REFLECTIVE PRACTICE

Psychodynamic Ideas in the Community

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Edited by
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Contents

Foreword

The mission of the relaunched Human Sciences Research Council (HSRC), under the leadership of Mark Orkin, is encompassed in its slogan ‘Social Research that Makes a Difference’. In the New Priority Area of Child, Youth and Family Development, we focus on what we term ‘the people at the heart of social and economic development’. Without due consideration for human factors in our complex and changing society, no programme of innovation can succeed. All too often we hear of ambitious socio-economic interventions which flounder in response to community and organisational politics, interpersonal issues, and painful legacies of oppression which affect all our lives.

This book is modest in scope in that it focuses on the experiences of one child mental health clinic in the difficult and sometimes painful process of transformation. Different projects from the clinic are discussed in different chapters, but all the contributions are linked. The book links with the HSRC through Leslie Swartz, who has joined us as a Director in the Child, Youth and Family Development programme. He brings with him a rich and much appreciated network of colleagues.

What is clear from the book as a whole is that any serious engagement with community change must at the same time involve a high degree of introspection on the part of those trying to make this difference. In transforming our practice and in attempting to transform people’s lives, we similarly transform ourselves. This book shows that without a consciousness of ourselves and our reflection in our work, we lose an important source of information.

Many of the programmes of the HSRC are large in scope and some do not permit the type of detailed analysis presented here. This book is helpful to our work, however, and to that of all those trying to make a difference in society, in that it opens for scrutiny the very source of much change – human commitment in all its challenging complexity.

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Carol Sterling is a clinical psychologist who was amongst the first to begin the Child Guidance Clinic's tradition of work with local communities. She is now in private practice but continues to remain involved in training lay people in psychological skills.

Leslie Swartz is a clinical psychologist and has a chair in the Department of Psychology at the University of Stellenbosch. He is also Director, Child Youth and Family Development with the Human Sciences Research Council. He was formerly Director of the Child Guidance Clinic and was involved in the development of the community psychology programme based there.

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1

Introduction

LESLIE SWARTZ, KERRY GIBSON AND TAMARA GELMAN

Freud showed consistent interest in broad social phenomena and the application of psychoanalytic thinking to these issues (1985). Nevertheless, psychodynamic thinking has come under consistent attack for having too narrow a focus. Some of these criticisms (and probably a substantial proportion of them) come from writers who appear to have very little understanding of psychoanalytic theories and practices (see, eg., Edwards, 1987, p.273) and who have particular difficulties with metaphoric use of language in psychoanalysis, and with the psychoanalytic method, which is commonly portrayed as lacking in rigour. Criticisms of this type are reasonably easy to rebut (Mitchell, 1974), but there are indications from within psychoanalytic thinking itself of a growing sense that the discipline needs to broaden its horizons to take on the challenges posed both by pressing social issues (Frosh, 1991; Richards, 1989; Young, 1995) and by the challenge to make what psychoanalysis has to offer available to a wider community than analytic patients. Indeed, some of the most interesting thinking in psychoanalysis in recent years has been at the boundaries of what is narrowly understood as the conventional purview of the discipline (Herman, 1992; Obholzer & Zagier Roberts, 1994; Sinason, 1992). In the context of the developing world, psychoanalysis has proved enormously influential in thinking about and acting to combat racial and class oppression, as well as in thinking about culturally diverse approaches to understanding selfhood and personal and social healing (Fanon, 1970, 1986; Kakar, 1991; Obeyesekere, 1984). In this book we consider this challenge in a context which, although similar to those of other transforming countries, bears a particular relationship to mainstream psychoanalysis in Britain.

The relevance of psychoanalysis in South Africa has been actively considered and addressed by South African mental health professionals since the mid-1980s. At the recent International Conference of Psychoanalysis held in Cape Town (1998) this issue became one of central debate, particularly in relation to the question of whether or not formal psychoanalytic training should be instituted in South Africa. Of central concern to this debate is the question of whether or not psychoanalysis can make a valid contribution to mental health in South Africa. In addressing this question, this chapter will focus upon broad mental health needs in South Africa as they exist in a particular context as well as the issue of who can speak legitimately about mental health in South Africa.

Psychodynamic thought and practice in South Africa

There is a vital and growing tradition of psychodynamic thinking and practice in South Africa. In contrast to the Soviet Union, where for more than 60 years the Soviet government suppressed psychoanalysis (Etkind, 1994), psychoanalysis in South Africa has a long-standing and continuous history. Although South Africa does not have a formal psychoanalytic training institute, principles of psychodynamic thought and therapy have, for many years, been an integral component of many professional trainings in clinical psychology and social work. Moreover, although few have received formal psychoanalytic training, there are many practising psychotherapists who utilise psychodynamic thinking and a range of practices based on psychoanalysis. There are also established psychoanalytic reading/study groups which regularly invite international analysts to teach psychoanalytic psychotherapy through workshops and seminars, as well as established infant-observation groups and a journal edited by psychoanalytic psychotherapists entitled *Psycho-analytic Psychotherapy in South Africa* (with Trevor Lubbe as editor).

Whilst psychodynamic psychotherapy has been practised more or less traditionally in South Africa for many years (i.e., on a one-to-one, long-term basis), South Africans have also been able, and indeed forced, to interrogate and utilise psychodynamic ideas in innovative ways. Specific contextual factors related to mental health in South Africa have led many of those who think and practise psychodynamically to challenge the utility in South Africa of traditional psychoanalytic practice.

Mental health in the South African context – can psychodynamic thinking make a useful contribution?

At first glance, it is easy to argue that psychoanalysis (certainly as it is traditionally practised) is unlikely to make an important contribution to mental health problems and priorities in South Africa. Mental health needs in South Africa (as in other low-income countries) have such complex political, social and cultural underpinnings that a public health approach, with a fair degree of advocacy and lobbying, appears most viable in the development of equitable, accessible and appropriate mental healthcare. A recently published book, based on the World Mental Health conference that took place in Cape Town in 1995 (Foster, Freeman & Pillay, 1997) focuses on epidemiological realities of widespread problems in the mental health field together with inadequate resources. Epidemiological figures reinforce the clinical impression that rates of mental disorder in South Africa are on the high side, with some studies reporting very high rates (Ensink, Robertson, Zissis & Leger, 1997; Parry, 1996; Parry & Swartz, 1997; Petersen, Bhagwanjee, Parekh, Parukh & Subedar, 1996; Rumble, Swartz, Parry & Zwarenstein, 1996; Thom, Zwi & Reinach, 1993). It is clear that poverty, violence, the experience of racism and similar issues are unevenly distributed according to race in this country. Access to psychiatric and other health resources is uneven as well, with rural people being especially disadvantaged. In their chapter in the South African mental health policy book, Freeman and Pillay (1997) emphasise that we need to focus not only or not even primarily on mental health services themselves, but also on the contextual factors affecting mental health. Furthermore, they state that direct mental health services should be community-based wherever possible and that community involvement is central in planning and service delivery.

Freeman and Pillay (1997) point out that, as in other developing countries, there is a problem with the availability of qualified mental health practitioners. South Africa is 'within a mid-range of resources' (Freeman & Pillay, 1997, p.46) for developing countries, with a ratio of one psychiatrist to a population of 130 500. In developed countries there is an average ratio of one psychiatrist to a population of 14 000. Figures for other mental health personnel reveal a similar pattern (Lee & Zwi, 1997). Even allowing for the fact, though, that we in South Africa have approximately a tenth of the number of psychiatrists per capita available in developed countries, the picture is exacerbated when we look at the distribution of practitioners within the country. Some provinces are relatively well supplied with mental healthcare personnel. In another, though, there are one psychiatrist, two psychologists, and 12 social workers for a population of 2.4 million people (Freeman & Pillay, 1997, p.46–48).

Unequal distribution of resources occurs in other important ways. If you are wealthy and fluent in English and live in a white suburb of Cape Town, you will have the pick of a range of excellent psychodynamic psychotherapists, often within walking distance of your home, most of whom will be in supervision and in professional development support and reading groups. A black, Xhosa-speaking domestic worker also living in Cape Town would be exceptionally lucky to have any psychotherapeutic intervention in her own language from any of the existing state, NGO or private services. This state of affairs is not only through the fault of or lack of commitment on the part of practitioners. Infrastructural factors play a crucial role here – many psychologists who would like public-sector or NGO jobs, for example, are forced into private practice (and even into leaving the country) because of the lack of such jobs.

Given the extent of the need and both the scarcity and maldistribution of specialised resources, it is not surprising that a major policy thrust is to integrate mental healthcare into the primary healthcare system (Freeman & Pillay, 1997; Lee & Zwi, 1997; Petersen et al., 1996). If it is to work, this policy direction requires an enormous change in the traditional roles mental health specialists have seen for themselves. Consultation, training and supervision of primary healthcare personnel become central to what specialists are called upon to do. Some of this work at least, if rural areas are to be better served, involves travelling and hence heavy commitments of time from mental health workers. All of these factors impact inevitably on the amount of time and resources available for direct psychotherapeutic services offered by mental health practitioners.

Given this context one may well ask whether psychoanalysis or psychodynamic ideas in any form can make a contribution to mental health in South Africa. This book begins to answer this question. The contributors will show that the use of psychoanalysis in South Africa, not as a contextual dogma, but as a tool to think and work with, can provide ways of addressing difficulties and difference. It can also help us think about what we do and develop new ways of working. This is important not only for South Africa but for vigorous new developments in psychodynamically-informed work throughout the world.

The university-based clinic, which links all of the work discussed in this book, is a training and practice site for clinical psychology. The clinic was established over 60 years ago with an emphasis on developing a sound model of psychological practice for children and families. Until recently most of the clientele were middle-class and white. Since the mid-1980s the clinic has come to see an increasingly diverse clientele and has been providing consultation services in a range of community settings. It has also been mindful of its position and responsibilities in a rapidly transforming society.

In the opening chapter, Kerry Gibson provides an overview both of key issues as they affect psychodynamically-based work in South Africa, and of the particular context around which much of the work presented in this book developed. She shows the way in which the conflicts in South African society have been deeply internalised not only by clients but also by psychologists themselves. She suggests that reflexivity on the part of psychologists about their own internalisation of the politics of the country is central to any intervention, a theme to which many authors return. Psychoanalysis tells us that the past cannot simply be left behind. As Gibson shows, there is a pull in the newly democratic South Africa to 'wipe the slate clean' – this cannot be done, and to attempt to do so could be therapeutically and politically dangerous. If we wish to transform psychological practice, therefore, we need both to look to what is new and hopeful and to the complex legacy of what has gone before.

A concrete and visible way in which change can occur in a profession lies in the diversification of those who practise it. At our clinic, there has been an important shift in the demography of those who are trained, with increasing numbers of black students enrolling to become clinical psychologists. In their chapter, Rucksana Christian, Molefi Mokutu and Matshediso Rankoe reflect on their experiences as black trainees in the programme. Their critical stance on their own positioning as the vanguard of the 'new' black psychology, in a context of continuing white power, is important not only as a document of the process of change but also as a landmark in the experience of self-reflection so important in professional psychology.

Changes within the clinic itself have of course been accompanied by changes in methods and sites of practice. All of the remaining chapters in this book explore issues raised and lessons learned from this practice. Carol Sterling records the first major outreach programme with which we were involved. She demonstrates well how a degree of naivety was necessary to the start of working in new ways but also, ultimately, a hindrance to providing the best possible service to a small community. The lessons learned from the project in which she was central have been important in the planning and evaluation of later work.

Two issues highlighted by Sterling as features of our hopes for a transforming psychology were the idealisation of the 'community', and the belief that change in community work can be quick and relatively painless. Rika van den Berg's discussion of work in a home for abandoned children emphasises the fact that psychological practice in new contexts is as complex and challenging as the traditional ground of psychodynamically-informed interventions. Her careful recording of the interplay of dynamics between consultants and consultees makes a strong case for the importance of a reflective analytic approach even in a situation in which material and emotional deprivation would appear to call for more action-oriented approaches.

If psychodynamic thinking is to contribute broadly to mental health in South Africa and other countries experiencing transformation, it is essential that the terrain of this thinking be broadened to reflect the lives and concerns of the population as a whole. The public health sector represents a series of institutions with which the majority of citizens will interact at many points in their lives. Hester van der Walt's work with nurses in the tuberculosis (TB) control programme illustrates the utility of thinking about the psychological, even in contexts where discussion of psychological issues is traditionally absent. Hester van der Walt's chapter echoes the pioneering work of Menzies Lyth (Menzies, 1960) on nursing in Britain, in a context highly indicative of health systems in the developing world. It also sheds light more broadly on the process of institutional change.

All change processes are both personal and political, and South Africa is a country in which politics is writ large. Anastasia Maw's analysis of the dynamics of her relationship, as a white, privileged psychologist, with a consultee from an under-resourced community brings home the impact, for consultee and consultant alike, of a harsh political history on the minutiae of current interaction. As with the work of van den Berg, Maw shows how a key factor in coming to understand the interpersonal consequences of political positioning is the safety of an ongoing and contained relationship. She also shows how open consideration of the political issues is fundamental to the development of the relationship.

Where both the personal and the political are recognised and taken account of, a key issue becomes that of whether personal change and development can be considered separately from the process of empowerment. This is a central concern of Carol Long's chapter. Her reflection on work with community health workers in an impoverished community underscores the importance of thinking psychodynamically at a range of levels, from the emotional interrelationship to the enactment of political process. How we know if and when political change and empowerment have occurred is a complex question which Carol Long calls on us to ponder.

The dynamics of power and authority, explicitly and implicitly considered in all the chapters thus far, come into sharp focus in the contribution by Mark Tomlinson and Leslie Swartz. These authors underline the importance of a critical stance towards professional ideas and professional practice in themselves. Like Long, they argue that power hierarchies cannot simply be wished away and, in fact, we wish them away both at our peril and at the peril of those with whom we work.

An important arena in which power is operative but in a hidden way is in the construction of disability and therapeutic attempts to deal with its consequences. In a country and, indeed, a world in which other issues of power and exclusion – for example, those around race, class and gender – loom large, there can be a tacit complicity from even apparently the most politically sensitive practitioner in the disavowal of disability as a political category. Brian Watermeyer's chapter has an important place in a book on changes in psychological practice, reminding us as it does that the dynamics of exclusion are diverse and various. His work shows, furthermore, the important links between thinking about race, gender and class, and thinking about other issues of difference.

This book raises many more questions than it answers. We do not offer any package of solutions for the challenges facing psychological and political practice in a rapidly changing world. The contributions to this book demonstrate, though, that rigorous and reflexive thinking is important in new contexts. In fact new contexts deserve and demand this type of thinking. Editing this book has been an exciting experience for us as we have been given the opportunity to reflect on our own work and the work of our colleagues, and to think about how apparently diverse ideas can contribute to vigorous debate and, we hope, some measure of change for its readers.

Note on racial terminology

Given the racial history of South Africa, and especially the bureaucratisation of all aspects of race in the apartheid era, enormous controversy exists over the use of racial categories in South African scholarship. Mindful of these issues though we are, it is essential to recognise that historically constructed racial categories in this country carry important social meanings. In this book, we use the term 'African' to refer to indigenous South Africans who generally speak indigenous languages such as Xhosa, Zulu and Sotho. 'Coloured' refers to South Africans of diverse and mixed racial origins, most of whom speak Afrikaans and/or English. 'Black' is used in a generic sense for all South Africans disenfranchised under apartheid (and includes Africans and coloureds). 'White' refers to South Africans of European ancestry who were enfranchised under apartheid.

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2

Healing Relationships Between Psychologists and Communities: How Can We Tell Them if They Don't Want to Hear?

KERRY GIBSON

In South Africa, as with many other internally divided countries, conflict is not a neatly circumscribed set of events but is a deeply ingrained part of each person's history, identity, values and traditions (Summerfield, 2000). This situation presents many challenges to local mental health professionals who are trying to find ways to deal with the emotional aftermath of apartheid and the ongoing conflict which has accompanied the transition process. Not only do they need to develop particular sets of skills which are helpful in working with people who have been subjected to diffuse forms of 'traumatic living', but they also have to confront the powerful, and often unconscious, ways in which they too have been affected by their experience of a conflict-ridden society. This chapter explores some of the implications of political conflict for relationships between mental health professionals and the communities who come to them for help.

The reflections in this chapter are drawn from my work at the University of Cape Town's training clinic where we have been involved in offering support to a variety of human-service organisations which in turn provide mental health services to a wide range of people who have suffered under apartheid and its aftermath[1]. In this three-part relationship we, as the psychological consultants, the service organisations we work with and the traumatised children and families they provide services to, very often mirror the divisions

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[1] A previous version of this chapter was included in a collection of papers, Smyth, M. & Thomson, K. (Eds.) (2001). 'Working with children and young people in violently divided societies.' Belfast: Community Conflict Impact on Children.

and conflicts which are present more broadly in our society. Each of us brings to this relationship our own experience of political conflict and with it our hostilities, suspicions and mistrust, our allegiances and sensitivities. I shall show that unless these issues can be brought to the surface and openly discussed, they inevitably sabotage efforts aimed at healing and leave some of the most profound emotional consequences of political conflict untouched.

In this chapter I look at some of the ways in which the South African experience of apartheid, and the violence and repression which accompanied it, has affected the people who live here. In my discussion of its implications for the relationship between community-based organisations and professional psychologists, I focus on three main themes: first, difficulty of achieving 'safety' in the relationships between psychologists and their clients; second, the implications of the social and economic disparities created by apartheid for this relationship; and third, the anxieties about power and powerlessness that seem to be an inevitable part of this kind of psychological work.

'Traumatic living'

The notion of *trauma* has become an increasingly popular way for psychologists and other mental health professionals to describe the emotional consequences of various kinds of political conflict. Here in South Africa the word has been widely used to refer to the effects of various political atrocities which occurred both under apartheid and afterwards – including such things as detention, torture, participation in violent protest action, inter-factional fighting and so on (Gibson, 1990). The idea that these kinds of experiences can have serious consequences for people's emotional lives is of course an extremely important one and one which has assisted valuably in raising national and international awareness about the impact of oppressive actions (Swartz, Gibson & Swartz, 1990). However some of the associations conjured up by the medicalised notion of trauma can also obscure the ways in which the experience of living in a politically divided country has a profound impact on all who live there. The concept of *trauma* has been fiercely criticised for depoliticising the suffering associated with war and drawing attention away from important social and economic factors that underlie these kinds of conflicts (Young, 1995; Summerfield, 2000). It also gives the impression, certainly a false one in our context, that the difficult experiences people have been exposed to are discrete and occur against the background of an otherwise harmonious existence. In an attempt to challenge this idea, Straker and the Sanctuaries Team (1987) coined the phrase *continuous traumatic stress syndrome* which captured something of the ongoing nature of the stresses created by political violence. More than this, however, it needs to be recognised that the emotional consequences of living in a conflictual society are not adequately represented through reference to psychiatric symptomatology. Instead they exist in their most profound form in ways which are harder to measure and code. They exist in people's ideas about themselves, their country and their future. Fundamentally they also exist in the quality of relationships people develop with one another – the degree to which these can be open, respectful and compassionate or are damaged by hatred and suspicion.

Conflict, which is, in essence, a distortion of relationships between people, has perhaps its most powerful, but not always recognised, effects here.

The diagnostic category of trauma further creates the illusion that trauma – 'a disease' – can be cured by neutral interventions administered by an appropriate expert. This, however, obscures the messiness of the real situation within which both client and mental health professional bring their own unresolved experiences of conflict – whether this be as victims or as perpetrators, or more usually as some less comfortable mixture of the two. The way in which both mental health professionals and their clients – the so-called 'victims' of trauma – may unconsciously act out and reproduce some of their experiences of conflict in relation to one another is the focus of this chapter.

Conflict in South Africa

For many black people the experience of apartheid impacted on every aspect of their lives – where they lived or went to school, with whom they associated or even married and which jobs they were allowed to do. On top of the legislated constraints on their everyday lives, they bore the brunt of violent repression, the massive social disruption created through this and the protest against it (Marks & Andersson, 1990). Although there can be no moral comparison made between the effects of apartheid on black people and on whites in South Africa, the lives of white people were certainly also fundamentally moulded by the political climate. Young white men were conscripted into the army to fight against their own countrymen and the fragile 'superiority' created by apartheid provided only a thin veil across the imagined threat of a *'swart gevaar'* (black danger) and the shame of international isolation (Cock & Nathan, 1989). For blacks and whites the history of apartheid carries a tapestry of painful emotional experiences of loss, inhumanity, terror and shame.

In the period since our first democratic election in 1994 there has been enormous pressure on South Africans to focus on the future and to rejoice in our rebirth as the 'Rainbow Nation'. Although processes such as the Truth and Reconciliation Commission have tried to acknowledge the terrible consequences of the gross human-rights violations under apartheid, the strong thrust towards reconciliation has, in many everyday contexts, created an ambivalence about recognising the impact of the past and its legacy in still-existing injustices and inequities (Nuttall & Coetzee, 1998). Through this difficult process of political transition, in which levels of violence have ironically continued to be high (Hamber, 2000), there is a powerful impetus to leave apartheid behind and create a more hopeful future. As valuable as the optimism implicit in this is, it is equally important that the profound consequences of our past on our present are not ignored and that new, potentially oppressive, silences are not created around these difficult issues.

White psychologists and black communities

As one of the legacies of apartheid, the professions – including those linked to mental health – remain largely white-dominated in South Africa. Attempts are being made to rapidly alter the imbalances in educational access that gave rise to this situation, but they cannot address the backlog of inequity nor take away the strong historical associations between whiteness and professional status. As a psychologist, my interest is particularly with this group of professionals and the way in which their location in our society has helped to shape their relationships with black communities. I cannot do justice to the history of South African psychology here, but suffice it to say that there were elements that actively supported apartheid and others that inadvertently gave credence to many of its racist assumptions (Manganyi, 1991). For most of the apartheid years, the psychological profession remained, with few exceptions, concerned primarily with providing good-quality care to white middle-class people (Swartz, Dowdall & Swartz, 1986). This situation continued until the 1980s when there was some attempt to consolidate the efforts of a growing group of 'progressive' psychologists opposed to apartheid (Swartz, Gibson & Swartz, 1990). Although many branches of psychology have adopted a more progressive political outlook in recent years – and there is certainly a very powerful group of black psychologists within this – the association between the practice of psychology and white middle-class interests is still strong. This continued association seems even to influence the experience of black psychologists currently being trained. Some of our own trainees have written about their experience of entering a 'white profession' in which they have to struggle to make an effective place for themselves (Kleintjes & Swartz, 1996; *see also* Christian, Mokutu & Rankoe, this volume).

Burdened with this history, psychologists at the clinic where I work have tried very hard to move beyond the white middle-class group which was once the focus of their attention. We have tried to develop a 'community' programme which is specifically aimed at reaching disadvantaged black people who might not otherwise gain access to the scarce psychological resources available for them. Mindful of the difficulties of being accepted by these communities, we decided to work through organisations that had already established good links with local communities and were mostly staffed by local people with usually only a few 'outsiders'. Our intention in this was to offer support and training to various organisations such as schools, youth groups, children's homes, community health projects and so on. This, in terms of our aims, would empower these organisations to better serve their own communities and in turn strengthen the functioning of those communities (Gibson, 2000). Of course this arrangement had the added benefit for us of offering a kind of cultural mediation within which our (largely Western and middle-class) psychological ideas could be translated into forms appropriate for the various black communities in which we worked. In a more obvious way they also helped us deal with the problems of being a largely English-speaking group of psychologists who needed to speak to people whose first language was an indigenous one.

