have suffered from physical and emotional trauma (Dawes, 1989; Dawes & De Villiers, 1989), and more recently in some measure also provided an understanding of the work of the Truth and Reconciliation Commission (Allan, 2000; Swartz & Drennan, 2000). It is of course ironic that after several decades the same Department of Psychology that housed academics such as Verwoerd and Wilcox has now explicitly committed itself to serve the interests of all of the people of South Africa and not only a racial elite.

Social relevance is not only about undoing the legacy of apartheid and of redressing historical injustices. It is also a question of defining and redefining our vision of a society in which citizens have the freedom to realise their potential, not only as individuals but also as communities that make up the nation and the continent as a whole. In my work as a researcher and teacher, I have tried to demonstrate a relationship between behavioural science research, specifically health psychology research, and social relevance.

Health psychology addresses issues related to the prevention and treatment of illness and disability, the promotion and maintenance of health, and adaptation and coping with illness and disease. Historically, health psychology has been concerned with the study of individual behaviour as it relates to health. It has seldom considered the inter-relationships between individuals, communities and populations (Bellah *et al.*, 1985). A more integrated approach would suggest a convergence and synthesis of various fields that include public health, health promotion, evidence-based health care and community development. This convergence represents a way to apply behavioural principles to enhancing health outcomes in our society.

The application of behavioural knowledge to advance public health requires an emphasis that directly addresses the social fabric that dictates the opportunities, limitations and challenges within communities (Campbell, 2000). Individual behaviour in general and health behaviour in particular are not always volitional. The social context often dictates and imposes limitations on personal and lifestyle choices. If the aim of public health is to reduce disease and maintain the health of populations (Katzenellenbogen *et al*., 1997), then the study of human behaviour is integral to an understanding of enhancing health outcomes.

Public health has historically been concerned with the socio-economic determinants of health and disease (Gilbert *et al*., 1996), while health psychology has in the main been concerned with understanding the individual factors associated with health outcomes (DiMatteo & Martin, 2002). The interaction between these macro and micro factors offers an epistemic interface between public health and behavioural science. This disciplinary synergy may potentially position psychologists to contribute to the resolution of public health problems in our society in a creative and dynamic manner. To this extent community-based, faith-based and non-governmental organisations need to become increasingly sites of data collection and service delivery for academic researchers and practitioners. My challenge to South African health psychology, then, is to augment its knowledge base, epistemological assumptions and research agenda by considering an interdisciplinary stance that goes beyond the concerns of a psychology focused mainly on the individual. This approach will then allow us to move in the direction of social relevance at the level of epistemology, methodology, a research agenda and professional practice.

ISSUES IN HEALTH PSYCHOLOGY RESEARCH IN SOUTH AFRICA

I would like to now discuss some of my own research, specifically my work on post-traumatic stress disorder, treatment adherence in primary health care, and the behavioural aspects of HIV infection.

Post-traumatic stress disorder: A cultural artefact or universal syndrome?

One of the questions that has concerned behavioural scientists is the appropriateness of applying diagnostic categories among populations that are culturally diverse (Eisenberg, 1996). The general question is whether we are uncritically imposing diagnoses on people in a manner that is culturally and contextually inappropriate. One area of my research has been around the question of the contextual relevance of post-traumatic stress disorder. Is it a cultural artefact of Euro-American psychology or is it a universal nosological entity applicable in other cultural contexts, including South Africa?

In many parts of the developing world where there has been political violence, counselling centres have been established with the intention of providing services to survivors who are presumed to have been traumatised by these experiences (e.g. Stubbs & Soraya, 1996). The goal of many of these trauma centres is to treat patients for post-traumatic stress disorder and other psychiatric conditions. At one level the argument in favour of providing services of this nature is very compelling. People are disturbed and therefore they need treatment. There is, however, another perspective.

Derek Summerfield in the United Kingdom has argued that in many parts of the developing world post-traumatic stress disorder is a pseudo-condition. Summerfield opposes the notion that traumatisation is a universal response to highly stressful events. He takes issue with the idea that Western diagnostic frameworks always appropriately conceptualise peoples' experiences following disturbing events. These assumptions, he argues, suggest that large numbers of trauma victims the world over suffer from related psychiatric disturbances, for which Western psychiatric services are indicated (Summerfield, 1999). By trying to intervene with the intention of helping victims of trauma in developing countries, mental health professionals may be at risk of unwittingly perpetuating "the colonial status of the non-Western mind" (Berry *et al*., 1992). Summerfield argues that Western psychological concepts, as embodied by the Diagnostic and Statistical Manual of Mental Disorders III-R (American Psychiatric Association, 2000), are a product of a globalising culture that increasingly presents itself as definitive knowledge. Survivors of political violence are then unnecessarily pathologised by the uncritical application of these psychiatric concepts.