The organisations with which we worked usually identified themselves closely with the black communities they served – although in fact many of them had a small number of white staff. Regardless of their specific composition however, many maintained a strong allegiance to 'grassroots' concerns and many were historically linked to the activism of the anti-apartheid struggle. We in fact used the label 'community organisation' to refer to them in acknowledgement of their close tie to the communities within which they worked. This stood in contrast to our own position, not only as professional psychologists attached to a historically white institution, but also as academics attached to the 'ivory tower' of the university. The scepticism about the usefulness of 'empty theorising' in academia as opposed to the 'grassroots activism' of community organisations represented a further potential division between us. The high levels of education of those working at the university also stood in marked contrast to the lack of training resources available for community organisations. Although some staff there had specialized training in various areas, the majority had little formal training of any kind, let alone the intensive training over many years that is needed to become a psychologist.

In turn, the black clients served by these organisations were amongst the most disadvantaged within their communities – suffering often from poverty, permanent disability, the absence of family or other conditions which had interacted with the broader effects of apartheid. These people experienced considerable distress that resonated with the staff of the organisations and seemed to increase the sense of identification between them. Our role as consultants was to try to sustain the community organisations in their difficult work and, through training and support, aim to help them to manage the burden of their secondary exposure to trauma (Figley, 1985).

Initially we had begun our work assuming that our aim – 'giving psychology away', in the established tradition of community psychology (Orford, 1992) – was a relatively simple one. We would empower the staff of local organisations through various sustained interventions and they would in turn be more effective in doing their work. However, it rapidly became apparent that our interventions were being derailed by powerful emotional responses that manifested themselves in our relationships with organisations. Mistrust, anger and apparently inexplicable misunderstandings seemed to sabotage our best intentions. In light of these difficulties we began to reformulate our model and to recognise that these difficulties in the relationship between psychologist and community organisation were not simply an impediment to the work. Rather, these issues were themselves the very consequences of political conflict and needed to become the focus of our work. We continued to provide support and training to these organisations but our emphasis shifted to creating a space in which these more subtle dynamics could be thought about and discussed in a way which helped us to understand the effects of political conflict on all the groups involved, not least of all ourselves.

Relationships between psychologists and community organisations

It took some time for many of the issues I describe here to be openly considered or discussed in the way I do here. For us, as well as the organisations with which we worked, the emotions that dominated our relationships were initially only confusing rather than illuminating.

Importantly, it has only been through ongoing work over a long period of time that we and our partners in the organisations have come to an understanding on some of these issues. Initially there was considerable anxiety about even thinking about some of these things and many of the issues emerged only indirectly or in some kind of symbolic form. Later, as we were more able to acknowledge and take responsibility for some of our own responses, we were also able to talk about them more openly with the organisations and get their valuable insights into these difficult areas. In the course of our relationships with various community organisations there were obviously many changes in interactional patterns as well as considerable diversity between organisations. In this chapter, however, I have chosen to discuss only three themes that offer a sense of the dynamics that may need to be addressed when doing psychological work in contexts marked by a history of political conflict.

Fear and safety

For those traumatised through political conflict, the restoration of a sense of safety is usually thought of as one of the fundamental requirements for healing. Through the years in which apartheid was sustained with high levels of repression, the lives of many people were marked by fear. The fear was in relation to those threats that could be easily perceived but also operated at a more insidious level. The apartheid government maintained its power partly through brute force and partly through a powerful combination of manipulation, censorship and double speak which created a profoundly ambiguous and uncertain environment (Manganyi & du Toit, 1990). Black people, in many cases, feared for their lives and were safe nowhere – not even in their homes. They were rightly mistrustful of many white people, even those who appeared to be friendly, and also had reason to be cautious amongst black people who might equally turn out to be informers. For members of the liberation forces both in and outside the country, secrecy and stealth were a necessary way of life. White people, on the other hand, feared losing their precarious position in the country. This fear was translated into a whole set of other related fears of some kind of retaliation from black people, of communist infiltration, which was represented as the primary political threat, and of crime which seemed to concretise some of their more intangible fears.

When fear and mistrust have been such an integral part of people's lives, it is very difficult to sweep these feelings aside with the macro-political changes. This is made even more difficult when, as Hamber (2000) notes, there are still many sources of danger for people living here. There is ongoing factional fighting in some parts of the country, high rates of crime, urban terror in the form of bombings and gang warfare, to name just a few. As the title of his article notes: 'Have no doubt it is fear in the land.'

In our consultancy, work with organisations' fear and danger – both real and imagined – seemed to be a fundamental part of our work. Many of our partner organisations worked in areas that were periodically subjected to violence of one kind or another. Staff were often expected to contain and support those who had been victims of violence while they themselves lived with realistic fears for their own safety. We, as outsiders coming into these areas, would also experience enormous anxiety about our own safety – especially with the added disadvantage of being unfamiliar with recognised cues for danger and knowledge of networks of support (Gibson, Sandenbergh & Swart, 2001). Many of our consultants faced enormous guilt about their fearfulness and struggled to make decisions about whether this particular flare-up of violence was sufficient to justify the cancellation of a visit to the organisation. How could this be justified morally when the staff of the organisations themselves were coping with so much more on an ongoing basis?

In one case, this kind of dilemma was made even more difficult by the organisation's response to the gang violence that was common in their area. Their way of protecting themselves was to behave almost as though it wasn't there. When gunshots were heard in the street outside there would be no overt reaction from the staff who would typically go on talking as though nothing had happened. It was guilt that initially led the consultant working with this organisation to conceal her own frightened reactions. Ironically, however, it was only when she was able to confess her fear and face the subsequent disparagement of the staff for her cowardliness that the staff were able to begin to acknowledge their own fearfulness. With the acknowledgement of their fear they were then much more able to attend compassionately to the fears of their clients as well as take measures to protect their own safety more effectively.

Many of the fears the consultants dealt with, however, were not about the realistic threats of entering danger zones, but rather stemmed from their own imaginary fears of entering the territory of their historical enemy. Some of our white trainee psychologists were entering black township areas for the first time in their lives and carried strong fears about the 'dangers' that lurked in these previously forbidden areas. These in turn carried many more associations than simply geographical ones. They also carried the anxieties about leaving the familiar divides of apartheid behind and letting the 'other side' become visible. When these anxieties were sensed they of course provoked anger and resentment from community organisations – but also sometimes a degree of tolerance and understanding that was quite surprising.

Fear and suspicion also reflected themselves, perhaps even more strongly, in the extent to which people felt able to speak out. Almost all forms of psychological work rely to some extent on helping people to 'open up' and talk about their experiences and their feelings. This is thought to be the cornerstone of the healing process and the 'safety' we talk about in relation to this is a metaphorical one (Gray, 1994). It is, however, also this level of 'safety' which is damaged by the traumatic exposure to ongoing political conflict. How can you talk openly when speaking may be risky – producing retaliation, punishment or perhaps the more muted, but still hurtful, response of misunderstanding? One organisation we worked with had a particularly vivid way of expressing some of their anxieties about talking. It was part of the common organisational discourse to express anxiety about 'being shot down' if you ventured an opinion in a meeting. These kinds of feelings were of course even more pronounced in the kinds of groups and workshops we set up in which we expected people to share more personal and emotionally laden thoughts with us and their colleagues. We were often surprised at how long it took people to be able to share their feelings about even relatively superficial concerns and much longer, of course, to risk talking about the things that really mattered to them. Along the way, we struggled with our own feeling of inadequacy that we were unable to help people feel safe enough to talk. We were also subjected to more direct challenges on issues like confidentiality and doubts about whether we would be able to manage the 'fireworks' that could come out if people began really to express what they felt – especially where this touched on the many reasons for anger given by our political history.

The difficulties were, however, not only with the staff of organisations being afraid to speak out. There was a parallel difficulty amongst the consultants which emerged as a fear of hearing. Although psychologists pride themselves on their ability to listen, in a situation where their own emotions are so fundamentally involved, this frequently creates areas of 'blindness' – or perhaps rather 'deafness' – that screen out cues around issues that may be painful to them (Casement, 1985). One of the staff at an organisation we worked with said she had sensed that the white consultant did 'not really want to hear' about this black person's experience of racism. She believed it made her too uncomfortable. It would be all too easy to dismiss this kind of sentiment as a product of the staff members' own phantasies about white people – but in a context like ours, where no-one can claim they were not affected by racist thinking, the psychologist would also have to take some responsibility for this reluctance to hear. Indeed, I am convinced that in many unconscious ways we may continue to screen out those things we feel unable to bear, particularly those issues that evoke our guilt and shame in the role of perpetrators within the apartheid system.

It seems that in a situation of conflict, fear and suspicion must necessarily be involved in the relationship between the psychologist and the community. In this kind of situation 'safety' in its absolute sense, cannot be the prerequisite for working psychologically. Instead a space must be provided in which safety might slowly be negotiated against a background of understanding the difficulty – or perhaps even the impossibility in the short-term – of attaining it.

The haves and the have-nots

Probably one of the most noticeable features of South African society to outsiders is the disparity between the rich and the poor. Although not all whites are rich and all blacks poor, the contrast between the fine houses of the formerly (and to some extent still) white suburbs and the townships where the majority of black people still live in abject poverty is a stark and highly visible one. This discrepancy between the 'haves' and 'have-nots' is to some extent duplicated between university institutions such as the one where I work and community organisations which often struggle with limited resources and ongoing funding difficulties (Parekh, McKay & Petersen, 1997). Ironically a similar contrast seems to be repeated in the relative wealth of the community organisations when compared to their clients. Not surprisingly, this kind of context creates and reproduces strong feelings around relative deprivation, including resentment, envy and guilt.

Often the organisations we worked with seemed to have responded to the all-too-evident needs of their clients with guilty attempts to 'give them everything'. This often resulted in attempts to address clients' needs well beyond the capacity of the organisation and created, amongst staff, cycles of omnipotence and frustration at the impossibility of the task they had set for themselves. This seemed to be exemplified in the aims of one relatively small grouping who aimed to 'recover the lost generation' – all those thousands of youth whose schooling and childhood had been disrupted by the struggle against apartheid. Another teacher working at a school for black disabled children gave us a similar sense of the enormity of her task as she saw it when she said to us: 'I can't change the past – but I can try'.

We, in turn, frequently found ourselves drawn into these kinds of dynamics, feeling intense guilt and shame about our advantages in contrast to the organisations with which we worked. This frequently led us to similarly futile attempts to 'change the past' and to promise more than we could realistically deliver. Quite often the urgency to provide something led to situations in which we were tempted to offer short-term material help or instant solutions, which did little to change the long-term functioning of the organisations. Where we responded in this way we found ourselves feeling the frustration of being able to offer only what felt like 'a drop in the ocean' of need. More importantly, however, we felt ourselves paralysed and unable to attend to those issues which we could reasonably hope to address. Our inability to live up to the expectations we had created also led to disappointment amongst the staff of the community organisations and fed into their existing feelings of deprivation.

Perhaps even more destructive for working relationships in these kinds of contexts is the inevitability of envy. Often the staff in the community organisations were regarded with a mixture of admiration and envy for their luck – in many cases their luck in simply having a job in communities where unemployment was extremely high. This was very difficult for them and some felt isolated from their communities because of it. On the other hand we also saw how hard it was for some staff to devote compassionate attention to their clients. In many of these circumstances it appeared that part of the problem was that the staff themselves, in their times of difficulty, had had no-one to care for them. It was as if they were saying: 'Why should they get such and such – when I had to survive without it?' In our role as consultants we were also experienced as objects of envy. Why was it that we were able to return to our comfortable homes in the suburbs and those who worked in the community organisations often had to endure the violence and poverty of the surrounding neighbourhood on an ongoing basis? During the initial stages of our development of the project, we were inclined, I think partly out of anxiety about our enviable position, to denigrate our own potential contribution to the organisation. In response to our anxieties about our privileged access to education we often downplayed the skills we had to offer to such an extent that it undermined our ability to be useful. In other instances it was hard to manage our feelings of being injured personally by what appeared to be attacks on us for our fortunate circumstances which we felt to be beyond our control. When these kinds of feelings are not addressed they can lead, especially amongst less experienced clinicians, to a kind of angry withdrawal or loss of commitment to the work.

The dynamics created through the relationship between the ‘haves’ and ‘have-nots’ are extremely difficult to confront – especially for groups who have a powerful interest in denying their relative privilege. It is extremely painful to take responsibility, as many professionals must, for having benefited from apartheid, if not supported it. Where clients or community organisations are in need of professional help, it may be equally difficult for them to voice their resentment at perceived inequities. If these can be addressed openly, however, they may provide a fruitful opportunity for different perspectives to be heard and for the feelings around these issues to be acknowledged and dealt with. This in turn may allow a more truly co-operative partnership to develop which can pursue concerted attempts to address the inequalities on a more realistic level.

The powerful and the powerless

The experience of years of repression and authoritarianism under apartheid has resulted in a deep mistrust of power. Power has few benign associations and rather is linked in many people’s minds to the experience of some kind of oppression or abuse. It is also significant that one of the most traumatic effects of violence itself is also associated with the experience of powerlessness in the hands of someone or something more powerful than oneself (Figley, 1985). In the wake of apartheid there appears to be an excessive vigilance about how power can or should be exercised in a democracy. Perhaps more surprisingly, there seems also to be a longing for some kind of ideal absolute authority figure who would help us through this difficult period of transition and recover the order that appears to have been lost in the shift to democracy. This contradiction seems similar to that described by Alexandrov [On-line] in relation to the transition process in Eastern Europe. As he says: ‘Relationships with authority are tense with ambivalent urges – to reject it and rebel against it or to comply with it and try and join it’ (p.3).

Concerns about power and powerlessness have been a major issue throughout our consultation work. One of the most common referral requests from organisations we work with has been to do with how to manage situations in which their clients are powerless in the face of abuse. While this to some extent reflects the reality of South African life (Hamber, 2000), it also seems at a symbolic level to carry some of the anxieties about the abusive exercise of power more generally (Gibson & Swartz, 2000). The children and families seen by these organisations have often been subject to multiple abuses both historically, from the state, as well as in more private forms such as sexual abuse, corporal punishment, family violence and so on. Staff of the organisations often also experience themselves as victims of abuse. Given their shared context, many have indeed been subject to similar experiences to those of their clients but also experience a degree of powerlessness at the mercy of some of the authoritarian institutions which continue to control public life in South Africa.

Within organisations, overwhelming feelings of powerlessness often seem to be translated into an anxiety about allowing the leaders to exercise necessary authority. Leaders' attempts to act may be weighed down with obsessive concern for the appearance of 'democratic functioning' which in this form hampers, rather than facilitates, communal action. Alternatively leaders may be proudly appointed, idealised for a short time and then fiercely denigrated when they are found wanting.

This ambivalence about the use of power is also brought to the consultation relationship, in which we, as the consultants, are often perceived to wield considerable power relative to the community organisation. Many of our projects have typically begun with anxieties about who in the organisation has authorised our entry and whether or not we are imposing ourselves on unwilling participants. Inevitably there may be elements of the organisation which are indeed reluctant to participate in the consultation project and may indeed voice their scepticism at our motives for being involved. 'Do they really wish to help or do they simply wish to further some of their own interests in this work?' would be a common kind of question. In one instance, one of my colleagues described how it was only after her consultation relationship had continued for more than a year that the consultee was able to admit that she had never wanted the help in the first place. It is often precisely because of the actual or perceived inequalities in the power relationship between the consultant and the organisation that these issues cannot be opened up and addressed. Instead, resentment seethes below the surface, expressing itself only indirectly through absenteeism or what appears to be a lack of motivation or co-operation amongst members of the organisation.

From our perspective, these issues, whether they are openly voiced within the organisations or not, are very much a part of our experience. Indeed, our own anxieties about power often make us all too ready to see examples of our abuse of it. We often wonder whether we may be 'abusing' an organisation for our own training needs or whether we are somehow robbing it of its own power through our involvement. Of course the whole idea of 'empowerment', one of the cornerstones on which our consultation work is built, is itself fraught with difficulty. After the earlier romanticised notions about empowerment, more recent writings have recognised some of the contradictions involved, contained particularly in the paradox of the psychologist having the power to 'give away' (Orford, 1992). In almost every intervention we seemed to struggle with anxieties about the ways in which we might inadvertently be imposing ourselves on organisations: If we have knowledge to give, will it undermine the existing knowledge of the organisation? If we take charge of difficult situations, do we challenge the existing authority structure?

The organisations seemed also to experience parallel concerns about their relationships with their clients. If they worked with children, as many of them did, these often took the form of anxieties about implementing appropriate discipline; or with parents, about undermining their authority.

Of course the need for people to reclaim the power they have lost through oppression is a very real and important one. However, when the psychologists' real and imagined fears about being too powerful combine with the community organisations' anxieties about being 'colonised', they seem to create a situation in which these issues cannot be spoken about or dealt with. Instead they operate below the surface to paralyse the participants and sabotage the development of the project.

Combined with concerns about the abuse of power – or instead of them – is the equally paralysing phantasy of the psychologist as the powerful expert who will come in and sort out all the organisation's difficulties. Our own omnipotent phantasies about being able to do this frequently lead us to collude with this initially very comforting idea of our capacities. However, when we begin to fail, as inevitably we must in relation to this idealisation, we are left with strong feelings of inadequacy and frustration that may make it very hard to continue with the project.

In all of these situations there is little room for a benign use of power which can allow an organisation or consultant to act with necessary and respectful authority. It also often leaves little room for the development of people with exceptional talent as all are required to operate at the level of the 'lowest common denominator' lest they threaten the power of others. Further, there is little opportunity for the expression of healthy dependency in which a junior may, for instance, learn from the experience of a senior colleague. Initially we had thought that through sensitive handling we would be able to avoid some of these difficulties. As the work continued, however, it became clear that issues about power were a constant in all of our relationships and needed not to be avoided, but rather to be spoken about and addressed. It was only through the opportunity to talk about people's experiences of being disempowered that it became possible to create the mutually respectful and equal partnerships we had hoped to develop with communities.

Conclusion

Ongoing political conflict does not only do damage to individuals but also to groups and particularly to the relationships between groups of people. Any attempts by professionals to address the emotional effects of 'traumatic living' must also address the ways in which they and their relationships with communities have been shaped by the conflict. It requires courage to confront our own prejudices, anxieties and resentments as professionals when our role seems to be built around the value of neutral expertise. Our experience, however, suggests that it is only when we can acknowledge our own involvement in our country's troubled history – that we can open up these painful issues in a way that allows them to be talked about – that perhaps the healing can begin.

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3

From Idealism to Reality: Learning from Community Interventions

CAROL STERLING

The transition period in South Africa was accompanied by considerable reflection on the way in which psychologists work and the contributions they make to the whole of society. This process is, however, not simply an academic task involving the substitution of one set of ideas for another. Rather, like the development of any true capacity to think, it involves a more fundamental emotional engagement with the anxieties of 'not knowing' (Salzberger-Wittenberg, Henry & Osborne, 1990). This paper explores my own thinking and the changes I went through in coming to terms with the emotional demands of working in a very deprived community where the body of psychological knowledge I had been taught seemed inadequate for the task I faced.

The experience of 'not knowing' is always a profoundly frightening one. It evokes primitive fears related to the absence of containment. Although we are accustomed to thinking about our clients – individuals or groups – as being vulnerable to these kinds of experiences, we are perhaps ill-prepared to find ourselves in a situation where our most solid professional container, knowledge, seems inadequate for the purposes of our work. Psychoanalytic theory teaches us that we quite naturally try to protect ourselves from the state of discomfort associated with uncertainty. This is no less true for psychologists than for anyone in this difficult state. In tracing the development of one of the first consultation projects started at the clinic, it is possible to see in retrospect my own struggles to come to terms with the difficulty of the work I was doing and my defensive attempts to simplify the task for myself.

Starting out

In the mid-1980s South Africa was in the grip of overt political violence on an unprecedented scale. The sense that the old order had to change in the interests of the majority was everywhere to be seen, including in the health and social-service sector. Large academic and research institutions which had until that time seen their chief role as promoting excellence in an international (Western) context now began to question their own practices. Science and research in the service of the majority came to be seen as a priority.

These realignments led to a reassessment of what was important in the health sector. Cape Town, for example, had produced the world's first heart transplant in 1967, but many residents of the greater Cape Town area had little access to primary healthcare, and diseases of poverty – notably tuberculosis – were, and regrettably continue to be, common. In this context, the Department of Community Health at the University of Cape Town and the Centre for Epidemiological Research in Southern Africa (a unit of the South African Medical Research Council) joined forces to promote expertise in the field of public health and in its scientific core discipline, epidemiology. As part of this initiative, epidemiologists and other health practitioners undertook to set up a demonstration site for developing expertise in epidemiology and public health practice. A secondary aim of the project was to improve the health of a small community in the context of learning skills which could be applied elsewhere in more complex settings in South Africa.

For a variety of reasons, the town of Mooidorp was chosen for the project. Mooidorp is situated approximately 50km from Cape Town, making it reasonably accessible. It is also a relatively self-contained village of approximately 5 000 people, making it a convenient site for health research, surveillance and interventions. It was established in the 18th century as a Christian mission station. Most of the residents are coloured. Many families have lived in Mooidorp for generations, and most of them belong to the local church, which continues to play a significant role in the life of the community. This stability and apparent cohesion and homogeneity are atypical of contemporary South Africa, which, like other developing countries, is experiencing massive urbanisation and also has a history of migrations forced on people for political reasons. However, it was these very conditions that made it an attractive possibility for starting out and developing an ongoing research site, especially as it shared the experience of deprivation, disenfranchisement and marginalisation common to many black and coloured communities. The aim was to develop psychological expertise and appropriate methods of intervention for this kind of previously neglected community, under what appeared to be more stable conditions than those presented by other less isolated communities.

A participatory research strategy was embarked on and, in 1986, the entire population of Mooidorp was surveyed to determine health status, needs and practices. Prominent amongst the findings of the comprehensive survey was that a surprising number of Mooidorp residents reported having trouble with their 'nerves'. None of the researchers was a mental health practitioner, but they gained the impression that mental disorder (especially anxiety and depression) and substance abuse were major difficulties in Mooidorp, and that related social issues, such as teenage pregnancy, were also cause for concern. For this reason, the Department of Psychology at the University of Cape Town was invited to participate in the study. A series of research projects followed, which confirmed earlier concerns about psychosocial wellbeing in Mooidorp, and which showed high rates of mental disorder in people presenting to health services in the area. Following extensive consultation with community representatives, it was decided to apply for funding to pilot community-based clinical psychology in South Africa.

In 1991, I was appointed as a part-time clinical psychologist in Mooidorp with a brief that was open-ended in some respects and focused in others. There was no direct prescription of the form my intervention would take. However, together with colleagues who had been central in developing the mental health component in Mooidorp, I decided to focus as much as possible on providing consultation and training for service providers and other interested people in the area rather than direct case management. My team and I took this approach for two reasons. Firstly, we wanted to build on existing skills in the community, an approach which was very much influenced by theory in community psychology (Seedat, Duncan & Lazarus, 2001). Secondly, as has been mentioned in the introduction to this book, professional resources are very scarce in South Africa, and we needed to develop a model which would take this into account – it is simply not feasible to envisage community-based psychologists undertaking the bulk of mental health work in the country.

It is important to note that when I began working in Mooidorp we were strongly influenced by prevailing progressive ideologies of the time. The violence of the 1980s had intensified, as had international pressure on South Africa, and progressive academics, health and social service workers had by the early 1990s gained the sense that they were preparing the way for a better society. Within psychology there was considerable stress on the skills, knowledge and resilience of oppressed South Africans. There was a sense that psychology had been complicit in pathologising the oppressed in South Africa by viewing them as deficient and less able than they actually were to take control of their own destinies. Psychology, and professional practice in general, was not recognised to be as central to people's lives as was informal knowledge held within communities themselves (Swartz, Gibson & Swartz, 1990). This was also an era in which the imperative to do as much as was feasible with as few resources as possible was very prominent, and there were high expectations of what short, community-based interventions such as workshops could achieve (Swartz & Swartz, 1986).