The questions of trauma and post-traumatic stress are highly relevant to South Africa and also to many countries in the developing world that have undergone the colonial experience (Amowitz *et al*., 2002; De Jong *et al*., 2001; Magwasa, 1999). We have high rates of community violence (Matzopolous *et al*., 2002), road traffic accidents (Bradshaw *et al*., 2002), child and spouse abuse (Madu, 2001) and a legacy of state-sponsored violence (Foster *et al*., 1986).

In my work on trauma I have focused on the psychological symptoms of South African former political detainees (Kagee, 2002a; Kagee, 2004a; Kagee & Naidoo, 2004). This series of studies addressed the validity of post-traumatic stress disorder as a diagnostic entity among this population using a combination of qualitative and quantitative methods and analyses. The results in part supported the concerns of the critics of DSM

nosology. The results of this line of research called attention to the inappropriateness of focusing exclusively on traumatisation in conceptualising the sequelae of political violence (Kagee, 2004b). The data showed that the most salient concerns of former detainees were non-psychiatric. These included somatic and medical problems, a sense of continued economic and social marginalisation in post-apartheid South Africa and non-clinical subjective distress (Kagee, 2005a; Kagee, in press). At the same time there was support for the notion that symptoms of post-traumatic stress disorder were indeed experienced by members of the sample, even when the demand characteristics inherent in the process of psychological assessment and measurement were minimised (Kagee, 2004c). One of the conclusions of this line of research is that it is inopportune to dispense with post-traumatic stress nosology or the sub-threshold symptomatology associated with this condition. DSM nosological concepts appear to hold some validity among South African survivors of political repression, despite the caveats issued by Summerfield and his colleagues.

The question of treatment for post-traumatic stress is then of course also important. The empirically supported treatment for this condition is based on the cognitive behavioural model (Foa *et al.,* 1999). My previous work has involved tailoring this model for use in the South African context and identifying the pitfalls involved in its application among South African patients (Kagee, Suh & Naidoo, 2004; Kagee, Suh & Naidoo, 2005). At the same time I have called attention to the potentially inert or harmful effects of certain interventions such as debriefing in trying to prevent traumatisation. The data in the literature suggest that such preventive interventions are actually iatrogenic, that is, they may result in highly symptomatic individuals remaining symptomatic or moderately symptomatic persons getting worse (Kagee, 2002b). My work in the area of trauma has also included examining traumatic responses among members of the South African police (Jones & Kagee, 2005). A colleague and I used a cluster sampling procedure to recruit police personnel in the Western Cape into a descriptive study. Ten percent of our sample reported severe symptoms of PTSD. We found a significant association between problem-focused coping and post-traumatic stress symptoms. We also found that the combination of emotion-focused coping and social support played a potential role against the development of traumatisation.

The question of trauma has become a major public health concern in South Africa. The development of effective interventions to prevent traumatic experiences and ameliorate post-traumatic stress is therefore an important public health imperative. Future investigations will centre on identifying best practice guidelines for the treatment of individuals who demonstrate symptoms of psychological traumatisation.

Treatment adherence in primary care

One of the major issues in the South African public health system is the question of adherence to treatment, particularly among those patients who suffer from chronic diseases. A second focus of my work has been examining the barriers to treatment adherence among patients with hypertension and Type II diabetes attending public health care clinics (Kagee, 2004c). The present post-apartheid public health care system is characterised by insufficient funding and a low ratio of medical personnel to patients. The question of adherence has far-reaching economic and social implications that include increased health care costs, poor health outcomes, high rates of worker absenteeism and decreased quality of life. The task appears to have fallen on social and behavioural scientists to develop a contextually and culturally relevant understanding of the barriers to adherence (Edwards, 1992; Kagee, 2004d).