Within the ferment of academic life of the time, there was an impatience with psychological theories and practice, which were associated with serving white minority interests. Conventionally, for example, psychoanalytic theories were taught in universities with no consideration for the relevance of these theories beyond the narrow framework of psychoanalytically oriented individual psychotherapy. Many progressive psychologists were suspicious of psychoanalysis because of its perceived limited applicability outside the consulting room frequented by wealthy clients from a similar background to most (white) psychologists. We were also concerned that the language of psychoanalysis could easily be used to infantilise and pathologise the oppressed.

Beginning the work in Mooidorp

I entered the project, and Mooidorp, then, as a member of an idealistic and committed team of health professionals and as a psychologist aware of my own position as a trailblazer in what we hoped would be the new trend in appropriate psychological practice. Community participation in Mooidorp itself was high, and I felt lucky to be working with community members who had an impressive degree of commitment and what seemed to me a remarkable clarity of vision. To add to this, although Mooidorp is a poor community, much of the setting is picturesque – there are beautiful old thatched buildings dating back centuries, willow trees, and a river with grassy banks. To some extent, the community seemed a country idyll protected from some of the harsh realities of South African life, if not from poverty itself. In keeping with the commitment to empowering others, and mindful of resource issues, I began work as a consultant and trainer as opposed to working directly with individuals. Our focus was on increasing the skills and capacities of a group of health workers who had been employed as part of the broader health project. My work involved, for example, running workshops with the team of health workers on a variety of subjects including sexual abuse, alcoholism and interviewing skills, with the hope that they would use this information in dealing with the clients who came to them for help. Initially my colleagues and I had a sense that we were doing useful and innovative work. We appeared to have established fairly good relationships with a number of key workers and I also received enthusiastic support from my colleagues back in Cape Town. With time, however, difficulties began to emerge which led us to think more carefully about Mooidorp and about our work.

(Re)discovering complexity

We had hoped that the apparent ‘simplicity’ of this quiet rural community would provide us with a model of how to operate in other, more complex settings. However, the ‘simplicity’ of Mooidorp was a myth – a useful fiction to help us manage our work with complex and painful issues for which we felt, at times, theoretically and experientially ill-equipped. Part of what we struggled with was a reluctance to give up our romanticised views of ‘the community’ which served to contain our own anxieties about what we felt we could not manage in the work. However, as we allowed reality to challenge our preformed ideas about Mooidorp, we were able to begin the difficult process of learning from experience.

Idealisation and shame

Much was at stake for us in establishing the service in Mooidorp, and the project was imbued with a significance for us far beyond the establishment of services in a small village. Given my political investment in the success of the project, it is not surprising that I tended to downplay at first the difficulties we faced in the work. Consultees were often reluctant to accept help for themselves, and many people in the village continued to make direct referrals to me in spite of my policy of keeping my own clinical work to a minimum. When referrals were made, many who were referred did not keep their appointments.

Initially this left me feeling impotent and frustrated. I could not understand why those in need of help seemed unable to use my services in the way I had envisaged. However, as time passed and I became more familiar with the fabric of this community, I began to understand some of the complex dynamics which lay beneath people's apparent reluctance to engage with the offered services.

I came to recognise that in the small society of Mooidorp there were major concerns with confidentiality that linked into broader social dynamics. The consultees knew most members of the community and were often blood relatives of potential clients. Gossip was prominent and much feared, and as Forrester (1997) has pointed out, there is some continuity between gossip as a way of 'working through' and the talking cure itself. Even the fact of a client coming to see me would quickly be known by the rest of the community. At a later date, I moved my place for consulting with clients from the house where the community health workers operated to a venue on the outskirts of the town. This provided some distance for clients but did not solve the problem.

The issue of gossip was related strongly to other issues in the community. It is to be expected that any new outsider will be treated with mistrust, and this appeared to be exacerbated in my situation by the political context, the fact that I was white and a professional, working in a predominantly coloured community. Community representatives seemed to feel ashamed of the many problems in the area. This shame manifested in either attributing most of the problems to a nearby socio-economically deprived town which functions as a labour reserve for local industries or to 'other people' within Mooidorp. Within the community health project, the team presented itself as a happy family to outsiders such as the psychologists who visited the project when, in fact, this was far from the case. This shame also manifested in shaming, a central means of societal control in Mooidorp, which is expressed between groups and individuals in all aspects of the society.

The legacy of shaming is expressed in the tradition practised until recently in which pregnant unmarried women were excluded from the church for a period of time and then allowed back to sit on what was known as the *'skandebank'* (bench of shame) before the eyes of all the congregation. But the most graphic example of how shame operates in Mooidorp is the spring day at the local school, where we witnessed 'good' children wearing spring flowers on their uniforms while 'bad' children had to wear weeds. Yet the myth of the happy family is strongest where children are concerned. I was often told in my first two years of working in Mooidorp that abuse and neglect of children happened only elsewhere. The impression I was given was that while Mooidorp people might be poor, their children were their priority. This claim was at odds with my clinical experience.

Shame was obviously a crucial element in concerns about confidentiality. Within the bounds of a small rural community, these issues were exacerbated by the fact that those who provide mental health services also are themselves community members. As professionals, we use the boundaries between ourselves and our clients as a basis for much of our work. Psychodynamic approaches emphasise the importance of the therapeutic frame as well as of the processes of transference and countertransference as a basis for understanding and contributing to personal change. Maintenance of boundaries is important also in the protection of practitioners from the potentially damaging effects of their work. Professional ethics mandate us to have a safe distance from clients – for the protection of the clients as well as ourselves. These boundaries are however less clear in a small community such as Mooidorp. This lack of clarity about boundaries provides an opportunity for close identification between client and health worker. Despite what we knew about the importance of boundaries in a therapeutic process, in our initial idealisation of the community, we assumed that this identification would be useful for the work. We imagined a unified understanding linking the community workers with their clients and we struggled to accept the fears and suspicions that divided them.

In summary, the idealisation which I carried on behalf of my professional colleagues in Cape Town (and the rest of 'progressive' South Africa) conspired with the dynamics of shame in the community to make me naive to important issues and difficulties in the work. In the following section I discuss some of the challenges of working with a team of para-professionals in this context.

'Happy families' – the myth of therapeutic teamwork

Following the survey of health needs in Mooidorp in 1986, two types of community health workers had been appointed. I was closely associated with the group employed to deal with psychosocial issues and substance abuse in the community and amongst youth in particular. This group was known as the 'health promoters' and it was their brief to operate largely in a preventative and promotive way. The second group of workers (the 'health supporters'), provided palliative care and home-based support for chronically ill and disabled people, and much of their work consisted of home nursing, giving bed baths, and so on.

Early in the project the two teams worked reasonably closely together, and it was recognised that there was an important psychological component to all the work. As time passed, however, the workers operating at the preventative level and with complex, less tangible social problems, began to be seen as not doing any 'real' work – they were denigrated and described as lazy. In all service work there may come to be an association between the client group and those caring for them – for example, psychiatrists are commonly seen by other medical personnel to be 'mad', and social workers may take on some of the stigma and shame of their clients (see, eg., Light, 1980). This certainly played out in Mooidorp, and matters were exacerbated by the fact that family and historical ties between people in the small community were also played out within the team. Part of what made team difficulties almost impossible to address directly was the notion of the happy idyllic family in which we all, as I have shown, had some investment.

Strains on the health-worker team were exacerbated by envy which other community members felt towards them as a result of their having jobs with some status in a community with a very high level of unemployment. Those people in Mooidorp who are employed have to work out of town, and often travel on public transport for three or more hours each day. There are very few jobs in the town, and the jobs which the consultees applied for were strongly contested. They were constantly under scrutiny from the community and subject to criticism. All of the consultees were at times criticised for not working or being lazy. While a level of accountability to the community within which one works is desirable, these criticisms were hurtful and based on misinformation or misunderstandings of the nature of the work they were doing, much of which could not be talked about if confidentiality was to be maintained. The work of the health promoters, being both stigmatised in itself and not yielding clearly visible results, became a particular target.

The focus on youth work presented further difficulties. As we have seen, the 'happy family' and 'idyllic community' myths were important both to the community's self-presentation and to the early relationship between the community and the professionals involved in the project. In the context of these myths, youth are well cared for and respectful of their elders. Inevitably, the health promoter role threatened these idealised stereotypes and therefore caused enormous resentment and criticism. Part of the criticism, not surprisingly, was from people who questioned the health workers' skills. Implicit in this was the theme of the workers themselves being, professionally at least, too 'young' to do the work and to have a legitimate voice. This issue will be expanded on in the following section.

Giving skills away and the question of expert status

In keeping with the ideology of the time, we hoped to undertake a brief intervention in Mooidorp and to skill the local community to deal completely independently with its psychosocial difficulties. This hope of 'giving skills away' was very much in keeping with South Africa at a time of transition and with notions in community psychology more generally (Miller, 1969 as cited in Orford, 1992). Experience led us to question these goals.

Consultees dealt with extremely difficult cases, cases which would challenge any professional even in the context of much support and supervision. Why then were we expecting people with limited, non-professional training not only to do the work but also to work independently of support in the long term? On the one hand, this related to our own naivety about consultation work and the nature of the commitment this implies. In our desire to be democratic and to recognise the skills of community members, we lost the sense of the value of our own professional skills. Paradoxically, in our desire to recognise the worth of community members, we burdened them unfairly with the work we hoped they would do and, indeed, with our own unrealistic expectations.

At another level, however, our overestimation of community-based knowledge and skills was intended to protect us from some of the anxieties about what we experienced as our own lack of ready answers. In order to legitimise the void in our expertise, we chose to construct community members as experts whose abilities could sustain them independent of our help. Ironically, this defence served only to erode further our belief in our own capacity. When we started out, we had a vague sense (supported by both local politics and international professional literature) that we could train people in a short time, give them extremely difficult work to do, and then leave. We have learned that however much community members do know (and this local knowledge is not to be underestimated), there are severe constraints on what they can do. This relates partly to insufficient professional training but also partly to their difficult position in their community. From our side this involves engaging in long and often emotionally demanding relationships with community-based consultees within which we have to assess constantly the relative usefulness of our respective sets of knowledge.

Reflection on experience

What, then, have we learned from our experiences? Clearly, the hope of a template of work which can be adapted for more complex contexts has not been realised. But the process of our recognising our own idealisation and naivety has been extremely useful. In reflecting on the Mooidorp experience we have had to look carefully at what consultation is and can be, and what it cannot be.

The experience at Mooidorp was important in providing us with the opportunity to try out new models, and from reports from community workers and community members themselves, some people were greatly helped by our work. The central lesson taken from this new way of working was rather different from what we had anticipated. We learned partly about new ways of thinking and about how to change our practices, but probably more significantly we realised the importance of monitoring and learning from our own emotional engagement with the difficulties confronting these communities. When we were able to manage our own anxieties about our work, we were also able to access more effectively some of our existing skills and understanding and use them creatively in this new context.

Our initial concerns in our work had been about the inadequacy of our existing theories for the new work we were undertaking. Certainly, in retrospect, there are many ways in which traditional psychological theories – and particularly the psychodynamic framework we were accustomed to – were inadequate to make sense of Mooidorp. However, we came to realise that this same body of theory also provided us with helpful insights about community issues and our own relationship with them. The challenge in our work was then recast, not as how we can get away from the restrictions of psychodynamic thinking, but as how to create possibilities for psychodynamic thinking in contexts when it is not obvious how to set this up.

What were the factors which enabled us to lose touch with so much of what we already knew about therapeutic work? We cannot claim to understand all of these fully, but perhaps primary was our strong desire to contribute to change in South Africa and to be part of a new society. Along with the idealism of this aspiration went our own idealisation of the notion of ‘community’ in general and the community of Mooidorp in particular. It was a time in which the impossible had to be made possible, in phantasy at the very least – and indeed, much of what has happened in South Africa has defied all expectations. The level of oppression in the country during the 1980s and the need for change led to a widespread and somewhat romantic view of how we build a future discontinuous with our bleak past. Psychodynamic theory takes a rather more sober view of personal change and of the past's inevitable role in colouring and determining the present. Idealisation, psychodynamic theory tells us, is part of a relatively undeveloped way of viewing and experiencing the world. The path, though, to more maturity, and a more realistic view, is the path which recognises the difficulties and ambiguities of experience. Perhaps our route from naive and romantic ideas about what a community psychologist could do to a more realistic appraisal of our limitations would have something in common with the shift between paranoid schizoid and depressive styles of thinking (Klein, 1959). Kleinian theory helps us to recognise that we do not travel on a unidirectional path. When confronted with the threats of change and uncertainty, we all revert to more primitive ways of protecting ourselves. Reflection in combination with theory allows us to understand our use of these defences and to manage the disappointments involved in the slow process of change.

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4

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

RUCKSANA CHRISTIAN, MOLEFI MOKUTU AND MATSHEDISO RANKOE

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

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

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

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

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

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

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

Selection for training – merit or obligation?

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

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

We all felt that having been accepted into the course was part of a blanket affirmative-action policy. Rationally, we could see that, for example, one of us was the most experienced of all the trainees (regardless of colour) in the mental health field, having extensive experience as a social worker. Another of us had had the unique experience of teaching handicapped children, and the third had experience of trauma, exile and return – key mental health issues in contemporary South Africa. Notwithstanding this, there was constant internal pressure to perform well – to prove to staff and ourselves that we were worthy of being chosen. This experience is similar to that described by a participant in a research study into the experiences of black students undertaken by one of us (Mokutu, 1998, p.47):

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

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

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

The racial dynamics of supervision

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

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

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

Racial dynamics within the clinical team

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

Language

It is hardly surprising that in a divided society such as South Africa, language, as a concrete manifestation of difference, has assumed both political and emotional weight. In the interests of making services as accessible as possible to the public, black trainees are often assigned black clients who speak the same language. This issue, however, introduces its own complexity. One of us (who is Afrikaans-speaking – the predominant language amongst the coloured community in the Western Cape) had the experience of an initial telephone interaction with a coloured family whose first language was Afrikaans but who lived in an English-dominated suburb in Cape Town. They were experiencing obvious difficulty communicating in English over the telephone but were offended when the trainee offered to communicate in Afrikaans. Their refusal to speak Afrikaans, which was clearly their home language, made communication extremely difficult and hampered the intervention. To make matters more complex, the child's difficulty with English was part of the presenting problem. It seems that the parents were prepared to struggle with English. This may have been based upon a desire to portray to the clinic a particular image of themselves – English is considered the highest status language in South Africa amongst some groups. The clients may also have felt that they needed to present themselves as English-speaking in order to receive help from a historically English-medium institution.

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

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

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

Cultural conventions and the ambiguities of identification with black clients

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

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

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

Identification between client and clinician can be used in many ways, including defensively. A black male client would repeatedly say to one of us, 'You know what it is like – you have also experienced oppression'. In this case, it seemed to the therapist that race was being used by the client to project blame onto white people and to deflect from his own responsibility for his difficulties. In the post-apartheid context, with racial issues a source of pain for most South Africans, there is something particularly attractive to a black clinician in participating in a collusion with a client when the primary issue is racial. Sensitive supervision is important for trainees to help them not to be drawn into this.

Power and identity in work with white clients

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

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

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

Many people who seek psychological help feel vulnerable, powerless and at the margins of mainstream society. On occasions white clients have mentioned to us that they feel more comfortable seeing black clinicians because they assume we understand, as black South Africans, what it means to feel marginal and powerless. Though there are obvious advantages to this perception in that some clients immediately feel more comfortable with us, there are complexities too. For example, these clients may feel that by working with black clinicians they can avoid confronting the difficulties they may have with authority figures. There may also be an implicit perception of the black clinician as damaged, which has implications for how robustly the client is able to engage, especially with the negative and more painful aspects of the transference and also within the work more generally.

Liminality and licence in interactions with white trainees

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

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

Conclusion

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

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

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

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5

Providing a Containing Space for Unbearable Feelings

RIKA VAN DEN BERG

When psychologists work in situations of extreme deprivation, they may feel a pressure – both internal and external – to produce solutions for their clients, and to produce them quickly. If clients are to be given the best of what psychological help has to offer, though, more space needs to be given to thinking and reflecting, and not just to action. Understanding and working with resistance is central in this process.

In this chapter, I discuss the resistance to a training intervention in a home for abandoned children. I illustrate how the resistance related to defences which were developed to protect the staff against the painful feelings they experienced while working with the abandoned children. There was no container which could facilitate the conscious processing of these feelings. As a result, practices were developed which ensured the denial of the anger, sadness and anxiety inevitably felt by both children and staff.

These defensive practices will be elucidated, and the process of creating a container for the feelings through the establishment of a staff support group will be discussed. The containment led to feelings becoming more bearable, which enabled the staff to focus more effectively on the needs of the children, and to be receptive to in-service training.

The role and importance of supervision and theory as containment for the consultation team will be emphasised.

The history of the training intervention

The university training clinic was initially contacted by a social worker who was running an in-service training course for the staff at a home for abandoned children in a historically disadvantaged community. Babies came to the home via different routes such as the police and hospitals. The request for assistance came as childcare workers had difficulty in managing children's behavioural problems. During the next two years psychologists in training at the clinic ran a number of educational workshops, disseminating information about emotional and behavioural problems among the children, discipline, stress management and ways of fostering self esteem.

The following year the clinic was again approached by the social worker for assistance to the staff at the home. Two psychologists in training (interns) and I were appointed to act as consultants to the home.

The training intervention

Initially two informal visits were conducted. We had conversations with the matron and social worker and met some staff members. Our first impression was a sense of urgent deprivation of both staff and children. Numerous comments about the lack of resources and appeals for assistance were made. The children communicated their neediness very powerfully by continuously competing for attention and physical contact. One girl, for example, repeated her name over and over – conveying her need for recognition.

The staff discussed the ways in which they were providing for the physical needs of the children (such as feeding, bathing and educational tasks), but we hypothesised that there were unconscious aims being pursued in the organisation which hampered the effective management of the children's emotional needs. Groups (organisations) may have an unconscious life in pursuit of tasks that may be different from the conscious life and tasks of such a group. A task may have a seemingly valid, overt aim, which may differ from its covert aim, derived from a hidden, unconscious meaning. The effective functioning of an organisation (i.e., a group) may be impaired by the impact of the covert aims, which are unconsciously pursued (Bolton & Zagier Roberts, 1994). Hence we hypothesised that there were unconscious aims which were impacting negatively on the effective management of the children.

A group session was set up with all the staff members in the home to explore the hypothesis further. In the group session we became aware of a strong animosity from staff members towards us. While the matron had organised for everyone to attend and was actively attempting to engage us in conversation, a palpable resistance was present in the group. While exploring the resistance, it became clear that there were very angry feelings with the clinic following from the previous two years of intervention. In particular there were strong feelings of having been abandoned by the clinic at the end of the previous year. One woman voiced it by saying: 'You come in here and you bring out all the conflict, and then you take your bags and go, and you don't care at all about those left behind.' The interruption in the intervention at the end of the previous year had left the group with a strong defence against a repetition of the trauma – of bonding and being abandoned by the clinic. Considering the nature of the work in the organisation, the process of engagement with and disengagement from the clinic mirrored the process that repeated itself almost daily in the home – bonding with the children, and separating to give them up for foster care.

Therefore the conscious resistance towards a clinic intervention can be seen as an expression of the unconscious aim of protecting the staff against further trauma. The feelings towards the previous clinic consultation teams were transferred onto us. These feelings contained the transference of staff members' early object relations. These past internal object relationships are expressed in the present relationship with the consultation team, as they are with a therapist. 'In unravelling the details of the transference it is essential to think in terms of total situations transferred from the past into the present as well as emotions, defences and object relations' (Klein in Joseph, 1985, p.61). Later in the year the matron referred to me as the authority in the consultation team saying that I was 'like Leslie' – the psychologist who worked with two interns in the home in earlier years – and similarly held a senior position in relation to the interns. This reference confirmed the hypothesis that transference to us (a fear of connecting and being abandoned) was a transference which had been evoked in the earlier years in relation to the clinic team and re-experienced in relation to us. We worked with the anger towards the clinic and interpreted the resistance against further traumatisation. Once we had established some trust we could contract for a continued intervention.

Creating a container

Klein (1940, 1975) understood the notion of projective identification as an early primary means of communication whereby parts of the self felt to give rise to unbearable experiences are split off into an object. If the object can contain the split off parts, it can be taken back and integrated into the ego; otherwise the experiences remain unbearable and incomprehensible. This process can be facilitated in the transference and countertransference relationship in analysis. Bion (1963) formulated that the therapist acts as a container of unbearable and unthinkable feelings and in the process of digesting transforms the feelings through thoughts into bearable feelings. Klein theorised that a child internalises experiences, which give shape to the internal objects. If this takes place at a pre-verbal stage then the experience is remembered in feelings (what Klein called memories in feelings) which are then conveyed to the therapist through projective identification.

The infant establishes a primal differentiation between good and bad experiences at an early age. The infant tries to hold onto good experiences and to be the 'good', and to get rid of the bad experiences, by splitting, projection and projective identification. The undesirable feelings are split off and projected and attributed to someone else (Klein called this the paranoid-schizoid position). Anger may then be denied, split off and projected into the other person, who may then be experienced as persecutory. If good experiences dominate, there is a strengthening of the ego and an increased capacity for realistic perception, (i.e., not projections) and the infant can be said to be functioning in the depressive position. People are then not experienced as either good or bad, but a person can have a range of feelings towards one person. Equally the child is then more able to accept their own 'bad' parts – feelings such as anger, envy and jealousy.

An individual functioning in the depressive position has developed an internal container, which allows for a full range of emotional responses to be available and to be dealt with internally. An organisation (group) functioning in the depressive position similarly will be able to contain the emotional complexity of the work in which the group members share, and members will not carry fragments of the emotional experience in isolation (Halton, 1994). Uncontained feelings are split off, denied or projected in order to relieve the group of conflicting emotions and needs. Considering the effectiveness of the interpretation of the resistance to the intervention as a resistance to further traumatisation by the clinic, it became clear that the group was functioning in the paranoid-schizoid position, with no container for the unmanageable feelings encountered in working with abandoned children. There was no conscious processing of feelings, which would lead to containment of painful experiences; hence primary defences such as splitting and denial were operative in order to manage these feelings.

When a group is not functioning in the depressive position (as with an individual patient), some provision needs to be made for the external containment of the feelings. As we felt that the unbearable feelings of loss and abandonment were not contained in the home, it was decided that the two psychologists in training and myself would continue to run a weekly staff support group to provide a container for the unmanageable feelings.

The group operated on various levels. Firstly, the group process was interpreted in a psychoanalytic framework, and related to the psychodynamic processes at work in the organisation. For example in initial discussions the staff chose to focus on the behaviour problems of one child for whom, as a result of his unruly behaviour, no foster home could be found. On reflection, it became clear that this boy was caught in the unconscious organisational defence against separation and loss. This child must have known unconsciously that by being naughty in the foster home he would be sent back to the home. The 'mothers' equally did not want to separate from him. As one group member put it: 'When he goes to foster parents, my mouth says go, but in my heart I say come'. A child needs the parents to let go first before being able to take the steps towards separation (Lubbe, 1996). Knowing that the child's stay is temporary, the anticipation of the loss probably results in an ambivalent attachment to the child. Negotiation of separation in an ambivalent attachment poses more problems than it does in an uncomplicated attachment.

While we suggested practical ways of dealing with his misbehaviour, such as time-out, we spoke about his need for attention and affirmation. We discussed the staff's sense of being reflected on as 'bad parents' when he misbehaves on visits to foster parents. Furthermore, while the substitute mothers provide for the children, there may be a phantasy of their own 'badness' as parents if they are 'abandoned' and left for foster parents. We linked his difficulty in separating to the ambivalence of letting him go and the sense that he would not be looked after by his new parents. One group member reflected on her concern that new parents might not know that it was not the child's fault that he had been left – reflecting on the sense of a child's 'badness' when abandoned. The group was able to express their own feelings about giving up babies when they were not sure that they would be loved in new homes. A safe space for difficult feelings such as loss, abandonment and rejection was being created in the discussions. We used this group process to illustrate that it would be useful for the children to face similar feelings in the organisation, and developed a metaphor of unworked-through feelings remaining like an abscess in the psyche, which contaminates the flow of normal activity.

Secondly, the experiences and feelings of the childcare workers were discussed and contextualised within the organisational process. The resources of the matron were as depleted as those of the staff members and she was unable to be a container for the feelings of the staff or the children. Situations which evoked strong feelings – such as the loss of a child to foster care – were therefore avoided. Staff were mostly expected to part very abruptly with the children without a process of saying goodbye and working through the separation. While there were all sorts of practical reasons given by social workers for these occurrences, it seemed as if the unconscious need to protect against the pain of separation hampered the effective management of the children. It impacted on the staff's capacity to bond and separate from the children and therefore hampered their ability to facilitate a healthy separation for the children (Lubbe, 1996).

In another instance a staff member brought her distress about the sores on her body which she had contracted from working with the children. She felt that the children had contaminated her, and that the matron and social worker had ignored her pain. The issue was discussed on various levels. We spoke about the physical distress and what the practical arrangements for relief could be – the policy and compensation when staff were injured on duty. We discussed the feeling of contagion by the children and the sense of abuse that staff carried – the way in which the emotional scarring and pain was projected into them by the children (Riesenberg-Malcolm, 1999).

There was a felt shift in the openness and trust between the facilitators and the staff in the course of the year. While discussions had initially been focused on problem children, staff members started to reveal more of the painful and hurting aspects both in relation to their personal circumstances and with regard to the work. This was mirrored in the structuring of the time for the group sessions. Initially we encountered the children on arrival at the home and spent some time nurturing them. Soon the staff organised their routine so that the children would be fed and put down for the afternoon rest before we arrived, hence directing our attention to their own unmet needs.

Thirdly, particular children's behaviour and difficulties encountered with the children were discussed. For example, staff found it difficult to deal with the issue of children sleeping together and fondling each other intimately. Educational input was given about age-appropriate sexual behaviour, and the link between sexual play and the institutionalised child's strong attachment needs were drawn. Sexual play may then be viewed as seeking closeness and emotional comfort. Discussions of material around sexual issues were contentious and staff were able to recognise how their own inhibitions related to unhelpful educational practices around these issues. Through self-reflection the staff members learned to understand the children's feelings and experiences.

The ongoing group intervention allowed us to develop the initial hypothesis that there were unconscious hidden aims being pursued in the organisation. For example, staff were treated as minors and, while acting as substitute mothers, were given no information about the histories of the children placed in their care. While a rationale was given that it was to protect the confidentiality of the information about the children, it seemed as if the covert unconscious aim was to prevent the staff from becoming too acquainted with and hence too attached to the children. This arrangement served as a defence against the pain of loss, as the denial of the personhood of the babies (histories imply continuity of identity) maintained a more superficial level of intimacy between 'substitute mothers' and babies. Babies were often referred to by the month of admission, eg., the 'March baby' – a further denial of the real identity and therefore prevention of attachment.

The provision of a container for feelings which had previously been split off altered the group task of denial and silencing of painful feelings as there was now space for reflection on and working through difficult feelings. For example, three sessions were spent on the feelings evoked when one little boy left the home.

Preventing a repetition of the trauma

Considering the initial resistance to bonding with the facilitators, we realised that the separation from the facilitators at the end of the year needed to be worked through very sensitively. We appreciated the need for some continuity in the process of the clinic intervention. It was decided that I would continue to work there on my own as a group facilitator and that two new training psychologists would join me the following year.

The issue of the child who could not find a foster home re-emerged as a symbolic expression of the regression to the feelings of abandonment, separation and neglect which the group had been struggling with before. Members fantasised that he would want to return to the home as he felt safe there, but on the other hand that institutionalisation was destructive to his individuality.

The group found it very difficult to terminate with the interns, but where there had initially been an inability to talk about the feelings which separation evoked, the separation could now be spoken about in the group. The group struggled with a sense of being left because they were not good enough for the interns. They wanted to know whether they had been telling too many sad stories, and therefore burdened them too much. They wondered whether the interns would remember them. They wanted to know where they were going and showed concern by asking directly: 'Will you be okay?'

Despite the continuity in the running of the staff support group, the sense of cohesion in the group was noticeably interrupted with the arrival of the new intern psychologists the following year. Bion (1963) formulates the idea that there can be movement between the paranoid-schizoid and depressive positions. The group moved back to paranoid feelings of suspicion in relation to the consultation team (the transference object) and reverted to the defences of the paranoid-schizoid position. The facilitators were split and the male intern was idealised and referred to as the 'daddy' and the matron's new 'haan' (a term which in English would mean the 'king of the castle') while the female intern was excluded and criticised, for example, about her inability to speak the group language – Afrikaans – fluently. (This had not been raised as an issue in the past with other training psychologists.) She battled not to withdraw from the group or to take it personally but to see it as a splitting of the container into a good and a bad part. After eight sessions in the group and hard work in finding a working relationship between the members of the consultancy team, one group member called her 'Perseverance' (in English), signifying her acceptance in the group. It was interesting, looking back, that the interns had been writing their clinical notes separately, but at this point had decided to write a combined set of notes. It may well have reflected a process of projective identification in the facilitator's group mirroring the process of splitting in the staff group.

Later in the year, when an intern missed a session due to illness, the group was concerned that they had 'made her ill'. Once again this was an expression of the sense of contagion that the staff members carried, and their fear of the destructive and damaging potential of angry feelings.

Moving towards the end of the second year there was a looming sense of threat in the group, and a group member wanted to know whether I was going to run away with the interns. The group was again able to work with the separation from the interns in a direct and open way – with words and tears. One group member linked the process of saying goodbye to the interns to that of saying goodbye to the children. An important shift in the organisational defence against separation had taken place. The group became more able to operate in the depressive position because a container for the painful feelings had been established.

Containing the container

The countertransference feelings of the therapist are taken into consideration in supervision of therapeutic work. Heimann (1950) defined countertransference as comprising all the feelings which the therapist has in relation to the patient. These emotional responses provide the therapist with a means of non-verbally discerning the experiences of the patient. Since Heimann's definition of countertransference, more attention has been paid to the psychology of the therapist and the notion that the therapist brings a relational history, a cumulative representation of lived experience of interaction, to the relationship with the patient. Thus the object relationships of the therapist play a part in the treatment process. The concept of intersubjectivity has been formulated to conceptualise the interplay of the analyst's subjective experience with the subjective experience of the analysand to form the intersubjectively generated experience of the analytic pair (Ogden, 1994). These conceptualisations complicate the previously easy labelling of feelings experienced by the therapist as being countertransference feelings.

Furthermore, the supervisory situation can be considered from a perspective of parallel processes. The patient's relational difficulties may be enacted unconsciously towards the supervisor by the therapist. If the supervisor is aware of this process, enactments can be discussed as important information conveyed about the patient (Jarmon, 1990).

In the two years that I had been working in the organisation I acted as the container for the consultation team and the consultation team as a container for the group. The interns and myself met weekly for a supervision session among us. I had supervision from Valerie Sinason, an analyst from London who visited once a year, and occasionally at difficult moments from Kerry Gibson, the Community Psychology programme co-ordinator. It was important for me to know that I could draw on these containers.

Ideally the staff consultation team functions in the depressive position and the team has a capacity to process the projected feelings of the group members and the children (our countertransference feelings) and to distinguish between the countertransference feelings, the feelings stirred in the consultation team because of our own unresolved immature object relations, as well as the feelings aroused between the different members of the consultation team in relation to each other – which belonged solely to our own process. The extent to which the feelings could be distinguished in our weekly consultation-team supervision session, depended on the extent to which the feelings could be analysed and owned within our team. My focus was on creating a trusting environment where we could process the feelings, analyse our countertransference feelings in relation to the group material, and own the parts which belonged to our own object relations. For example, one of the interns in the staff team found it very difficult to relate to the overwhelming neediness of the children. We were able to look at his resistance in the light of his own deprivation and the concomitant pain and sense of loss re-evoked in his contact with the children, but also to look at it as a process of projective identification where the neediness and pain of the children were projected into him. Initially this intern was immobilised by the feelings and found it difficult to operate as part of the clinic team. Working through the feelings in supervision and his own analysis freed him up later in the year. As he started to find a voice in the group, some of the quieter members were able to take part in discussions. This may be seen as a parallel process between the functioning of the consultation team and the functioning of the staff support group.

Another intern spoke about his sense of incompetence. The metaphor that came to mind was a sense of having made a crap in the supervision session – as his ideas and comments were so worthless. The metaphor used by the intern was an expression of his own sense of incompetence as a developing therapist, but could also be seen as the communication of a pre-verbal experience of the child communicated through projective identification. In dealing with the staff group, the projection of the feelings into us could be seen as unprocessed projections from the children 'passed on to us via the staff member', or a sense of each staff member's own early experiences re-evoked by contact with children. The intern gave an image (of a smelly crap) to an unprocessed feeling of helplessness and incompetence passed on to him unconsciously through projective identification.

The supervisory process acted as a container for the unbearable feelings of incompetence. We processed these feelings in our consultation team and focused on taking these understandings back to the group.

A change in the container

The function of a consultancy team includes analysis of the relationship between the staff group and the management of the wider institution, as the dynamics of the staff group may reflect the dynamics of the wider institution (Rifkind, 1995). The leadership style of the matron was authoritarian and mirrored the management of the home by the board of religious ministers. Staff were treated as minors, and while acting as substitute mothers were given no information about the histories of children placed in their care. Staff had no representation on the Management Board, no representation in decision-making processes with regards to the management and running of the home and were ill-informed of any decisions taken by the Management Board.

During the first two years the interns and I had been working in an undifferentiated unit. Although the one intern had often wanted to intervene more actively in the second year, I had not actively encouraged him to do so. Retrospectively I realise that as my own capacity to contain grew through experience, I was more able to allow and contain differentiation between me and the interns, and to encourage them to assert themselves in the group, and to challenge me directly. My management of the consultation team was a parallel process of the management of the home by the matron, and of the management of the organisation by the Management Board. The power dynamics between me and the interns were mirrored very clearly in the group during the year. There were at times power struggles in the consultation team, which facilitated a developmental process in the group. The consultation team acquired a different confronting property in conjunction with the holding, containing function. The interns took an oppositional stand in relation to the management style of the Management Board in the staff support group. The group dynamic shifted, and the themes in the group became a striving for autonomy and self-empowerment. The staff unionised themselves for the first time in the history of the home. They requested a meeting with the Management Board to air their grievances, and to ask for direct representation on the board.

As the staff members grew in their definition of an identity as a group with needs and rights, they also seemed to separate from the consultation team, which made it easier to separate from the interns at the end of that year. They expressed gratitude for the interns 'having been there for their interests' and had a strong sense of having been empowered by them. Group members also expressed feelings of sadness at the parting. There was a growing ability to deal with a range of feelings evoked by the separation.

Conclusion

I have argued that the overt aims and tasks in the home for abandoned children (for example the naming of babies) masked covert aims, such as erecting defences against the feelings of loss and abandonment which were evoked in caring for the children. Because the feelings were not contained they impacted on the effective management of the children's emotional needs. The staff resisted efforts of training and support in order to protect themselves against re-traumatisation. Through the staff support group the consultation team attempted to provide a space where these processes could be brought to consciousness and the feelings could be processed. An experience of being contained provides a model for working with and containing the feelings of the children.

The effective working of this process of containment was dependent on providing containment for the containers. It required a supervisory process where different levels of analysis could take place: an analysis of the countertransference feelings of the consultation team, the intersubjective space between the clinic team and the staff group, the parallel processes between the consultation team and the staff group, and an analysis of the parallel processes of the management of the home by the Management Board and the matron of the home. Supervision and theory provided the necessary containment to the consultation team, which enabled us to provide support to the staff group. Key to all of this was patience and an understanding of, and faith in, process from a psychodynamic perspective.

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6

The Consultation Relationship: Reflections on a Psychological Consultation Partnership

ANASTASIA MAW

In a context where there are few professional resources, psychologists and others have to support mental health work by non-professionals. The psychologist's role in this is similar to that of a consultant in other parts of the world, but the specificities of our situation throw light on some of the hidden challenges in this type of work. The work – in our context – involves not only information sharing but also often crossing divides of race, class, culture, language and knowledge. The power dynamics created through these kinds of differences are probably present everywhere, but are very prominent in our work in South Africa where difference has been institutionalised through apartheid.[1]

My experience of a three-and-a-half year consultation relationship, established with a non-professional mental health worker in an apartheid-created dormitory town for coloured people, offered me an opportunity to reconsider the dominant definitions, underlying assumptions and general working principles of consultation.

Although psychodynamic ideas have been used widely to inform consultation work in other contexts, in South Africa there has been considerable scepticism about whether this kind of approach has anything to

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[1] This chapter draws heavily on my masters dissertation: The Consultation Relationship as a Complex Partnership: Experiences of Psychological Consultation in Atlantis, 1996. For a more in-depth discussion of the issues highlighted in this chapter please refer to the above-mentioned dissertation.

offer community mental health (Anonymous, 1986; Dawes, 1986; Hayes, 1986; Swartz, Gibson & Swartz, 1990). In this chapter I hope to show that a psychodynamic understanding of the consultation relationship was in fact extremely valuable for my consultee and for my own understanding. It provided a way of making sense of the dynamics unfolding between us, and a creative way of arriving at practical solutions in the consultee's work with children and families in the particular context of deprivation and abuse in which she worked.

In June 1994, as part of my clinical psychology training, I began a four-month community placement in a small village outside of Cape Town. In close proximity to the village is a larger town which was created in 1975, ostensibly as part of state strategies for industrial decentralisation. The development of the town formed part of the apartheid policy of separate development; in this instance to curtail the growth of the coloured community in Cape Town by offering employment opportunities to coloureds outside of Cape Town. In 1989 the national economic recession, political upheavals and the withdrawal of industrial subsidies placed the town in a dire situation. The economic crisis exacerbated existing social problems of family violence, substance abuse and high school drop-out rates. The population of this town is estimated to be 68 064, of whom 44 per cent are under 19 years of age. Unemployment is estimated to be 46 per cent (Richardson, 1994).

The local hospital in the town had no resident psychologist, social worker or psychiatrist. There was one clinical psychologist working in private practice, and charging fees which most residents could not afford. When word spread that a psychological service had started and that an intern psychologist was based in the neighbouring village, numerous referrals were received from mental health workers in the town. As the service was unable to take on sheer numbers of individual cases, referral agents were instead offered consultation and training backup to assist them in working directly with those in need (Holdsworth, 1994). At the start of my placement I 'inherited' a consultation relationship which had recently been started with a coloured health worker, Ms L, based at the local hospital in the town. Ms L was officially employed in the relatively lowly position of a family-planning adviser, but in fact she had already, without any training or support, begun to deal with urgent mental health problems no other member of staff in the hospital would take on. Ms L and I worked in a consultation relationship for four months. I was obliged to complete my training in another setting for a further four months, but on completion of this training I returned to work with Ms L for a further two and a half years.

The consultation model within community psychology

In their seminal book on consultation Caplan & Caplan (1993) define consultation as:

> *A process of interaction between two professionals – the consultant who is a specialist, and the consultee, who invokes the consultant's help in a current work problem that he (sic) believes is within the consultant's area of specialised competence. The work problem involves*

> *managing or implementing a program to cater to the clients... the consultee will be free to accept or reject all of or part of this help... the consultant exercises no administrative or coercive authority over the consultee. (My ellipses, p.12)*

This definition hints at some potential difficulties with power and authority in consultation relationships. In South Africa, apartheid has constructed and divided power in very particular ways. In community settings, such as the one in which I was working, community health workers seeking out or being offered consultation are likely to come from disadvantaged black communities and consultants are often likely to be white professionals from middle-class backgrounds.

The community psychology paradigm, which guided our work from the university training clinic, has as its fundamental aim the wish to make mental healthcare more accessible, applicable and practicable to a greater number of people, particularly to those in communities which are structurally disempowered and marginalised. When Caplan and Caplan (1993), however, emphasise the consultant/consultee relationship as a 'co-ordinate relationship' (p.22) they seem to imply that power differentials can be addressed and neutralised relatively easily. The history of South Africa over the past few centuries amply demonstrates that such differentials can be very difficult to change indeed. The ideals of community psychology on their own cannot be sufficient to overturn a history of brutal enforcement of power imbalances and their legacy.

Because of their emphasis on the importance of respecting the consultee as an equal, Caplan & Caplan (1993) differentiate consultation from supervision, teaching and psychotherapy. They argue that the assumption of any of these roles will be disempowering to the consultee. They warn against dealing with any of the consultee's transference issues, suggesting that to interpret these would be an infringement on the consultee's right to personal privacy. This view is strongly supported by the work of others (Caplan & Caplan, 1993; Heller, Price, Reinharz, Riger & Wandersman, 1984; Koch, 1986).

However, as the consultation relationship between Ms L and I developed, it became apparent that in order for empowerment and 'sharing psychology' to occur, paradoxically, there needed to be a greater consciousness of the many ways in which things were unequal between us. To make matters more complex, we could not consider power as simply enacted by the consultant on the consultee. Foucault made the observation that power is more than a purely negative and destructive force. He sees power as something which:

> *Doesn't only weigh on us as a force that says no, but that... traverses and produces things, it induces pleasure, forms of knowledge, produces discourse. It needs to be considered as a productive network which runs through the whole social body, much more than as a negative instance whose function is repression.*
> *(Foucalt, 1984, p.61)*

The relationship would inevitably reflect and mirror the power relations that existed within the immediate context – a hierarchical hospital system – and in the greater context of a coloured community created by apartheid adapting to a newly post-apartheid South Africa. The creation of that interplay of power was not only a negative product, but in order for it to be useful to the consultation relationship, it needed to be named and addressed. By acknowledging and naming the power differentials, frequently through the constructs of race, class, language, gender and/or culture, I felt freer to include within the consultation work, elements of training, teaching, supervision (Morrell, 1979), advocacy and psychotherapeutic intervention (Lachenmeyer, 1992). Ms L, on the other hand, could begin to challenge and question assumptions and suggestions which she saw as informed by my position in relation to her.

In my work with Ms L, I found Lazarus's less prescriptive definition of consultation more useful and instructive:

> *Consultation is a helping process emerging from a personal relationship established between a person or persons who are trying to solve a problem or develop a plan {the consultee} and another person or persons who are trying to help in these efforts {the consultant} (Lazarus, n.d., p.6).*

The consultation relationship between myself and Ms L

Interestingly the basis upon which the consultation relationship between Ms L and myself was established, and the nature of the relationship which developed, appeared to contradict the criteria outlined in the literature. Nonetheless, a remarkable process of empowerment unfolded through the consultation sessions, not only in terms of Ms L's sense of competence, confidence and skills-building in counselling, but also in those aspects of myself as a consultant. In order to try to understand why this consultation relationship seemed to 'work', despite its deviance from the approaches suggested in the literature, the relationship needs to be considered through multiple constructs, which are all interlinked and, I believe, are to some extent useful in thinking about work in a broader South African context.

The unsupported consultee

Early on in the consultation partnership it became clear that Ms L felt completely unsupported and unacknowledged within the hospital hierarchy. Her counselling work was not considered to be 'real work' and the fact that she did not hold any formal qualification, either in nursing or in counselling, exacerbated the situation.

Hoping in some way to address this issue, and as a way of introducing myself to the hospital personnel, I requested a meeting with the matron and hospital staff. Much later, Ms L told me that the request had been met because I am white, with professional status. I was naive in assuming that this would automatically remedy the situation. Whilst the fact that a white professional was interested enough to work with Ms L gave Ms L's work legitimacy and recognition, which she was otherwise unable to gain, it also evoked tremendous resentment and envy – a situation remarkably similar to one experienced and elucidated by Seedat and Nell (1992). This was never directly expressed to me, but comments were regularly made to Ms L suggesting that she was not qualified enough to benefit from a psychologist's expertise. In addition, as Ms L's work came to be better understood and valued, doctors began making direct referrals to her, circumventing the usual process of going via the sisters. This worsened the resentment against Ms L for achieving a status nursing sisters did not feel she had earned. It has taken several years of constant liaising with the sisters for Ms L to be more warmly regarded, though Ms L has stated that the change in attitude has come with a gradual retirement of the older sisters and more enlightened and primary healthcare-oriented sisters taking their places.

Race, class, culture, language and gender

There were marked shifts and changes in my relationship with Ms L over time. When I returned in 1995, deeper, less accessible issues, which had been hinted at during our initial four-month consultation relationship, began to emerge and unfold more fully over the next two and a half years.

The issue of difference in race as a powerful and influencing factor in the development of the consultation relationship was inevitable. It is beyond the scope of this chapter to discuss the history of the development of coloured identity, but for the purposes of my discussion it is important to highlight that coloured identity was historically constituted as a buffer zone between white and African identity, and coloureds 'have rejected "black" culture as inferior, yet have been constantly lured, then rejected by the culture of their colonial masters' (Pinnock, cited in Bozzoli, 1987, p.34–35).

Ms L seldom referred to race during our first four-month period together. The disparity in power between us was marked and most obviously identified by race, but it was difficult to discuss this in any open way, although we frequently discussed the hierarchical system in which Ms L worked and how this affected her. In that system, those in the highest authority positions, such as doctors, the medical superintendent and the matron of the hospital, were white, while other staff were coloured. In later consultation sessions, Ms L openly stated that she had initially had serious misgivings about me because I was white. In her mind, my race meant that I would be able to exploit my involvement with her. I had the power to come in and suggest that we embark on a consultation process and, when I had taken what I needed from the experience, I would leave. My return in 1995 was therefore extremely important since it was evidence to her of my commitment to community work over and above my professional training needs. This allowed Ms L to begin to express her anger at my initial intrusion into her work. My unwelcome entry had been reminiscent for Ms L of frequent intrusions by white professionals who would assert their power by taking over her projects. She spoke of her deep ambivalence about the recognition our consultation work had gained for her in the hospital system. The recognition had resulted in strained relations with certain colleagues and had also served to reinforce for Ms L that, ultimately, coloured people remain dependent on whites for success and achievement, trapped in what Ms L described as a 'no-man's land, sandwiched between whites and black Africans'.

Race, in South Africa, is inextricably bound with issues of class and Ms L ventured that she had doubted *'dat 'n wit pampered vrou'* (that a white pampered woman) would be able to understand or contribute anything of value to a community such as her own. In her eyes, a white middle-class woman like myself could know nothing of the hard physical labour and economic deprivation that impacted on family life and relationships in her community.

Ms L mentioned a case of a battered woman she had been seeing on an ongoing basis for several months, whom she had not previously discussed with me. Ms L was particularly proud of her work with this client as she felt her intervention had brought meaningful change to the woman's life. She explained to me that the client had come to her as an extremely timid and frightened woman. At that time, the client had moved out of her home, with her child, and was lodging with friends. The counselling sessions seemed to facilitate a process which led to the client's laying charges against her husband and obtaining a court interdict against him. The client warned her husband that she would have him arrested if he injured her in any way. Ms L, however, encouraged the client in her decision to return to her home, in spite of the possibility of renewed abuse. Ms L told me that she had chosen not to discuss this case until she could show me a favourable outcome, as she felt that I would have disagreed with her solution to this client's dilemma. Ms L felt that I would not understand how few resources are available to such a woman and what the loss of a place to live, and the end of her marriage, would mean for the client. The 'victory' for Ms L and the client lay in the fact that she could return to her husband and her home protected and not destitute.