My findings so far suggest that the issues related to adherence in semi-rural communities are multi-fold. The historical and social context plays an important role in the way that patients from poor communities perceive health and engage with the health care system. For many patients daily challenges often eclipse questions of adherence to medical and behavioural regimens. These challenges include financial concerns, an inadequate transport infrastructure as well as employment conditions that exclude remuneration during times of clinic attendance (Kagee, 2005b). In this context, for many patients a chronic medical condition becomes less salient than other concerns, especially in the absence of overt medical symptoms.

At the individual psychological level the challenge has also been to test the applicability of theories of health behaviour change in a semi-rural South African context, specifically, the Theory of Planned Behaviour (Fishbein, 2002). Very briefly, the Theory of Planned Behaviour states that people's attitudes, perceived norms and perceived self-efficacy regarding a health behaviour will have an influence on intentions to engage in the behaviour. Data that my research group and I have collected recently show that the Theory of Planned Behaviour, together with perceived social support, robustly predict behavioural intentions regarding adherence and also actual treatment adherence. These data give direction to the way in which the Theory of Planned Behaviour can be adapted to and applied among South African communities. These data also provide the basis for understanding the variables to be targeted in the next step in this line of research, which is to design and test an intervention study aimed at enhancing treatment

adherence among patients attending primary care clinics. My plan is that the data from this series of studies will inform best practice guidelines for use by primary care practitioners.

Psychology and HIV vaccine trials

A third area of my work is in the area of HIV vaccine research. Sub-Saharan Africa is hardest hit by the AIDS epidemic (World Health Organisation, 2004). It has been recognised that among the interventions needed to stem the pandemic is an affordable and effective AIDS vaccine (Grinstead, 1995). A vaccine does not yet exist and immunological research is being conducted to develop one. In the meantime behavioural research is aimed at, inter alia, enhancing the likelihood that people will make themselves available to participate in a future vaccine trial (Lurie *et al*., 1994). There will therefore be a need to recruit a cohort of subjects in a longitudinal trial and to prevent attrition of these subjects from the trial.

My work with the South African AIDS Vaccine Initiative came about at the invitation of Professor Leslie Swartz. Our work as the principal investigators of the Socio-Behavioural Working Group of SAAVI has so far involved establishing a national office in our department for socio-behavioural research related to the development of an effective HIV vaccine. The purpose of the national office is to build capacity for behavioural research and to generate a body of knowledge around the behavioural issues associated with Phase III HIV vaccine trials.

My colleagues and I have begun a series of studies examining the barriers and facilitators to participating in Phase III vaccine trials using a mixed method approach. We feel that studying willingness to participate in such trials is necessary for a few reasons: (1) Phase III trials require large numbers of participants of HIV negative volunteers who are at high risk of infection to enrol and return regularly for assessment over a period of time; (2) there are several barriers such as fear of stigmatisation and the possibility of testing positive for HIV antibodies, despite being HIV negative; (3) if individuals are empowered to make decisions regarding participation in a trial, this may not mean actual participation. Instead potential participants may feel empowered to decline to participate.

The role of decision-making theory and the manner in which this relates to the cultural, community and social context is the terrain of this line of research. The area of participation in HIV vaccine trials is one in which very little research has been conducted internationally. Our work is to some extent on the frontier of new knowledge in this field.

These three areas, post-traumatic stress, treatment adherence in primary care, and willingness to participate in Phase III HIV vaccine trials, represent the three main dimensions of my research since joining the Psychology Department in 2003. My plan is to continue with these lines of research and other related areas in the coming years. They represent some of the research imperatives in health psychology that are socially relevant and that have the potential of contributing to health-related quality of life in our society.

CONCLUSION

In this lecture I have sketched the epistemological paradigm within which my work is located and I have tried to demonstrate the relationship between this epistemic stance and social relevance. I have also provided a few examples of what I consider to be socially relevant research. As a relatively new person at the University, I have great optimism and hope that our Department of Psychology can take its place as a world-class site for socially relevant research, teaching and community service.

In terms of my vision for the future, the field of health psychology research can potentially contribute to a greater understanding of the barriers and facilitators to achieving optimum health for people in our country and on our continent. The understandings generated by research of this nature may in turn potentially play a role in social development.

To conclude, I would like to thank the University for providing me with an intellectual home that is supportive and nurturing and one in which I feel very comfortable. I look forward over the coming years to assist in growing research capacity in our Department so that behavioural science can continue to play a role in our nation's development.

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