I think Ms L was correct in assuming that I would not have considered the woman returning to her husband (and home) as a possible solution. In part, this may have been informed by class-based differences, since I may not have seriously considered and understood the implication of limited resources in the community. However, my objections would also have been informed by a feminist discourse and I would perhaps have argued for finding a way of having the husband evicted from the home. Having worked in that community for several years now, however, I see how such an approach could worsen the situation and delay, for a significant period of time, finding a workable solution for this woman's predicament. As illustrated by this vignette, our difference in perception was something Ms L was acutely aware of and concerned about. These profound yet subtle differences are born not only of race and class but also of culture, defined here as ways of seeing the world (Shweder, 1990). The incident was a very real challenge to me in appreciating how:

> *In reality, as much as we may intend to surrender personal interests.. this ideal remains out of reach... The human I is there... behind this I are one's multiple personal dispositions – the result of the aforementioned amalgam of one's class, status, gender, and value orientations... we do not know which of our dispositions will be engaged, but they are likely to be our enduring ones, those invested with the greatest affect. (My ellipses.)*
> *(Peshkin, 1985, pp.270–271)*

The communication of these subtle yet profound differences between us was made no easier by the fact that Ms L's first language is Afrikaans and mine English. Ms L spoke very good English, but felt unable to express herself freely and fully in this language. When I began working with Ms L, I determined to speak Afrikaans in spite of my lack of facility with this language. I felt that this was very important both in facilitating my entry into the Afrikaans-speaking community I was working in and as a sign of respect. It also, in my mind, represented a way of communicating my wish to be taught as much as to teach. Perhaps I also hoped, unconsciously, that the power imbalance between consultant and consultee might in some way have been leveled by my obvious difficulty in speaking Afrikaans.

The issue of language, however, was more complex than my initial cursory understanding suggested. I became aware of this when I noticed that, on first being introduced to people in the community, I was automatically addressed in English, the conversation slipping into Afrikaans only once I had indicated that this would be manageable for me. I noted, however, that speaking Afrikaans seemed to increase rather than lessen the tension and when I spoke English I felt more readily accepted. When, in the early stages of the consultation, I puzzled over this with Ms L, she did not venture an explanation. It was only later that she said she felt comfortable enough in our relationship to offer me her interpretation. According to her, I neither dressed nor behaved like 'an Afrikaner'. My difficulty in speaking Afrikaans verified this assumption.

The history of the development of the Afrikaans language goes some way to explaining the complexities of language in this context (Worden, 1985). Afrikaans has become a language whose origins and links with the dialects of the coloured population of the Western Cape have been denied and obfuscated by Afrikaners who wish to claim its association with whiteness. For this same reason, Afrikaans as a language has come to be reviled by black Africans because it is so closely associated with those directly responsible for engineering and maintaining the apartheid system. Many in the coloured community reflect these issues in their relationship with Afrikaans, which represents their own identity and operates also as a symbol of oppression.

What struck me was the power of subtle cues to layer interactions by introducing assumptions and stereotypical ideas of which I was initially unaware. Non-verbal cues seemed to signal areas which concerned both difference and commonality. Gender was one such area. Ms L had often commented that my being a woman had facilitated the establishment of the consultation relationship between us. The bias towards working with women, at least when that work involves the expression and discussion of feelings, has been well documented (see, eg., Gubrium, 1994; Finch, 1993). However, Finch (1993) also notes that the depth of rapport between women was dependent on, in her case, the interviewer being prepared to self-disclose so that the interviewee could place her within a framework or context. She argues that non self-disclosure on the part of the interviewer introduces an element of unease and doubt for the interviewee. I felt that this was applicable to the consultation relationship, and that a real 'giving away of psychology' and pooling of skills and perceptions could only occur if, as a consultant, I was both a professional and a person.

In the consultation relationship with Ms L, self-disclosure concerning details of my family life, what I liked to do over a weekend, whether I had a domestic worker or not, all went a long way to challenging and reframing the preconceptions that my race, class, language and gender evoked. My self-disclosure was, however, invariably accompanied by a reading of the psychodynamic process underlying the relationship, which had led to the asking of that particular question at that particular time and discussion with Ms L about it.

Establishing a therapeutic or working alliance

The use of a psychodynamic conceptualisation of the consultation relationship became essential to a style of working which developed between Ms L and me. It also provided me with a way of thinking about why this consultation relationship seemed to work. Essential to the apparent workability of the relationship was the development of a therapeutic or working alliance (Sandler, Dare & Holder, 1992) between Ms L and me. This alliance depended upon the establishment of a degree of trust which would allow for the development of a collaborative relationship: one which would lead to mutual or common agreement, albeit unconscious, about the goals of the relationship. The alliance developed very gradually over an extended period of time. In spite of the differences based on race, class, culture and language which could prevent the establishment of such an alliance, there was also a compatibility in terms of personal characteristics (Budman & Gurman, 1988), namely personality style, and general world view, which facilitated the development of a working alliance between us.

The alliance which developed between Ms L and me provided a stable and consistent enough relationship to tolerate the development and working-through of negative transference, inevitable in a consultation relationship where the socio-political context has such a profound effect on the interpersonal relationship between consultant and consultee.

Transference and countertransference

Working directly with the transference and countertransference seemed to me the most efficient and direct way of addressing many of the issues which emerged in the consultation relationship, despite the fact that a great deal of the literature cautions against this. I found such interpretations to be useful in elucidating and working through various issues, and in deepening rapport between us. Focusing on her own countertransference with her clients became a natural and facilitative way of discussing the cases Ms L was feeling overwhelmed by. The following vignette highlights this.

An adolescent boy was brought to see Ms L by his mother. His behaviour at the time of the referral was described as being uncontrollable; he was truanting from school and was disobedient and rude at home. During the interview it became apparent that the boy came from an extremely dysfunctional home where both parents abused alcohol and his father physically abused the children.

In our discussion following the session Ms L spoke of her difficulty in empathising with the boy. It then emerged that Ms L had difficulty in relating to what she termed '*onbeskofde*' (rude) teenagers. Further exploration of what feelings this case had evoked for Ms L revealed a sense of helplessness which was linked to the fears and difficulties she was experiencing with her own teenage son. Our discussion of the case thus focused on addressing Ms L's real concerns and difficulties with her own child, which were disabling her in her work with this particular family.

Transference interpretations were not restricted to Ms L's countertransference in relation to her clients, but were also related to transference and countertransference issues which emerged between us, as the following vignette illustrates.

At one point in our relationship, Ms L and I had spent several sessions in detailed discussion about some very difficult cases with which she had been working. The discussions focused on intervention strategies and to some extent on Ms L's feelings about the cases. I was deeply disturbed by the case material which involved horrific accounts of the sexual abuse of infants and the murder of a young teenager by a gang in an extremely violent way. I left the sessions preoccupied with how to ensure the safety of the abused infants and how to access additional support for the mother of the murdered child. I found myself making numerous phone calls and visiting child-abuse centres to collect pamphlets and information for Ms L.

In the next session I arrived, somewhat triumphantly but fairly tired out by the effort and worry, with a great deal of information and ideas about possible contacts for advocacy and networking. To my surprise Ms L seemed irritated and there was a growing sense of distance between us in contrast to preceding sessions. I was somewhat taken aback and not a little annoyed that all my work was being met with what seemed to me to be silent displeasure and disapproval.

Seeing that we could not proceed without addressing the feeling that was between us, I asked Ms L whether I was right in sensing a change in our relationship. It emerged that Ms L experienced my 'help' as an example of my tirelessness in dealing with the cases. This in turn placed pressure on her to similarly offer her tireless services to the cases when what she was feeling most predominantly at the time was exhaustion and despair. She felt that my focus had shifted from containing her and hearing her distress to containing the clients and hearing their distress.

Ms L was quite right about this. In response to my increasing sense of disempowerment and distress, resulting from the case material Ms L was presenting, I had responded by trying to fix the situation rather than by working in the countertransference. She was communicating a very real sense of disempowerment and hopelessness in dealing with the cases. When I could acknowledge that the cases were in a sense simply too painful and desperate to hold, I was finally hearing what Ms L was trying to communicate to me. Ms L could then again feel contained and understood by me.

Advocacy in the consultation relationship

I came to understand that my role as a consultant involved, amongst other things, advocacy and networking, and required me to balance my approach between attuned, therapeutic work with the consultee and the didactic teaching of techniques I thought might be of use to Ms L in her work with the clients. Thus, while a directive and networking approach had resulted in my failing to listen therapeutically to Ms L, the need for a more proactive and advocacy-based approach was equally important. In some situations, I have used whatever status and power afforded me by virtue of my position to advocate for resources, changes and reforms and to link Ms L directly to people with whom she can liaise in the future, for example, non-governmental organisations, welfare services, police and the court systems. Ms L and I established a careful record-keeping system. These records were used to produce statistics which were presented to the matron and the medical superintendent at the hospital. As a result, Ms L was nominated for, and subsequently received, a merit award. I was asked to write the evaluation report supporting such an award and I saw this as part of, not in addition to, my work as a consultant in a community setting.

General discussion

Over the course of my involvement in this project, some striking differences between my experience of consultation with Ms L and the guidelines suggested by the literature became apparent. Whilst I am not assuming that the insights I had would necessarily apply to other settings, I hope that some comments on developing an alternative framework for initiating and conducting consultation partnerships may be of use in contexts similar to this one.

Needs assessment

The literature on consultation has stressed the importance of a thorough pre-entry needs assessment, which focuses on organisational dynamics and systems which may influence the consultation relationship. It is assumed that a carefully negotiated entry will provide clear limits and boundaries to protect the consultation relationship from complex and unanticipated organisational, interpersonal and/or community dynamics.

My early involvement in the consultation relationship with Ms L was not in the first instance determined primarily by a careful assessment of Ms L's needs in relation to her work context, nor by the needs of the institution in which she worked or by the needs of the clients. This was partly because of the format of my training requirements, the time constraints this imposed and the need to hand over incomplete work. In addition, however, to gain the type of information required for a comprehensive needs assessment, one would have to conduct in-depth interviews with the consultees and possibly other key members in the institution. Given the complexity of the dynamics as they have unfolded, I doubt that such a process would have yielded the kind of crucial information being sought. Indeed, it may well have exacerbated the complex dynamics and power imbalances which slowly emerged during the course of my relationship with Ms L. The particular ways in which the relationship was understood at any given moment by both parties seemed to fluctuate in ways that could not easily have been predicted by an assessment. In a discussion with Ms L about her initial anger at our initiation of a consultation, she suggested that, given the complex dynamics at play, she was uncertain that any other approach would have felt less intrusive and offensive. Ms L did suggest that perhaps a letter outlining what services we could offer may have been less threatening as an initial overture. She then noted, however, that this was because a letter could simply be ignored in a way that face-to-face contact could not.

In retrospect, what Kottler (1996) calls the discourse of 'white guilt' (p.65) influenced, to some extent, the approach I adopted in trying to identify and meet the needs of Ms L. To a degree, the relationship was embarked upon because I had the power to offer the service (or withdraw it). The phrase 'white guilt' (p.65) has generally had a negative connotation and at worst conjures up images of well-meaning, but misinformed and patronising white liberals, desperate to, in some way, help the 'poor native folk' by sharing their superior knowledge with them. Progressive psychology has been anxious to avoid this stereotype and this in part informs the strong emphasis on an early clarification of the needs of the clients and a clear statement of what it is that the clinician will offer. Yet the wish to establish absolute transparency on the part of the psychologist in the initial contact phase is not easily achieved and belies the interpersonal and organisational interactions as well as the multiple contexts within which they are embedded. Within the South African context, embarking on a consultation relationship may at times seem like 'rushing in where angels fear to tread'. It is only in the gradual unfolding of understanding in the context of the developing relationship that the complex meaning of consultation can be properly apprehended.

Assessing suitability for consultation work

In spite of the necessary incompleteness of any initial assessment process, it may, however, still be useful to give some consideration to determining the suitability of both the prospective consultee and the consultant for this kind of work. I thought it might be helpful to consider some of the ideas that have been generated about these kinds of issues in therapeutic work done with individual clients and the criteria used for predicting successful outcomes.

Using the guidelines provided for the assessment of clients for short-term psychotherapy (see Sifneos, 1987; Malan, 1992; and Mann, in Nahmias, 1990), two central aspects are emphasised: a high level of commitment to the process and adequate ego strength, assessed by considering past adaptation and functioning. Within the consultation framework it would clearly be inappropriate to conduct an in-depth clinical interview in order to establish ego functioning, but this does not prevent the consultant from using their clinical judgement at least tentatively to consider and assess these aspects in the consultee. Furthermore Malan's (1992) use of responses to interpretations in the assessment process is easily transferred to the consultation context. It offers a useful tool not only for assessing the consultee's ability to engage in and make use of interpretation, but also their willingness to be open and reflective with the consultant, albeit tentatively at first.

There are also suggestions from this body of literature that the consultant might be able to use some of the conventional tools of assessment, including psychodynamic formulation, therapeutic forecasting and the availability of resources to maintain the relationship. As Malan (1992) suggests, furthermore, it is important that the therapist take care to bring into the open the client's expectations and apprehensions, and be aware of the effect of their own interventions on the client. In addition, both Roper (1994) and Dickman (1983) suggest that in short-term therapy it is often necessary for the therapist to work more flexibly and take on a variety of roles and functions, as the situation requires. This emphasis on the willingness to play a number of roles simultaneously and interchangeably is usefully transferred to consultation work.

Revisiting the goals and aims of the consultation partnership

The consultation partnership with Ms L was initiated with the primary aim of sharing psychological skills with, or in the famous words of Miller (quoted in Orford, 1992), 'giving psychology away' (p.13) to those in the frontlines working with children and families experiencing psychological difficulties. In trying to meet this primary requirement the partnership developed into a personal relationship, where support for the consultee's personal difficulties was as important as support for her work difficulties. In this respect the relationship bordered upon being psychotherapeutic. However, the constant need to address and negotiate the complex power dynamics between consultee and consultant required from me an openness and a capacity to self-disclose which is not typically encouraged in therapeutic sessions. In addition, at times, in order to facilitate Ms L's empowerment, I assumed various roles as teacher, advisor, mediator, networker or advocate around specific issues. Through the consultation relationship, Ms L shared the story of her personal and working life, which we used to develop and explore her work with families and children. Her stories helped me to begin to understand Ms L and the world she lives in and I, in turn, shared some of my stories with her. Rappaport (1992) has suggested the use of such narratives and personal stories as a resource for implementing social change and organisational and community development.

In South Africa the shortage of mental health professionals and the urgent need for the delivery of mental health services to those who have been denied access to such services in the past has created pressure to maximise existing resources. The consultation model has been regarded as a useful way of linking mental health professionals with frontline workers who may be in a good position to provide such services. The complexities of the consultation relationship in this context, however, precludes it from being a rapid short-term intervention. Certainly Ms L and I did achieve a certain amount during my four-month internship placement, but the greatest learning which fundamentally altered and shifted the ways in which Ms L worked with clients and both her and my understanding of the clients' problems occurred over a much longer period of time, and through this time her capacity to intervene more effectively with her clients developed noticeably.

There are, however, potential dangers of overloading and exploiting frontline workers. These have been noted by Freeman (1990) and Holdsworth (1994). Firstly, the romanticisation of frontline workers as natural helpers with the inherent capacity to do psychological work places a tremendous burden on the mental health worker. The idea that they need just a little 'extra specialist knowledge' (Orford, 1992, p.138) denies their right not to know. Secondly, whilst wishing to work against an elitist and guild-like mentality with regards to the profession of psychology, it would be equally disempowering to frontline workers to insist that six years of tertiary training (in the case of clinical psychologists) does not in some way equip one to cope with psychological problems and issues, and that such training can be easily compressed into several months. The development of conditions within which a consultee can really gain from a consultation process is not easily achieved. The provision of such conditions, the creation of such a language and the sharing of these beliefs is not easily achieved, and demands a level of involvement which challenged me ideologically, theoretically and personally.

Conclusion

In retrospect I learnt four central lessons:

i. In order to revisit and reconsider the practice of consultation, I had to let go of the political correctness which had informed so much literature on community psychology and consultation. In a sense I came to believe that, whilst the phrase 'the personal is political' challenged us to understand and conceptualise the world in a less individualised way and to take cognisance of political and social contexts, its corollary was as important when working one-to-one within complex contexts: 'the political is personal'.

ii. This meant reframing powerful and complex terms such as race, class, culture, language and gender in such a way as to make sense of these within the intersubjective field between consultant and consultee.

iii. That psychodynamic theory and practice provided me and Ms L with a liberating and insightful way of understanding and developing the consultation relationship and Ms L's work.

iv. The uncomfortable and paradoxical experience of 'poorness of fit' between ideology, academic, political or social and grassroots experience needs to be spoken about, written about and openly debated to develop and enrich the empowerment agenda underlying community psychology and consultation work.

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7

Too Close for Comfort: Emotional Ties Between Nurses and Patients

HESTER VAN DER WALT

It is not enough that community psychology focuses only on specialist mental health services in community settings. It is imperative that we use our skills to contribute to understanding and working with the emotional processes involved in the broader social arena. In a country undergoing major transformation there is a particular need to attend to some of the psychological demands this places on its citizens. To date, change management in many institutions has focused on structural changes such as salary scales, integration of services and formation of new management structures. This paper raises the need to take into account the emotional issues that play a significant part in blocking changes at the level of individual and interpersonal adjustment.

In this chapter I highlight some of the emotional issues that occur in everyday work settings between nurses and patients in public health services. In the 1950s, Menzies Lyth (1960) described the defences used by nurses in hospitals in Britain. Using psychoanalytic theory, she argued that many of the institutional routines of the hospital served the function of protecting nurses from their difficult experiences of patient care – including the demands of working with people who are very ill and even dying. This classic description of the ways in which nurses and service organisations as a whole defend themselves against the anxieties associated with their work has important lessons for the contemporary South African public health system (van der Walt & Swartz, 1999). Health authorities in South Africa are faced by enormous challenges including limited resources, high demand on their services and high levels of poverty amongst their patients. In this paper I explore the kinds of anxieties faced by nurses working in several tuberculosis (TB) clinics and the effects of their interaction with their patients.

It is important to note that these observations were made during the early years of political transition in South Africa. I hope to illustrate the subtle yet powerful ways in which issues of race, colour and self-identification influence the relationships between nurses and patients. The backdrop to the case study I present here is the Tuberculosis Control Programme in the Western Cape Province.

Tuberculosis in South Africa

Apart from HIV/Aids, TB is the single biggest public health problem in South Africa and one which carries significant social stigma for those who are infected. The notification rate of 578 per 100 000 in the Western Cape is the highest in the world (Department of National Health and Population Development, 1996). The TB Control Programme takes up most of the nursing staff's time in local authority clinics (Dick & Pekeur, 1995). The best modern drugs are freely available, yet the cure rate is not satisfactory, with high levels of drop-out and non-compliance (Dick, Groenewald, van der Walt & Rose, 1996). Up to two-thirds of patients leave the programme before the end of treatment. They run the risk of becoming re-infected, and could remain a source of infection to others, or even worse, contribute to the spread of the new strain of TB which is resistant to most anti-TB antibiotics and therefore incurable. This has serious consequences for the efficacy of treatment and curbing the spread of this disease. Although TB patients in this system receive a minimum of six months' care, this has been based on a routinised, mechanical, biomedical model which largely ignores the illness experience of patients. The morale of staff working in the programme is often low. Nurses feel overburdened and frustrated when patients fail to adhere to the full treatment regime.

Addressing the problem

It was in this context that a provincial TB co-ordinating committee agreed to pilot an in-service training programme for the staff of two local-authority health centres. The purpose of the course was to update staff with the latest knowledge on the TB epidemic, to encourage them to critically examine their own practice and to stimulate them to change their work patterns. Each clinic was ordered by top management to send a group of nurses to attend the course.

I shall refer to the two centres as Deepvalley and Vista. Deepvalley is a typically segregated coloured township which was built in the early 1970s during the height of the apartheid era. The health centre is overcrowded and on busy days the queues spill out onto the veranda. All the nurses at the centre are coloured women who live elsewhere and commute to Deepvalley. Vista is a run-down industrial neighbourhood on the edge of the inner city. It is equally crowded. The patients are mainly coloured and black with a small sprinkling of whites. The nursing staff is more of an ethnic mix: roughly half of the nurses are coloured and the other half white. The course organisers were taken by surprise when the entire Vista delegation to the course turned out to be white nurses. When asked about this, they said that their coloured colleagues were not available to attend the course at the time.

The training team was headed by health systems researchers of a government medical research unit and by senior managers from the health authorities. My particular task was to do a qualitative evaluation of the outcome of the course. This included an assessment of staff morale before and after the programme. I was also required to monitor self-initiated changes following the training.

Prior to the course, both groups were reasonably pleased with their performance. Vista said their clinic ran 'like a well-oiled machine'. Deepvalley felt that they were doing well 'under the circumstances'. They said, however, that they were frustrated by the poor motivation of patients to take responsibility to complete treatment and seemed to convey a feeling of futility and hopelessness about their work.

The course itself was based on adult education principles and experiential learning. For instance, staff were asked to map the flow of patients through their clinic and to study the amount of time patients spent waiting for, and being attended to, by staff. In another exercise, they visualised their ideal clinic and were then asked to analyse the potential barriers to implementing their ideal. At the end of the course the participants planned the changes that they wished to initiate.

During the course the Vista nurses appeared to make some dramatic discoveries. They found that patients were spending too much time waiting in different queues and that there was no continuity in care. They planned a complete overhaul of the work routine which would allow more time for patients to be attended to individually. Despite considerable resistance from their doctor and nursing colleagues, they forged on and managed to persuade even top management to make some fundamental changes that facilitated the implementation of their new ideas.

Deepvalley, on the other hand, made no startling discoveries about their practice. They seemed to accept the 'conveyor-belt' orientation to their work as a reality that could not be changed. They, however, took pride in mastering the new administrative system for registration of TB patients. Their other idea for change consisted of a plan to improve patient support, but this was to be organised as an additional task that had to be added onto the exiting service routine. The nurses planned to encourage patients to run self-help groups. This would mean that patients had to come to the centre for an extra visit to attend the support group. In monitoring the effectiveness of this change later, we were not surprised that patients who already came in every weekday were reluctant to participate in such a scheme.

Discussion

The two groups had attended the same course; they both did similar work and yet their responses to the course could not have been more different. While both groups recognised the need for patients to receive support in order to help them adhere to treatment, they had different ideas on how to address this need. Trying to make sense of this difference gave me the rare opportunity to uncover some of the deeper emotional dynamics which inform such responses.

A safe distance?

What was immediately evident to me was that the two groups spoke about patients in very different ways. There were individual differences in each group, but on the whole it seemed as if the group of white nurses were less angry and judgemental about their patients than were their coloured counterparts. In trying to makes sense of this unexpected phenomenon, I began to think that it might have something to do with the white nurses' sense of distance from the personal reality and racial identity of their coloured patients. It appeared that when patients were seen by their nurses as different in terms of class, race, income and educational background, closer contact was less threatening. This distance seemed to enable the white nurses to tolerate and make allowances for the behaviour of their coloured patients in a way that coloured nurses could not. White nurses perhaps did not have to fear 'contamination' by their patients when they allowed social contact or presented themselves as being more human. They seemed instead to be able to allow feelings of charity and compassion to guide their behaviour. It is possible, of course, that with the legacies of apartheid these feelings of white nurses for their coloured patients may have been strengthened by guilt. The similarities between coloured nurses and their patients may, on the other hand, have led to fears about losing their identity which hampered their capacity to relate warmly and empathically in their work.

Too close for comfort?

The Deepvalley nurses seemed embarrassed by what they saw as the 'deviant behaviour' of their patients. Some of these nurses, it appeared, grew up in similar areas and under similar social conditions of poverty and deprivation. Members of their families and some of their neighbours may in fact have had TB. Nursing was, at the time, one of the few career options that offered young coloured women the opportunity for professional qualification. A nursing qualification, often obtained with great determination and sacrifice, represented an 'upliftment' out of the situation of the average patient with TB. The nurses, it seemed, now expected a similar capacity to better themselves in their patients. Ironically, this close identification frequently manifested in a top-down relationship in which the nurses would set themselves up as critical authority figures in relation to their patients. In speaking of their patients the implicit message appeared to be: 'We know "our people"'. They presented themselves as knowing what was best for the patients and retaining their right to 'scold' on the basis that they cared for and wanted to help them. In turn they expected the patients to take responsibility for their own treatment. Some of these nurses spoke with great anger and frustration about patients who failed to comply with the treatment regimen. In order to enforce compliance, they were keen to increase their control over their patients. This was clearly illustrated when a nurse suggested that Robben Island[1] should be used as a prison colony for non-compliant patients.

In general many TB clinics operate on a task-centred system which is designed to keep patients moving through a series of stations where a nurse fulfils a single task, for instance history taking, weighing or collection of sputum specimens. There is little opportunity for the patient to actually get to know any individual nurse. Although apparently designed with efficiency in mind, this system functions to prevent closer emotional contact between nurses and patients. At Deepvalley, although the nurses were aware of the need for patient support, they saw this as just one more task to be added to the existing range of one-stop stations, where it could be offered by the patients themselves or by one of the health educators.

This compartmentalised system, which seems to offer a degree of emotional protection to the nurses in their dealings with patients, takes on further meaning in the South African context. It is important to remember that, under the apartheid government, it was official policy to ensure that each 'population group' be given healthcare by its own members. As early as 1952, Cape hospitals started a scheme for the training of 'non-European nurses to take care of their own people' (Marks, 1994, p.171). Marks shows how the early missionary-based training schools influenced nurse trainees to 'wage war against the ignorance, disease and superstition of their people' (1994, p.109). This, together with the drive for professionalism and higher status for nurses, understandably widens the distance between nurses and their TB patients.

One of the most typical features of service delivery in the local-authority clinics I visited was the very impersonal way in which nurses appeared to interact with their patients. Menzies Lyth (1991, p.361–364) describes how British nurses who worked in stressful situations developed coping mechanisms to deal with their anxiety. One of the mechanisms she describes is the way in which nurses seem to deny the significance of the individual (patient or nurse) through rituals which emphasise uniformity and therefore diminish the risk of too close personal contact. This behaviour is common to clinics (van der Walt, 1995), regardless of the colour of staff, but it is interesting that the coloured staff of Deepvalley chose to maintain their distance from patients, while the white Vista group were prepared to consider changing their routine in order to make closer contact with patients.

Talking about colour

It took some time for me to acknowledge these observations, even to myself. At the start I expressed them very tentatively, largely because of the fear of being, or being seen as, racist. During the years of resistance against apartheid, progressive academics drew on critical theory to support a discourse emphasising similarities between cultures in order to counter the government's focus on differences between ethnic groups (Kottler, 1996). To talk or write about differences came to be seen as support for apartheid and as being racist. In the initial attempts to find an identity for the 'new' South Africa there was great support for

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[1] The infamous offshore prison in which Nelson Mandela and many other anti-apartheid activists were imprisoned for long periods of time.

non-racism in the context of an overarching concern for 'nation-building' which emphasised commonality between different groups (Swartz, 1996).

I do not believe that all coloured nurses deliberately avoid closeness with their coloured patients, nor that all white nurses are willing to experiment with getting closer to patients of a different racial group. I suspect rather that this is a complex phenomenon and one which happens at an unconscious level. My sense was that closeness was also tied to the extent to which nursing staff identify themselves as being 'insiders' or 'outsiders' in relation to the community of patients. This was well illustrated by the behaviour of a black nurse who worked at Vista, who felt like an 'outsider' because she was from elsewhere in the country. She established remarkably warm and close relationships with both coloured and black patients. It seemed to me that her experience of being an 'outsider', and the absence of a strong identification with her patients, or colleagues, enabled her to establish more human relationships in the course of her work.

While I was thinking about these kinds of issues, I had a vivid memory of a time when I was employed as a nurse in a community-based primary healthcare service. After working in areas designated as coloured, I was transferred to another area to do relief duties. I was shocked at what I found there: white people, mainly Afrikaans-speaking like myself, who lived in sub-economic housing. Many of the patients were unemployed and there were high rates of many of the difficulties associated with poverty, including alcoholism and malnutrition. I remember thinking angrily that since these people were privileged because of their colour, they had no excuse to be like this. I felt ashamed of them and embarrassed by them. I never had these feelings about coloured and black patients. Thinking back, I recognise how my insider status of being close to the white patients could have triggered my discomfort.

Given our histories under apartheid, it is perhaps hardly surprising that race and identity seem to play such an important role in our working lives. The deliberate implementation of segregated neighbourhoods, schooling, professional training and health services in South Africa has strengthened and emphasised these feelings of identity with people of our own colour. I suspect that in a more open society people's feelings of being 'too close for comfort' would be less overwhelming. In South Africa we have a long way to go before we reach that stage. The legacy of apartheid lives on in most public health services such as Deepvalley, where deeply internalised racial politics play themselves out in unexpected ways.

Colour and course dynamics

It is not only between nurses and their patients that the dynamics of race play themselves out. The course itself helped to reveal the ways in which racial identity became a fundamental part of the way that colleagues within the nursing system interact with one another. Coloured people under apartheid were constructed as second-rate citizens and provided with limited opportunities to exercise their own choices in life. Coloured nurses were forced by state authorities to attend segregated schools and nursing colleges, and to work in health services situated in coloured areas. For the coloured nurses who were instructed to attend our particular TB training course it might have felt like yet another example of being 'sent off' somewhere by those in authority. Their *en masse* attendance on the course may say less about their enthusiasm for its subject matter and more about compliance and a feeling of safety in numbers. At the first session of the course, the coloured nurses from Deepvalley would have found that the entire training team was white. Unwittingly, the fact that those in authority were white reflected the power dynamics of the apartheid era.

Not only were the staff team white, but the whole group from the Vista clinic were also white. These two factors in combination seemed to place the group of coloured nurses in a potentially threatening position. When evaluating the course, both groups said it was a good experience to meet the other group and it made them realise that theirs was not the only clinic that was having problems. However, the Deepvalley group seemed to have a particular investment in presenting their clinic as running more smoothly than that of the Vista group. This representation of their clinic's functioning would have helped them to manage any feelings of uncertainty about their position on the course and perhaps reflected their anxieties about opening up their own practices to potentially unsympathetic scrutiny. This would have been particularly painful given the disparity in the circumstances of the two groups. Furthermore, it is likely that the energetic strategising and initial successes of the Vista group in identifying areas in which they wanted to make changes would, ironically, have highlighted Deepvalley's own feelings of impotence to make changes.

Group processes

The work of Bion on psychological processes in small groups (Stokes, 1994) may shed some light on the behaviour of the two groups during the training course. In this view, group behaviour is directed at trying to meet the unconscious needs of its members. Bion recognises that while groups may appear to be attending to the rational demands of their 'primary task', there is also a powerful unconscious tendency in groups to respond irrationally in an attempt to avoid painful areas of conflict.

In helping institutions staff often lack adequate task definitions and receive little guidance from managers on their effectiveness (Strachan, 1995). Lawrence (cited in Zagier Roberts, 1994) suggests that organisational behaviour can be studied by examining the way in which employees pursue different kinds of primary tasks within an organisation. He distinguishes between the normative primary task which is the official task defined by the senior managers; the existential primary task which is the task that the staff believe they are doing; and lastly, the phenomenal primary task which can be inferred from people's behaviour, and of which they may not be aware. When a group does not know its primary task, it tends to invent another task. This is usually the case in basic assumption groups who display anti-task behaviour to meet the psychological needs of the group members. The sophisticated work group, on the other hand, gets on with the primary task which relates to the demands of the external environment.

The Vista team operated as an open group whose purpose was to improve the cure rate of patients by re-arranging their clinic routine in order to provide maximum contact time between patients and nurses. In order to achieve this, they operated like a task-focused working group. Back at their clinic they had to convince colleagues of their vision and to obtain their participation. Deepvalley, on the other hand, closed their ranks and turned inward like a closed group that exists solely for the protection of its members. This was already clear in their decision all to attend the course. Their leader collaborated in this process by protecting them against painful changes. This became evident in the way they held on to their existing clinic routines (their existential primary task) which contained their anxiety, rather than the patients' need for support.

Another feature of group behaviour is its relationship towards authority. Vista staff acted with authority when they presented their plans to the management. The staff at Deepvalley described themselves as 'adaptable' to any changes proposed by head office. Yet there was an underlying anger about not being consulted: 'Everything is already planned and sometimes we feel... look we know a lot about the problems on the ground... why don't they discuss things with us and ask our views?' These rumbles remained in the group. In the basic assumption dependency mentality groups assume that authority is based entirely in the hierarchy which calls for unquestioning behaviour.

Why the complete acceptance of the register and the pride that they are the only clinic staff who understand the rationale for it? Obholzer (1994) describes the defensive structures in public-sector organisations. He uses the concept of containment to describe how employees make their anxieties more bearable or contained. Defences against the painful realities of the work are managed by arranging the work into certain tasks, rules and procedures ('Yes, the patients need more support, but limit it to Thursday afternoons from 2 to 3p.m.'). Only if there is an agreement on the primary task of the organisation and a willingness to be in touch with the anxieties inside the container rather than blocking them out, is it possible to deal with or contain anxieties. For this to happen it is necessary to have opportunities for dialogue within the organisation. Unfortunately our public health services do not function like this – managers are kept at a distance from patients. The 'caring' component is removed from management and clinical staff have to protect themselves from the realities of pain and illness. This is done through learning to turn a blind eye to the realities and to organise work in such a way that anxieties are pushed back. This could stand in the way of doing the primary task, which in this case is to support patients in adhering to the lengthy treatment of a stigmatised, infectious disease. The emphasis on administrative work could be part of this process. If we fail to recognise the anxiety-containing function of an organisation, changes can create more problems because they lead to the dismantling of structures which were created to defend us against anxiety. In the case of Deepvalley, a change from a task orientation which served to contain anxieties by providing distance between patients and nurses, to a more patient-centred approach, could lead to staff burnout and illness.

Implications for health systems reform

Human beings are resistant to change and therefore managing change will require managing the anxieties and resistance which will arise from the change process. The more well-known sources of organisational resistance are a threat to established power relations, threat to established resource allocation, threat to expertise, the limited focus of change, structural inertia and, lastly, group inertia (Robbins, 1993, p.637). The case of Deepvalley has illustrated a form of group inertia and has provided the opportunity to dig beyond that label in order to unearth some of the deeper-lying anxieties.

What can be done to facilitate change processes? Obholzer (1994), suggests a few pointers. It is important to be clear that any proposed changes will serve the primary task of the organisation. Staff and management need to have similar views of what the primary task is. Group consultation with outside consultants may be necessary to raise the awareness of situations when groups change from working groups to basic assumption groups.

Work-related staff support should be legitimised in order to contain the anxieties of the work and those related to change. This would enable staff to discuss feelings and problems in a climate that regards problems as a normal aspect of the work, rather than as evidence of personal or group pathology. This will require a major change in the public health system where nurses and other groups of caregivers have systematically been socialised to suppress their feelings. The use of external consultants could facilitate the process and protect the space from being eroded by work pressures or group defences.

In-service training programmes need to be planned with the utmost care. Important guidelines would be to meet participants before the onset of the course in order to assess their needs and their perceptions of the course. The group composition in terms of colour and gender needs to be considered carefully and where such stark divisions are inevitable, as may well be the case during the transition period in South Africa, needs to be opened up for discussion. It will require much courage and sensitivity to break through the taboo of talking about colour and to uncover the underlying experiences which inform our behaviour. Similarly, the anxieties and fears of change should be addressed as part of the agenda of the course. And, lastly, the facilitators should show equal respect for those groups and individuals who choose not to adopt any changes.

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8

Disability and Psychotherapy: an Ideologically Charged Relationship in Community Mental Health Service Provision

Brian Watermeyer

The design and delivery of social services surrounding disability have, through the deeply fraught and politically charged nature of disability issues, been the site of pitched theoretical struggles for some decades. The history of disability-related social services is one saturated with evidence of oppression and control, exercised in the guise of empiricism and altruism (eg., Marks, 1999; Scott, 1969). Persons with disabilities have suffered institutional domestication, through interpellation into discriminatory ideological assumptions surrounding what it means to have an impairment. From this oppressive background has latterly arisen a deep suspicion amongst critical disability theorists regarding the latent motivation of, for example, mental healthcare intervention surrounding disability. Psychological theory has a long history of pathologising responses to disability, which have incontrovertibly been appropriated by dominant political forces within society to justify and reproduce the oppression of persons with disabilities.

A central issue for our consideration in the context of this book relates to psychotherapy as an interventive resource in community-based social services surrounding disability. The political movements sketched above have included a violent rejection of the notion of psychotherapy as a potentially useful resource to persons with disabilities, as a response to the fact that it has previously been pervasively and oppressively assumed that 'persons with disabilities needs psychotherapy'.

This assumption has formed part of a broad patterning of oppressive and pathologising ideas surrounding disability which have served to reproduce the image of persons with disabilities as broken, damaged, defective, vulnerable, helpless, incapable and the like.

In this chapter I shall revisit the issue of the relationship – if one does or should exist – between disability and psychotherapy. It is my hope that the discussion will to some extent clarify this wrangle, in order that community-based disability social-service policy may usefully be developed. I will begin with a terminological distinction, followed by a brief orientation to theoretical approaches to disability. Accounts within the 'disability and psychotherapy' debate will then be reviewed, followed by an articulation of my own position. The reflections contained in this chapter are largely the product of my experience as a group psychotherapist working with an analytic psychotherapy group composed of visually impaired persons. Inter alia, I discuss the ideological defensibility of such an intervention, relating this to my broad position on whether persons with disabilities may benefit from the availability of psychotherapeutic services, and why.

A terminological note

As in all fields of study and concern which evoke uncertainty, anxiety and strong emotions of various kinds in individuals, shifting trends of political correctness with regard to terminology have been a feature of disability-studies literature. Not having the space to do justice to these debates here, I have undertaken, for the purpose of clarity, to make use of only one of the many conceptual distinctions which continually emerge. This is the distinction between impairment and disability, as delineated by Finkelstein and French (1993, p.27). They define these concepts as follows:

> *Impairment is the lack of part of or all of a limb, or having a defective limb, organ or mechanism of the body. Disability is the loss or limitation of opportunities that prevents people who have impairments from taking part in the normal life of the community on an equal level with others due to physical and social barriers.*

Disability in society: theoretical movements

For much of the 20th century, institutional understandings of, and responses to, disability have been dominated by what has come to be termed the biomedical model of healthcare practice. This model, situated as it is within a philosophical paradigm which regards illness or disability as residing within damaged bodies (Kleinman, 1986), has been severely criticised for its inattention to the context of societal responses to disability which serve to systematically exclude and disadvantage individuals with certain impairments (e.g., Abberley, 1996; Barnes, 1990; Lunt & Thornton, 1994; Marks, 1999; Oliver, 1986). Conceptions of disability which have thus construed the locus of experienced difficulty as being 'within' the individual have been (critically) termed 'personal tragedy theory' by proponents of the 'social model' – a politicised and critical societally contextualised view of disability (e.g., Barnes, 1990; Oliver, 1986). The 'social model' aims to debunk the ways in which the biomedical paradigm is purported to have oppressively situated disability-related difficulties within 'damaged' bodies, rather than in societies which cater selectively to the needs of persons constructed as non-disabled (Abberley, 1987; Barnes, 1990; Lunt, 1994; Marks, 1999; Oliver, 1990). As such, the social model may be regarded as embodying a politically adversarial response to medicalised constructions of disability. Post-structuralist and social constructionist thought (Gergen, 1985) has further attempted to interrogate traditional and reified notions of disability, serving to demonstrate the 'disabled' identity to be one selectively, yet arbitrarily, inflicted on persons whose needs are systematically disregarded within the structure and functioning of Western societies (Ingstad & White, 1995; Marks, 1999; Murphy, 1995; Wendell, 1996). Ideas and attributions associated with the 'disability' label, such as notions of personal tragedy and dependency, have similarly been critically deconstructed (Barnes, 1990; Lonsdale, 1990; Marks, 1999). Such deconstruction serves to crystallise a conception of the predicaments of persons with disabilities as arising through the perpetuation of disablist ideological machinery which serves to maintain, justify and obscure oppressive political relations (Bartky, 1990; Corker & French, 1999; Marks, 1999).

Views of the disability phenomenon within psychoanalytic thought have similarly been characterised by strong positions, with concomitantly strong and politicised adversarial responses. Early psychoanalytic conceptions of disability often regarded persons with impairments as 'unanalysable', due to 'their' typically having poorly developed egos and primitive defence structures (Asch & Rousso, 1985). Causal links were posited, which attempted to firmly associate disability with various forms of psychological illness, notably narcissistic psychopathology (Asch & Rousso, 1985; Marks, 1999). The emergence of the social model, thus, embodied a rigorous disidentification with such research writing, owing to its subscription to individualising and pathologising modes of understanding disability experience. Psychoanalysis, with its traditionally individual and intra-psychic focus, became regarded (by critical social-model theorists) as an approach which would inevitably serve only to compound stereotyped beliefs surrounding disability, thus serving potentially to justify discriminatory practices such as segregation (Lenny, 1993). With notable exceptions (e.g., Sinason, 1992), psychoanalytic thinking was expelled from a politicised disability movement which (understandably) regarded the sociological analysis of group identity and oppression as the exclusive route toward emancipation.

Against this backdrop of conceptual and political wrangles, it is unsurprising that the relationship between the disability movement, and psychology and psychotherapy, has been a complex and fraught one (Lenny, 1993; Oliver, 1993). Critical disability theory has strenuously rejected psychological models of disability which have borrowed concepts from grief and bereavement theory in attempting to 'map' disability experience (Abberley, 1993; Finkelstein & French, 1993; Oliver, 1995). In addition, psychological theorising on disability has been criticised for its purported ascription of emotional distress exclusively to the loss of bodily ability, whilst neglecting to recognise the impact of discrimination and oppression.

Disability and psychotherapy

A central point of conflict which has polarised positions on the issue of helping intervention surrounding disability relates, unsurprisingly, to the question of where the problems of disability are located (Oliver, 1993, p.61). The tendency of professionals working within the medical model to locate such difficulties within the functional limitations of impairment, with insufficient interrogation of the failure of social and physical environments to make equitable provision for the needs of impaired persons, has served to compound a schism between adherents of the social model, and the endeavour of psychotherapy as it pertains to disability. In addition, McKenzie (1992) found that many persons with disabilities regarded 'mainstream' mental health practitioners, such as psychiatrists and psychologists, as demonstrating little understanding of issues and struggles relating to acquired disability (McKenzie, 1992 in Oliver, 1995, p.263). Of crucial importance, though, was the further finding that virtually all respondents felt that they could have gleaned great benefit from counselling support in the wake of the onset of disability (ibid.). Such support which was not rooted in the stage-theory assumptions of the medical model, however, was found to be largely unavailable (ibid.).

Mental health practitioners who have disabilities themselves have been argued to be likely to possess a particular empathic ability in understanding and managing psychological distress relating to disability (Asch & Rousso, 1985; French, 1988; French, 1993c).

Finkelstein (1993) notes that the issue of goodness of fit between individual and therapeutic intervention is to some extent dependent on the individual's personal and philosophical understanding of the nature and aetiology of their struggle. That is, someone who sees their difficulties as arising primarily from impairment would find meaning and utility in an intervention very different from that required by one who viewed their struggles as a function of discrimination (Finkelstein & French, 1993, p.19).

Abberley (1993) asserts strongly that if persons with disabilities experience psychological difficulties, these should be ascribed to socialisation which discriminates against impaired persons. Psychological distress would thus be understood not as relating simplistically to impairment, or to flaws in personality, but rather as an aspect of the oppression of persons with disabilities (Abberley, 1993, p.108). He advocates that, rather than denying the psychological costs paid by persons with disabilities, these costs should be clearly identified as 'a most directly experienced aspect of oppression' (ibid.). Finkelstein and French (1993) note that, in the light of the fact that persons with disabilities are as much steeped in, and thus influenced by, stereotyped and limiting assumptions regarding disability as non-disabled persons, it is hardly surprising that the perception of such barriers may manifest in 'depression, passivity, anxiety and hopelessness' (1993, p.32). The cycle of self-fulfilment may then be reproduced by perceptions of such feelings experienced by persons with disabilities feeding into stereotypes of unmotivation, poor adjustment and unreliability (ibid.). Finkelstein and French comment: 'It is very important that these barriers are seen as providing the context for personal mood states and psychological reactions, rather than seeing these states as psychological reactions to impairment' (1993, p.32). It is of crucial personal and political importance, thus, that an analysis of psychological distress in persons with disabilities be thoroughly contextualised within the nature of experienced social factors, which may include the attitudes of others, exclusions or poor access to services and participation, unemployment or poor career opportunities, poverty, amongst many others (ibid. p.31).

Morris (1992) observes with regret how persons with disabilities have often been drawn into denying personal or psychological experiences of struggle, through the need to challenge the assumptions and images of the 'personal tragedy' and medical models. She writes:

> *To experience disability is to experience the frailty of the human body. If we deny this, we will find that our personal experience of disability will remain an isolated one; we will experience our differences as something peculiar to us as individuals – and we will commonly feel a sense of personal blame and responsibility.*
> *(Morris, 1992, p.164)*

Disability and community mental health intervention

The contribution to the current debate which is the essence of this chapter stems from my personal experience of psychotherapeutic work with a group of persons with disabilities. Over a period of two years I worked as group psychotherapist within a group of visually impaired students at the university clinic at which I am employed as lecturer and clinical psychologist. The group was initiated because many visually impaired students needed some form of supportive therapeutic space. The students had voiced this need to the staff of visual impairment-related special-needs units at the universities. This need related to the range of profound difficulties with the university's cultural and physical environment, and with the practicalities of study within a vision-centric academic world, which the students held in common. It is not my intention to describe in full this therapeutic process, as such a description has been performed elsewhere (Watermeyer, 2000). Rather, I aim here to refer to the process insofar as it has informed my own position on the complex relationship between disability and psychotherapy. Essentially, and in light of the foregoing critique, I wish to address the question of whether and why persons with disabilities may benefit from psychotherapy in ways which pertain particularly to the oppressive social predicaments which disability often affords. Furthermore, I ask whether it is ideologically defensible to provide a psychotherapeutic service exclusively for persons with disabilities within an organisation such as a seat of tertiary learning, or any other social-service structure.

Disability and trauma

The crux of the vast body of critique which has been directed at the psychotherapeutic endeavour as it pertains to persons with disabilities relates to a single basic assumption. This assumption may be expressed as follows: if a person with a disability requires, or would benefit from, psychotherapy, this person may be assumed to be suffering from some form of psychological difficulty or disorder which is aetiologically related to the impairment of bodily structure or function. The historical association of disability with psychotherapy has been rooted within the medical model, firmly situating persons with disabilities within a system of assumptions which locates deficit and difficulty within the individual. That is, disability has been, in practice, equated with psychopathology. To exemplify: Siller (1969) writes: 'Occasionally a newly disabled person does not seem to be particularly depressed, and this should be a matter of concern. In almost all instances, something inappropriate is taking place… not to respond as such [with depression] is denial' (Siller, 1969 in Lenny, 1993, p.234). As noted earlier, it is a painful and atrocious reality that persons with disabilities are often led to denying their own experiences of struggle through the need to avoid being identified with this oppressive stereotype. What the stereotype does through its individualising assumptions is subtly identify persons with disabilities as inevitably bearing pathology which relates 'exclusively' to the nature of impairment. The definitive influence of oppressive relationships and structural exclusions on the experience of disability struggle is thereby obscured. Persons designated as disabled find themselves in a predicament in which, if emotional struggle or vulnerability is disclosed, they will be discursively incorporated into an homogenising and entrenched stereotype which ascribes that difficulty to the structural (and immutable) nature of impairment. The nature of unique and individual experience is thereby silenced, whilst simultaneously the oppressive and politically embedded social relationships which are at the core of disability are obscured and hence reproduced. As a person with a disability, therefore, if one is to disclose experiences of emotional struggle, one is potentially liable to reinforce the mechanisms of oppression which are, most definitively, at the centre of that very oppression.

This double bind is one with which I struggled long and hard during the course of the group psychotherapy work performed with visually impaired students at our university. The level of trauma which group members carried with them was palpable, expressing itself in strong ambivalence regarding psychotherapeutic exploration of experience. There was also a profound sense that the nature of the struggles which individuals faced could not be held, understood or tolerated by others. Group members spoke of two parallel levels of experience; one speakable and one not. Alongside the overt and ongoing discourse of everyday life in interaction was a layer of experience which was consensually regarded by all members as, to a large extent, unspeakable in the 'broader' social realm. This layer was *that* part of experience which felt the plethora of exclusions and misattunements afforded by a social world unaware and unprepared for the presence of persons with limited sight.

As noted above, emotional difficulties – clearly disability-related or not – experienced by persons with disabilities are often silenced through the danger that disclosure will render an oppressive and stereotyped defining of the individual from without, incorporating a potential reinforcement of discriminatory ideas predominating in societies unused to difference. Furthermore, what often happens when persons with disabilities disclose emotional struggle is that the difficulties tend to be ascribed by the observer exclusively to impairment. The power of bodily impairment to evoke in the observer universal and deeply anxiety-provoking feelings of dependency, shame, vulnerability and fear originating from early infantile experiences has been well described (see, eg., Marks, 1999; Sinason, 1992; Watermeyer, 2000). It is this evocation of the universally human, and universally frightening, experience of vulnerability which is at the root of the stereotyping association of images of disability with dependency, brokenness, loss and shame. In turn, these feelings are, in my opinion, psychically managed – individually and collectively – through the controls exerted by marginalising and oppressive social structures and cultural conventions surrounding disability. Thus, the predicament articulated by members of the psychotherapy group could be expressed as follows: Either:

i. I do not disclose my experience of emotional struggle, notwithstanding the fact that I inhabit a world in which many of my basic human needs for equitable access to participation and the means to self-fulfilment and development (e.g., educational/occupational/social opportunities) are denied. Here, I deny myself not only recognition of struggles I am afforded through the arbitrary oppression of exclusionary societal practices surrounding disability, but, by association, also of the opportunity for support in the most basic and universal emotional struggles which human life brings; or

ii. I disclose my experience of emotional struggle, perhaps identifying psychotherapy as a needed resource, and hence potentially usher in amongst observers a confirmation of a well-defined stereotype. This prejudicial view attaches my struggle firmly to my impairment, thereby obscuring or silencing the complex nature of my experience, of myself, and thus positioning me more clearly as vulnerable, incapable and damaged. Here, I am defined more ardently from without, as acknowledgement of my struggle may render a release and stronger projection of incipient feelings of anxiety, shame and dependency evoked in others by my impairment, and now confirmed through my disclosure of struggle.

As alluded to earlier, it is the feelings which images of disability evoke which are at the root of disablist oppression (Marks, 1999). In terms of a pervasive and oppressive discourse on disability, impairment is equated with trauma, and thus with psychopathology. Thus, if a person with an impairment is to acknowledge the experience of trauma, this is ascribed to impairment, hence rendering their being associated, in a manner which is inevitable and immutable, with damage, incapacity and lack. In debating the relevance and ideological defensibility of a psychotherapy group existing expressly for persons with disabilities, I was accused of being myself drawn into this very stereotyped association. Was I not assuming, prejudicially, that the students with whom I worked therapeutically had suffered trauma since they were visually impaired? Was I not myself reifying and compartmentalising the experience of sight impairment?

The therapeutic process offered its own answers to this crucial question, with its central implications for the philosophy of social service provision and community intervention surrounding disability. My position became the following: It is not possible, and it is necessarily prejudicial, to make broad or universalising statements about the experience of impairment. When the observer is confronted by images of impairment – of blindness, for example – the dynamic often set up could be described in the following terms: the image of impairment may evoke in the observer fearful and anxiety-provoking fantasies surrounding their notion of 'what it would be like to not be able to see'. It is these evocations of dependency, of awkwardness, of uncertainty and vulnerability, that are at the centre of what Goffman (1963) terms 'sticky' interactions between 'disabled' and 'non-disabled' persons. It is crucial to recognise here that the feelings evoked in the observer, which may then disrupt engagement between the persons, are not feelings related to how the blind person actually experiences themself, their life, or their disability. Rather, the feelings are the emotional component of what the observer imagines their life – as someone who does not have sight – to be. Typically, though, these emotional evocations are not 'owned' by the onlooker as parts of themself that are 'touched' by the notion of blindness, but rather wordlessly disowned and projected onto the person with an impairment who stands before them. Thus, I believe that persons with impairments are often responded to by the 'broader' populace as living realisations of the anxiety-provoking fantasies of dependency, vulnerability and loss which they evoke in observers. Making any statement regarding the experience of impairment, would, I believe, thus mean falling into this trap of projection. When we make assumptions about the experience of someone with an impairment we express, in fact, much more of our own emotional worlds and internal experience than we possibly could of theirs.

However, surely it is within this very discussion regarding the oppressive and emotionally scapegoating manner in which persons with impairments are often regarded in segregated societies such as ours that some solution to our dilemma is to be found. Shakespeare (1994) has referred to the group of persons culturally designated within society as 'disabled' as 'dustbins for disavowal' – that is, psychic dustbins into whom are projected those parts of human experience which are felt universally to be difficult to tolerate and manage. Persons with disabilities are 'othered' as the custodians of dependency, vulnerability and marginality, thereby reaffirming the 'in-group' positive distinctiveness of the observer. Surely, it is possible, it is defensible, to assert that being psychically appropriated for this purpose by society (to a greater or lesser extent) constitutes trauma. To live in a barrage of projections, having to struggle against powerful forces of oppressive definition from without, with the relentless experience of not being truly known and recognised which this may afford; surely it is possible to assert that filling such a space is trauma. In other words, it is my assertion that, whilst an association of impairment with trauma has rightfully been regarded as oppressive and indefensible, it is arguable that the culturally contextualised notion of disability is one which may imply a level of trauma. Based on the fact of pervasive disablist oppression of many forms.

In very concrete terms, the accounts of members of the psychotherapy group reflected this relentless barrage of experiences of a misattuned social and structural world. In terms of structure, procedure and culture, the university environment has been created exclusively with the needs of sighted persons in mind, rendering an over-arching sense amongst students with visual impairment of ‘not having been thought about’. Furthermore, existing within an organisational system in which the basic *modus operandi* of activity is undertaken within media which are unusable, excluding and inaccessible to one, may lead the individual quickly to experiencing their needs for basic access as excessive, unreasonable and uncontainable. Group members described the experience of a constant stream of messages of various forms, communicating that one is different, difficult, alien, frightening, embarrassing, unwanted, uncontainable and out of place. Sinason (1992) has written extensively regarding the role of the communication of a violently negative social identity in the functioning of persons with mental handicaps. She argues that persons with mental handicaps are the most negatively valued group on our planet, and explores the very profound ways in which the lives and experiences of mentally handicapped persons are constructed and constrained by the hateful and fearful projections of the broader society. Along identical lines, I believe that it is possible to make aggregated statements regarding what it means to carry a visible impairment in a discriminatory society – to know that one is often first and foremost seen as an embodiment of the unspoken shameful emotional parts of those who see one. In essence, I feel that such an experience of not being seen, of having to battle significant and pervasive forces in order, to some degree, to have the opportunity to define, circumscribe and express oneself, would increase the likelihood of emotional distress and the possible need for psychotherapy amongst any population. At the heart of this chapter is a deep and painful irony. The irony is this: persons socially designated as disabled are arguably amongst the most powerfully marginalised and oppressed groups in most societies, forced to suffer pervasive deprivations and exclusions, whilst occupying a strongly negative ascribed identity. Yet these persons are, in my experience, thoroughly socialised into a violent sense of de-legitimation of their experience of struggle, such that the allowing for oneself of, for example, psychotherapeutic support, is extremely difficult, and hence relatively rare. Bluntly put, it is those persons whom the society treats most oppressively, who are simultaneously the most alienated from access to support and assistance.

It is the nature of our predicament as humans that we all struggle to cohere ourselves at times – to feel whole, to feel accepted, to be able to trust in the positive regard of those around us. At times of struggle our ability to fend off negative messages from our environment regarding our adequacy, ability or desirability becomes eroded, and we may become depressed or distressed. What occurs at these times is that events in our external worlds evoke or awaken vulnerable parts of ourselves which we all carry. A small failure at one’s occupation, for example, may bring forth archaic feelings and fears surrounding adequacy and capability which are rooted in our developmental milieu. Living with an impairment in an inequitable and discriminatory society means having to withstand a plethora of such messages, since it is in the nature of disability oppression that the insufficiencies of non-adapted physical and cultural environments become individualised. That is, disability-related difficulties rooted in lacking physical environments tend to be overtly or covertly ‘blamed’ on the individual. ‘Holding’ on to a sense of one’s legitimacy, one’s ability, and one’s right to equal opportunity at times when one’s sense of self is coming under such attack, requires much energy and inner strength and is, at times, impossible. I believe, with much sadness, that vast numbers of persons with disabilities in this country have been socialised into a thorough acceptance of this communicated blame, rendering the internalisation of a sense that one is rightfully and justifiably marginal, and can hope or demand nothing more than a menial or domesticated existence.

The words of Frantz Fanon are as applicable to persons with disabilities as to the racially oppressed groups to whom he referred:

> *I am talking of millions of people who have been skilfully injected with fear, inferiority, complexes, trepidation, servility, despair, abasement.*
> *(Fanon, 1968 in Abberley, 1993, p.108)*

The imputation of a negative sense of self to which Fanon referred relates to the same process of projection of the bad, of the disavowed, that applies in the case of persons with disabilities in South Africa.

Psychotherapy

The utility of psychotherapy relating to disability lies, in light of the foregoing, in its capacity for providing an environment in which the experience of carefully obscured and internalised oppression may be debunked and exposed. The notion of loss is one which has ubiquitously, and prejudicially, been attached to impairment in 'traditional' psychotherapeutic writing. As argued above, it is indefensible, and discriminatory, to assume loss or trauma, much less psychopathology, as a necessary correlate of impairment. However, and again ironically, I believe that some experience of loss is almost inevitably associated with a recognition that one is to be forced to dwell within a barrage of unconscious projections; to be defined from without in terms of the fears and vulnerabilities of others; to have less chance of finding experiences of feeling truly seen and known by others, because of the force and valency of emotions which one's impairment may evoke. Of course, the experience of impairment itself is a separate and highly significant issue which has, for each individual, its own unique and complex meanings.

Through systematic and empathic exploration of the experience of disability in psychotherapy, I believe that a process of re-finding of the legitimacy of needs robbed by the action of disablist ideology may be usefully undertaken. Such ideology has interpellated 'disabled' and 'non-disabled' persons alike into a code of silence which may render absurdly oppressive contradictions surrounding disability-related discrimination seemingly sensible, or simply invisible. The therapeutic philosophy which I propose, thus, is an emancipatory one, not unrelated to the critical conscientisation model of Paulo Freire (1970; Peters, 1999). Through examining experience, the carefully obscured contradictions which have led to oppression becoming internalised may be exposed, hence harnessing a righteous anger and outrage which may be channelled into self-advocacy.

What is to be deconstructed, furthermore, is a form of oppression which stretches beyond the overt actions of material social forces to an internal exile, consistently self-imposed by and upon individuals incorporated into disablist ideology. Priestley (1999) draws attention to the hegemony and pervasiveness of negative portrayals of disability, potentially causing particular and far-reaching effects upon children with disabilities (Priestley, 1999, p.92). Within medical or special education settings, children with disabilities may develop within environments steeped in 'institutional discourses of tragedy, medicalisation and otherness' (ibid.). Furthermore, even when outside of institutional settings, most children with disabilities grow up surrounded by non-disabled people, rendering the development of alternatives to the dominant culture of assumptions surrounding disablement unlikely (Zola, 1993 in Wendell, 1996, p.59).

Thus, unlike other marginalised groups (eg., ethnic minorities), persons with disabilities are afforded little opportunity, especially during crucial periods of the development of a sense of self, for the consolidation of views alternative to the hegemonic assumptions regarding their place, status and role (Wendell, 1996, p.59). The psychotherapeutic environment may provide an opportunity for the development of such alternatives, incorporating the stronger coalescing of a sense of just entitlement arising from the recognition of mechanisms of oppression. Silenced experiences of trauma relating to the social and psychic ways in which persons with disabilities are often politically situated may be validated and normalised, thus serving to reaffirm the locus of oppression, of defect, as external rather than internal, as imputed within disablist ideology.

Conclusion

Thomas (1999) refers to 'the psycho-emotional consequences of disablism', which are defined as the 'personally or subjectively felt effects of social forces and processes which operate (not in a direct, mechanical, or unidirectional way) in shaping the subjectivities of people with impairments' (Thomas, 1999, p.48). Thus, the effects of living with disability in a disablist world are becoming increasingly able to be voiced and considered, within theoretical frameworks which make provision for the group political struggle, as well as the subjective nature of life-worlds. The link between broad discursive patternings of assumptions and practices surrounding disability, and the profiles of individual subjectivities, is one which bears much promise in debunking essentialist notions of the sequelae of impairment, beginning with persons with disabilities themselves. What is required is that experiences of struggle be recognised, articulated and owned, not in a way which carries with it the weight of a long history of oppressive identities and assumptions, but rather in a manner which legitimately voices the meanings and the pain of the mutually constitutive experiences of disablist oppression and impairment.

Expressing such experiences within the context of an overt highlighting of the (mutually constitutive) relationship between subjectivity, struggle and discourse may allow for the recognition and exploration of feelings and parts of self hitherto obscured by shame and disentitlement, through interpellation into essentialist notions of normality.

The essential issue with which this chapter has dealt relates to the question of whether it is ideologically defensible and appropriate to, in any way, structurally integrate psychotherapeutic services into disability-related community intervention. To live with disability in a society such as ours, saturated as it is with systematic exclusions and discrimination surrounding disability, embodies, in my opinion, an experience of trauma. As any psychotherapist is deeply aware, the challenge of feeling whole, of feeling legitimate and able to be contained and held by one's world, is a difficult life task for all humans. However, if the ideological milieu within which one dwells has served to position one as being seen to carry a host of unvalued and undesirable qualities, and has relentlessly demonstrated its unwelcomeness through experiences of the lack of basic access provision, the task of feeling whole, and of continuing to attempt to elicit experiences of feeling known, is simply that much harder.

It is my position that persons with disabilities, besides having to deal with the myriad of experiences of structural discrimination which are commonplace, often live as the incarnations of a barrage of projections from those around them, in a manner which oppresses and constrains the experience and expression of self. Experiences of being mirrored by those around us, of feeling known and held, are of crucial importance to our sense of self, and to the process of individuation and the elaboration of our personal potentials. The negative and shame-ridden emotional associations which have become culturally attached to the notion of disability have the power to profoundly disrupt the business of mutual engagement between individuals in the presence of disability, hence reinforcing boundaries of knowing, and hence of stereotype. If one suspects – consciously or otherwise – that the experience of a person is painful, frightening, alien or shame-ridden, one is far less likely to open oneself to its exploration, and hence to some form of real 'meeting'. Thus, persons with disabilities are often forced to manage the knowledge that they are defined from without, in terms of the fears and disavowals of the broader society. Again, I believe that this embodies trauma, and that this understanding self-evidently makes the provision of psychotherapeutic resources in community-based disability social services both necessary and appropriate.

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9

The ‘Good Enough’[1] Community: Power and Knowledge in South African Community Psychology

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In chapter six, Maw discussed ways in which the conventional, egalitarian approach to the consultation model in community psychology falls short of an understanding of power dynamics. This issue is especially relevant in the South African situation where it is impossible to ignore historically entrenched power differentials and recent attempts to reverse these. In this chapter, in order to interrogate issues of power as they relate to professional involvement in community work, we discuss a mother-infant intervention project in an informal settlement near Cape Town. The project[2] is a research endeavour devised almost entirely by mental health professionals and then presented to the community for their approval and participation.

Within the rhetoric of community psychology and of progressive social science in South Africa, especially during the final years of apartheid, it has consistently been argued that professionals should not impose their own ideas on communities. Ideally, it is expected that they wait to be approached by communities before intervening, and thereafter construct an intervention in accordance with expressed community needs (Berger & Lazarus, 1987). According to this view, professionals should not impose their own ideas about change onto these communities. Rather, it is considered politically important and necessary both to the development of community psychology and to progressive social science in South Africa to emphasise the role of communities in determining their own future (Webster, 1986).

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[1] Apologies to Winnicott. See Rodman (1987).

[2] This project is a partnership including the Child Guidance Clinic along with the Parent Centre, a Cape Town NGO; the Winnicott Research Unit at the University of Reading; and the Department of Psychiatry at the University of Cape Town.

In this chapter we explore some of the central tenets of community psychology in light of theoretical ideas about knowledge and power. Foucault (1997) particularly has assisted us in understanding some of the complexities of the relationship between power and knowledge. In light of this, we discuss the ways in which ideas about community empowerment may be flawed and insufficiently aware of the responsibility that professional knowledge brings with it. We use the mother-infant project to illustrate different ways of thinking about the role of the community psychologist.

'Giving psychology away?'

International literature on community psychology emphasises skills devolution for a range of philosophical and practical reasons. The literature highlights the need for communities to be empowered in the context of a democratic partnership with professionals (Orford, 1992). In South Africa, these issues are compounded by a scarcity of professional resources (Freeman & Pillay, 1997). In an attempt to address these kinds of concerns, local practitioners have drawn from the well-known community psychology dictum of 'giving psychology away' (Albee, in Orford, 1992). The aim is to optimise the capacity thought to exist already within communities and, in doing so, to strengthen the functioning of communities around mental health issues (Gibson, 2000).

The terrain of professional psychology in South Africa was, and is, characterised by a tentative ownership of skills. South African community psychology developed in a nation undergoing painful and conflictual political transition, and now operates in a fledgling democracy. Given the abuse of power that apartheid represented, progressive psychologists in South Africa expressed particular sensitivity to imposing their views on the communities with which they worked. In local writing on community psychology, therefore, there is an exceptionally strong emphasis on community knowledge and skills, and on the limits of professionals in understanding community strategies (Anonymous, 1986; Berger & Lazarus, 1987). Even during the period of political transition in South Africa, when progressive psychology overtly argued against professional power, it was recognised that this issue was more complex than the political rhetoric would suggest (Swartz, Gibson & Swartz, 1990).

The notion of 'giving psychology away' is of course a problematic one. The idea of giving something away assumes, by definition, that psychologists have something to give and that communities want what they receive. It also assumes that something like professional knowledge or skill can be given away simply as a result of egalitarian intent. Furthermore, when psychologists disown their expert status this may be understandably confusing for their clients. The community psychologist has been called upon precisely because of perceived knowledge and the response: 'I do not have the answer, I am no expert, but I am here to give my skills away' is baffling in its contradiction. The community may be left with the feeling that what they want is somehow being withheld. It may however be particularly difficult for them to voice their neediness given that they have been constructed as experts regarding issues in their own communities. The simultaneous offering of powerful skills and the denial of these implicitly limits the possibility for debate or conflicting views from the community. Furthermore, if professionals insist on the community owning all knowledge and skills, they implicitly limit the community recourse to interrogating and criticising the role of the psychologist in the intervention.

Faced with experts who place themselves in the position of the 'unknowing other', communities in distress may in fact feel disempowered rather than being left with a sense of increased autonomy. It has been argued that this obscuring of professional power can better be viewed as a form of enslavement rather than emancipation. Foucault (1997) suggests that so-called 'free democracies' maintain power precisely by presenting an image of democracy as natural and as conferring equal power to all, regardless of material circumstance. The availability of every conceivable product in an open market creates the illusion that everyone has access to them, and masks the reality that such access is determined fundamentally by resources. These resources are unevenly spread, and there is evidence that the differentials between those who have more resources and those who have fewer is expanding even as the rhetoric of a global open society grows (Falk, 1999).

In Foucault's view, power is not imposed unilaterally, but is exercised in a diffuse way by all participants in a relationship of power. In 'free democracies', then, communities themselves, by participating in the illusory free market, come to see all decisions about improving their own condition as their own responsibility. This leaves them, essentially, to blame for their own condition and for any failures that may occur when they are called upon to help. However well intentioned, the professional who disclaims the community's knowledge may help to disguise the operation of power and inadvertently create further disempowerment.

In the powerful rhetoric of community empowerment, the nature of the problem and the solutions that might be given for it are all constructed within the understanding that the community has the capacity to rectify its own expressed difficulties. In Foucault's words this kind of understanding constitutes a 'theology of meanings, in which the truth anticipates its own formulations and completely constitutes them' (Foucault et al, 1993). Given this, if an intervention is successful the assumption that the community knows best is affirmed. However, if an intervention is not successful this may be attributed to external impediments to the spontaneous emergence of the community's strength. In this way any criticism of the formulation that the community knows best is avoided.

Power and knowledge in the development of community psychology in South Africa

Community psychology as a discipline in South Africa had its vocal birth during the apartheid era, and specifically during the 1980s when state oppression was at its most obvious. A key feature of the community psychology discourse at the time was its accusation that traditional psychology had, at best, been silent on abuses of power during the apartheid regime and at worst colluded with these (Dawes, 1985). During this period, progressive psychology's dialogue with issues of power was, for the most part, concerned with the relationship with an authoritarian and brutalising state apparatus. Psychologists were thought to have a role in 'treating' the victims of the oppression and through this highlighting the various forms of social injustice. Additional concerns also arose at the time about how within community psychology there was a:

> *Strongly felt pressure on practitioners to act effectively and appropriately to ameliorate the situation, and to behave in such a way as not to reproduce power relations endemic to mainstream psychology.*
> *(Swartz, Gibson & Swartz, 1990, p.250)*

In the apartheid years, power differentials were brutally apparent. The dilemmas of action or non-action were profound and often, literally, took place in the realm of life and death. Under these circumstances the identification of the oppressor and the oppressed seemed a simple matter. Psychologists did offer theoretical contributions to understanding the nature of power relations, including those between clinician and client (Hayes, 1986). However, much of this kind of discussion focused on the easily identifiable enemy – the apartheid state and its forces of oppression. When power was articulated in terms of the relationship between psychologist and client, it tended to focus on overt areas of oppression such as race with a proportional neglect of more subtle forms of power. In fact (and this is by no means peculiar to South Africa or to community psychology in this country), formulations around the issue of power invariably begin at the level of the institution or the 'all-powerful other'. Foucault's important contribution has been to show that, if we wish to understand power fully, we need to focus not only on political structure or the dominant social order but also on questions of power within human relationships (Foucault, 1997).

In recent years concerns about power and its implications for community psychology seem to have received rather less attention than they did during the period of political struggle against apartheid. With the transition to democracy in South Africa, there has been perhaps a misleading perception that the problem of unequal power has been resolved. Nothing, of course, could be further from the truth. Power needs to be recognised as an ongoing part of community psychology and needs to be reconceptualised in ways which acknowledge its subtle and complex workings.

Power

For Foucault, power dynamics are at play in all human relationships, as well as in any organisation. Power is not a substance but a relation and is therefore not 'possessed but *exercised*' (Halperin, 1995, p.16, author's emphasis). Power then is dynamic, and should not be conceived of as being localised or held in one place, and then desired from another. In this conceptualisation, the important question is about how different people between themselves or within an organisation exercise that power. This has important implications for more traditional views which formulate power in terms of the oppressor and the oppressed, where the oppressed are placed firmly in the position of the 'other', trying to gain access to power.

Power is frequently conceived of as something which has a tangible quantity – 'I have power, you can take this from me, and now you have my "x" quantity of power' (Wallerstein, 1999). In talking of community empowerment, power is often thought of as being a zero-sum game (some have to give up power for others to take it). This is not the nature of power as Foucault conceptualises it. Importantly for Foucault, domination of the oppressed by the oppressor is not the whole story. Rather, power is constantly negotiated between people and therefore continuously shifting and changing in the context of relationships. In this analysis psychology no more 'holds power' than the community does. Deprived and depressed communities will invariably make demands. This parallels the individual client in individual psychotherapy – where an important part of therapy would be to unravel that demand and come to understand it. The 'demand' in any case should be seen as a 'demand… for power' (Weber, 1991, p.130). In terms of this view, community psychologists in South Africa correctly understood that the demand from communities was indeed a demand for power. Incorrectly, though, community psychologists located this power in their own professional status. Partly in order to avoid being powerfully attacked, community psychologists tried to level power imbalances by arguing that professional status could, by conscious decision, be sloughed off. Part of the mistake had to do with the nature of the link between professional status, knowledge and power. It is to this that we turn in the next section.

Power and knowledge

During community psychology's early grappling with the issue of power, questions around professional status and access to knowledge were strongly politically loaded. Under apartheid legislation, many people were denied education and jobs. To add to this, professional status in some cases was closely identified with the edifice of apartheid. In taking account of and trying to disown the power derived from professional status, however, community psychologists created an inappropriate separation between status and knowledge. They failed to take sufficient cognisance of the key role of knowledge in the constitution of status and the power associated with it. As Foucault argues:

> *We should admit… that power produces knowledge… that power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations.*
> *(Foucault, as quoted by McHoul & Grace, 1993, p.59)*

For Foucault, then, power and knowledge are inseparable. Denying one's professional status while exercising professional knowledge will not lessen the power associated with that knowledge – it might in fact obscure it and render it, paradoxically, stronger and more pervasive. Much of the rhetoric of community psychology still speaks of the disowning of the power that comes with professional status, and speaks little about our undoubted knowledge base and the power that this implies (Orford, 1992).

Rearranging the form of knowledge

Although concerns with professional status were predominant in debates about community empowerment, there did seem to be some, perhaps unconscious, recognition that, in order to shift power, the knowledge base itself needed to be addressed. Rather than address the fundamental link between knowledge and power, however, this concern seemed to take the form of attempts to 'rearrange' forms of knowledge within traditional psychology by shifting some of the existing 'rules' about how the work should be conducted. For instance changes were made to the site of the work ('out there' in the community rather than in the consulting room). Other changes included the shift towards a facilitation model which located significant knowledge within the community. The psychologist was expected to follow the dictates of a community that knew what it needed and requested the willing professional to perform the task. What happened in this rearrangement, however, is that power was merely reconstituted, creating an illusion of equality. This has some similarity to the kind of process Foucault describes in the shift of psychoanalysis from the medical model into its own realm. He argues that psychoanalysis has created its own non-medical space and mode of operation – including fees, the couch and the analytic hour. All of these distance the practice overtly from the medical realm (and allow non-medically qualified persons access to the profession), but maintain, in altered form, the power which medicine initially conferred.

A further source of the power of psychoanalysis, as Rose (1992) has argued, lies in its increasing surveillance of everyday life. This operates through its extension of practice and expertise beyond the consulting room into areas such as childcare, preschool education and organisational consultancy. There is of course a direct parallel between this and the development of community psychology in South Africa and its position within the broader framework of liberation politics. In spite of major challenges to the theoretical and practical tenets of conventional psychology, community psychology continues to enact the complex dynamics of power. Some of these processes are explored through a case study of a mother-infant project known as Thula Sana.

The Thula Sana project

The Thula Sana[3] project is a four-year controlled treatment-trial delivered by a small group of trained and supervised community health workers. The aim of the project is to investigate the extent to which a community-based early intervention programme may impact on early infant and child social, emotional and cognitive development. Most respondents in the study live in a shack settlement, which forms part of a historically black township outside of Cape Town. This area is characterised by high levels of unemployment and poverty. Dwellings predominantly have no electricity, irregular refuse removal and access to communal water supplies only.

In terms of the aims of the project, intervention begins with a community health worker visiting pregnant women in their homes on two occasions before the birth of their children.

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[3] This project is funded by the Wellcome Trust.

The intention is to establish a supportive relationship with the women and explain the purpose of the intervention programme. After the baby is born, the community health worker visits the mother a further eight times, on a weekly basis. This is followed by two more visits over the next month and, finally, monthly sessions for three months. This form of intervention has been adapted from a mother-infant interaction programme developed in Britain by Murray and Cooper (unpublished manuscript, 1997) and incorporates the key principles of the World Health Organisation (WHO) document 'Improving the Psychosocial Development of Children'. Local adaptations and synthesis have been completed following pilot work done in a working-class area in Cape Town[4].

The intervention includes counselling and an educational component. The counselling is intended to provide emotional support for the mothers and a safe place for them to talk about their early experience of parenting. The community health workers also help to develop the capacity of the mothers to recognise the individual capacities of their babies and the nature of their developmental needs. They also actively attempt to facilitate the engagement between mother and infant and provide specific advice around particular aspects of infant management (Landman, 1999).

Negotiating entry

The question of how or whether it is possible, in an intervention such as ours, to negotiate entry in a democratic and culturally respectful manner has implications for the work. The intervention described above depends heavily for its design on research in Europe and the USA, though there has been considerable care taken to adapt this to the local context. Before the intervention was implemented, extensive negotiations were undertaken with community leaders and people experienced in working with mothers and infants in the area in which the shack settlement is located. The political climate here necessitates sensitive and careful negotiations around entry, particularly for white professionals. The issue of cultural sensitivity and the dangers of cultural imperialism are well known in this community, and there would have been no possibility of our working in the area had community members felt inappropriately imposed upon. There are questions, though, about the extent to which we were able to receive informed consent from community representatives. Though we did try to do this, many of our specialised research-driven concerns may not have been fully understood. Furthermore, it is by no means self-evident that approval of the project by community leaders suggests equal co-operation on the part of individual mothers who are directly involved in the project. Although they could voice their willingness to participate, it remains unclear whether individual mothers felt able to refuse participation given expressed support by community leaders. These issues may also be exacerbated by concerns regarding cultural appropriateness. Community psychology, and progressive psychology in general, emphasise the extent to which psychologists may be guilty of imposing their world views on others (see, eg., Fatimilehin & Coleman, 1999).

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[4] Hanover Park is an area of Cape Town characterised by widespread unemployment, gangsterism and poverty.

Needs and demands

In the Thula Sana project, we have taken a position not common in community psychology. Much of community psychology has been built on the premise that a good intervention will be one which matches the needs of the community. In most models of community psychology, entry is negotiated through a needs assessment and an attempt to empower the community by way of facilitating their expression of what they want from the psychologist (Orford, 1992). This approach, however, masks the extent to which the consultant brings along with them skills, traditions and knowledge. It creates the illusion (both among professionals and in the community) that the professionals have no agenda of their own. In the Thula Sana project we were explicit from the beginning about what we had to offer. Based on research and previous experience, we had a belief that the type of intervention we were offering should be beneficial and have a good chance of working.

In many ways, however, relationships in community psychology are represented as being about what psychology can offer to communities. There is often less emphasis on the way in which community projects make demands on the communities with whom they work. In our case, for example, we require multiple assessments over a period of 18 months. We make a significant demand on a community not accustomed to the contribution we require. If empowerment is a serious aim of community-based research, we believe that it is not inappropriate for those offering services and expertise to have expectations of the community. From the beginning, however, the professional needs to be explicit about the collaborative demands of the project.

‘Giving away’ a mother-infant intervention

Our experiences on the Thula Sana project seemed to highlight many of the contradictions entailed in the community psychology principle of ‘giving psychology away’. At a superficial glance our training-intensive approach might appear to be compatible with this set of ideas. In this project, community workers have been through extensive training, by both local and international professionals, and receive weekly supervision. This spreads skills into the community and the workers in turn disseminate knowledge directly to the mothers with whom they work. This linear account of the spread of skills and knowledge is, however, deceptive. It is only very particular and limited skills which are passed on by time-limited training and a far more fundamental and broad-ranging knowledge remains in the hands of the professionally trained psychologist.

For example, in our choice of approach we have drawn from the knowledge generated by similar international mother-infant intervention programmes (Olds, 1993; Olds & Kitzman, 1997). Our use of this training model is further grounded in our access to knowledge about evaluation research and the outcome measures that will serve as part of our study. Through our extensive theoretical understanding we also have come to realise that the programme is implementable only by trained personnel – in our case, community workers. In training these community workers we are disseminating skills, but this is not the same as ‘giving psychology away'. If we were to claim that we are 'giving psychology away', we would have to be able to show that our trained community workers could themselves implement the programme in its entirety. For this they would need access to the broad range of knowledge and understanding generated by professional training and research. Imparting a skill for a client to utilise or to think differently about something is not the same as giving professional skill away.

Knowing and 'not knowing'

It is clearly important for community psychologists to acknowledge that they do own and operate in accordance with a substantial body of knowledge. There is, however, a danger in treating this knowledge base as though it were capable of producing answers to community problems outside of a process of dialogue and collaboration. Psychoanalysis teaches us that the application of our theoretical knowledge is useful only if we are open to the particular needs, histories and circumstances of our clients. In relation to these issues we will always, as Fantelhelm says, 'know very little'.

Harper (1999) argues for assuming a position of not knowing as an ethical position in opposition to the discourse of mastery. He argues that this means not assuming what is good for another, and being able to endure not knowing. Harper (1999) goes on to state that being able to adopt a position of being empty and without attributes is important in therapeutic work.

This, however, does not suggest that psychologists are 'empty' of knowledge; while we may not have the only answer, we have a number of possible answers that may be fruitfully explored by the client. 'Not knowing' is not synonymous with a lack of skills and a complete professional and therapeutic ignorance. It is about a realisation of one's own limitations in the midst of another's life and difficulties. It implies an active attempt to create a space for the other to think about these difficulties in a different way.

However, in community psychology, debates about knowledge have often become polarised: either clients know nothing and psychotherapists know everything, or vice versa. It is perhaps far more helpful to think about a position somewhere between these two – there are knowledges, useful and less useful, on both sides. As professionals, we do have skills and should own them. But this does not imply that we should assume that we know better. In discussing psychotherapy, Orbach (1999) argues that:

> *The confidence in what she* does *know gives the therapist the capacity to doubt, to question and to surrender to the problems when she* doesn't *know and* doesn't *yet understand what is happening.*
> *{*Author's emphasis*}*.
> *(Orbach, 1999, p.5)*

Creating a space for thinking about infants

In the Thula Sana project and in work with infants in general, a crucial aim is to create a space in which the unspeaking baby can be thought about. Some of the dilemmas related to knowledge which have already been discussed are foregrounded by the fundamental need in this kind of work to accept a condition of 'not knowing' while at the same time continuing to try to think about and make sense of the baby's needs. For the community worker this involves taking up a quiet, but active and thoughtful role in relation to the needs of the mothers and their babies. It also involves encouraging the mothers themselves to adopt a reflective stance. In turn, the psychologist is called on to facilitate a thinking capacity in relation to the community workers and in relation to the project as a whole.

Harper (1999) states that an important therapeutic aim in individual psychotherapy is what he terms 'the gift of empty space'. While this is possible (although difficult) in long-term individual psychoanalytic psychotherapy, it is far more problematic in community work. A silent, reserved professional is easily perceived to be cold and withholding in a deprived context, where professionals are often expected to provide something concrete. Creating a space to think about infants is an important part of the Thula Sana project and is particularly relevant in South Africa, where for so many years (far from being in a thinking space) children were imprisoned and infants were separated from mothers and fathers. Infants and young children were often the first to suffer under apartheid and its disruptive effects on family life and health. Children, furthermore, were directly brutalised through oppression, even to the extent of being imprisoned and killed (Skinner, 1998).

There are important consequences of this for the ways in which a nation does or does not think about infancy. Children's pain may have become too unbearable for words or thoughts. Those concerned about children may have found it impossible to think about children's pain. Although it is clear that psychology and its power cannot simply be handed over, it can facilitate the development of particular capacities such as the space to think and perhaps the emotional containment that allows this to happen.

Importantly, though, the facilitation of these reflective capacities in Thula Sana is done hand in hand with a programme which is at times also quite didactic. Often community projects run into difficulty or fail because of a perceived sense by members of the community that they have not 'been given' anything. The idea of a silent listener is not always prized. On the other hand, where input is given (as in our case), we run the ongoing risk of being accused of 'telling mothers what to do', and of a naive cultural imperialism in assuming things about infancy, motherhood and the nature of gender relationships in the community. Not surprisingly, perhaps, there have been occasions when we have been criticised for claiming knowledge in what is ideologically constructed as the 'sacred' sphere of mothers and babies in a cultural and class context different from our own.

It would in many ways be easier to limit our role purely to a facilitative one which allows for the development of a thinking space. However, there are occasions on which our knowledge gleaned through training and research suggests a fundamentally different approach to that commonly held by community members. For example, in the Thula Sana project we were working in a deprived and embattled community, and found ourselves offering as part of our expertise a view of infancy which was at odds with the emphasis on the infants' strength and capacity to withstand harm held by many community members. We have often been told that young Xhosa children need not be pampered or picked up each time they cry. Growing up strong and 'getting on with it' are seen as important developmental milestones. In a recent interview, a mother said that during the apartheid years this was particularly the case with a boy child, because one never knew if he might have to leave the country and join the armed struggle. Independence was not so much a developmental task as a survival necessity.

In spite of recognising the importance of these kinds of ideas for the emotional protection they provided for the community, it also felt necessary to offer alternative ways of thinking which might facilitate shifts in understanding. In taking up a position on the need of infants for more active care-giving, we issued a strong and potentially painful challenge to the community. There were obvious risks in taking up this kind of role in relation to the community but these seemed to be outweighed by the potential benefits. This was another example of the demands we made of the community. These issues relate strongly to the central concerns of this chapter – questions of power and of 'giving psychology away'. In making demands on the community and in asking it to think about infants in a different way, we were foregrounding our own psychological knowledge about babies and implicitly asking that the community accept this view.

Conclusion

What we are attempting to create in the Thula Sana project is a space in which infants and young children (and their needs) can be thought about in a different way. This is not a prescription for living, nor an ideology derived from a position of professional arrogance, but rather a research-based attempt to affect improved outcomes. Our starting point is one of taking existing knowledges (both in terms of our skills and the present state of knowledge in the field) and then implementing these in a particular way. Importantly, we are attempting to avoid idealising the community; on the other hand, we do not believe that professionals always, by virtue of their status, know best. We are assuming that we have skills to offer and that this may have long-term beneficial effects to infant social-emotional-cognitive development. Assumptions of knowledge are unavoidable and intrinsic to our project. Pretending this is not the case is illusory and self-deceptive. At the end of the project, furthermore, we shall have a way of assessing whether we have or have not been helpful.

Having said this, however, inextricably linked to the assumption that we can help is an openness on our part to learning from the undoubted 'knowledges' which exist within the community. We do not and will never assume that whatever problem we are confronted with can be solved through our knowledge and understanding alone. We are hoping, however, that through a combination of the research component of the project and an intensive and ongoing tracking of the process, we will be in a position to make informed and reasoned statements. These concern both the efficacy of such infant interventions, and the nature and future directions of similar community interventions.

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10

Psychoanalytic Community Psychology: Crossing Worlds or Worlds Apart?

CAROL LONG

Armed with notions of empowerment, uneasily combined with ideas about the unconscious, we set off to begin a consultation relationship with a group of black, Xhosa-speaking[1], primary healthcare workers in an impoverished shack community in Cape Town. This chapter explores some of the complex issues which arise when attempting to undertake psychoanalytically informed community psychology in South Africa. Some of the challenges we encountered will be highlighted through a discussion of the shifting terrain of power and emotional experience during our intervention.

On the basis of our work it became increasingly clear that psychoanalysis could only be used effectively in community settings when it explicitly recognises socio-political influences and includes these in the object-worlds of our clients. Without recognition of the interplay of power in a variety of dimensions, and without recognition of issues of difference (cf. Kottler, 1990; 1996) between client and practitioner, the intervention may be limited or even harmful.

I shall explore the process of our community intervention, looking at moments of interaction between practitioner and client in a psychoanalytic and political light[2].

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[1] One of many indigenous African languages spoken in South Africa.

[2] A note on method: This chapter is situated within the case study tradition. As such, the interpretations offered rely heavily on the subjective experiences and reconstructions (from clinical notes) of the author. This paper does not claim to offer objective truths (of which the author, along with others (e.g. Giddens, 1976; Hollway, 1989; Parker, 1992) regards as an unattainable methodology for the social sciences). Rather the aim is to enter debate around interpretations, using these as a starting point for future critical thought around psychoanalytic community interventions. This paper thus offers a retrospective analysis of the process in an attempt to open opportunities for theoretical and practical advances in future community work.

Our point of entry into the discipline of community psychology

The development of community psychology in South Africa is a comparatively recent trend, and arose largely in response to ethical questions raised by psychological practice in apartheid South Africa (Maw, 1996). With a changing political climate, South African psychologists have increasingly called for more relevant practice (eg., Berger & Lazarus, 1987; Dawes, 1986; Kelly & van Vlaenderen, 1997), an emphasis on sharing of skills and greater political consciousness (Berger & Lazarus, 1987). Appeals to psychologists have encouraged a more self-reflexive stance and the need for psychology to 'emancipate itself from its own complicity with oppressive establishments' (Seedat & Nell, 1992, p.191). The idea is that psychologists should begin to 'redefine their psychotherapeutic practice as liberatory rather than curative' (Seedat & Nell, 1992, p.191). Change away from the monopoly of traditional therapy, however, continues to happen in the margins and so-called community psychology remains a largely peripheral enterprise (Swartz, 1996a).

Progressive practice in South Africa has drawn extensively from international literature on community psychology, including notions of empowerment and participation (eg., Orford, 1992; Rappaport, 1987; Serrano-Garcia, 1984; 1990). Such notions encourage clients to 'gain mastery over their own affairs' (Rappaport, 1987, p.122) through interventions driven by community participation. Much has been written about the complexities of achieving meaningful involvement from the community (eg., Edwards, 1990; Riger, 1993; Serrano-Garcia, 1984). Kelly and van Vlaenderen (1997, p.160) argue that 'participation' has become a 'buzz-word' used to legitimise any and all community projects' in South Africa and that this diverse usage has undermined its explanatory value. Referring to Habermas (1984), who suggests that dialogue can only take place when power dynamics are minimised, Kelly and van Vlaenderen (1997) imply that power dynamics are so salient and pervasive in South Africa that minimising asymmetrical power relations is an idealistic goal. Swartz (1996b) adds that the common strategy used by psychologists of disavowing their own expertise in an attempt to value the expertise of the other (eg., Orford, 1992) is equally idealistic since it denies the reality that psychologists are experts and have power. In a 1996 South African conference ('Child & Family Wellbeing: Strategies for Community Partnerships'), discussion often reflected disillusionment with the concept of empowerment and with the idea of 'giving psychology away'.

This suggests a need to find a new way of working in order to free us from tired notions of simple empowerment, and all the clichés this term sometimes attracts. In an attempt to address some of the concerns with naive notions of empowerment, the training clinic has developed a psychoanalytic approach to community psychology based on the Tavistock model of psychoanalytic group and organisational theory (eg., Menzies Lyth, 1988; Obholzer & Zagier Roberts, 1994). It was within this model that the intervention described here was initiated. While some may regard 'psychoanalytic community psychology' as an oxymoron, we aim to demonstrate the possibility of combining psychoanalytic insights with ideals of empowerment and a recognition of the differential nature of power in community intervention.

Colliding worlds: psychology meets primary healthcare

This case study focuses on a healthcare organisation which is situated in a transient shack community in Cape Town. This area has historically received little structural provision to meet basic health needs, including mental health needs. The community was initially constructed under the apartheid regime to be close enough to Cape Town's central business district to provide labour but far enough away for strict geographical boundaries to be created between 'white' and 'black'. Dixon (1997) explores how such a rigid creation of boundaries reinforces identities marked by difference and confirms racist ideology. For him, 'the racial boundary is the geographical emblem of apartheid' (Dixon, 1997, p.24). Most people in the area are Xhosa-speaking and originate from a rural area designated part of an 'independent homeland' for Africans. The organisation is reliant on international donor funding (which at the time was in danger of running out) and the 18 healthcare workers service the needs of about 280 homes in the area. The need is great and all workers regularly work unpaid overtime. All except the co-ordinator live in the area and are often approached by clients after hours. Healthcare workers approached the clinic requesting workshops in psychological skills, which they felt they did not have and increasingly needed in their day-to-day work.

After an initial period of contracting, we agreed to conduct fortnightly workshops aimed at building community workers' psychological understanding of their clients. We positioned the process of learning as one which happens through experience and reflection (Senge, 1990) and in the context of a facilitative relationship (Salzberger-Wittenberg, 1987; Watt, 1994). While we approached the task with the notion of instilling a psychological way of thinking, many workers wanted concrete instructions about what to do. While this was incorporated to some extent, we felt strongly that psychological work could not be approached in a 'cookbook' manner and that part of our aim was to instil self-development and to transfer psychological understanding. We discovered later that the workers had actually hoped we would set up a clinic and deal with the 'difficult' clients ourselves rather than simply facilitate their work in this area. From the outset, then, expectations were different and a middle ground needed to be negotiated.

The content of workshops was planned from week to week. For the first half of the year, we vacillated between what we thought of as process-oriented and content-oriented workshops. We made changes most often in response to our perception of the workers' fluctuating engagement with us: sometimes it appeared that they were eager and responsive while at other times they were rejecting and disconnected. At times they communicated their feeling that we were withholding 'information' and wanted more structure while at others they rejected our information and seemed to want a more experiential form of learning.

After reflecting on this vacillation, we came to interpret the process of disconnection and connection (and the related metaphor we used of 'feeding' and 'spitting out') as a dual process of forming a relationship and a way of working. We felt that the vacillation was not just about structure versus flow, but about a struggle to find a relationship which had a deeper emotional meaning, in the context of broader political and social conditions.

As we continued to work with the organisation, we began to arrive at some understanding of the origins of some of these issues. Since the need in the community was great, the pressure on healthcare workers to provide some kind of caring assistance was considerable. Staff were overworked and provided a broad range of services, including health, those related to mental health, welfare and even those concerned with basic survival needs. It seemed to us that the healthcare workers had responded to their perception of the community's deprivation with a strong desire to fulfil a nurturing, almost parental, role in the community. Their connection to this sense of deprivation was, however, deeply personal: their own lives, both presently and historically, had been touched profoundly by these same issues of poverty and social disruption as those of members of the same community in which they worked. The fact that the organisation was under resourced and the staff overworked served to compound the healthcare workers' awareness of their own deprivation. The emotionally draining nature of their work seemed to result in staff alternating between over-involvement in their clients' lives and needing to distance themselves from the emotional intensity of the demands being made on them. One of the ways in which the healthcare workers struggled to manage the overwhelming feelings generated by their work was to disallow the expression of their own emotional responses. This was maintained through an organisational ethos which discouraged emotional expression and responded to the expression of feelings with shaming and ridicule. Thus, while there are clearly needs within the community for psychological skills, the request for assistance on the part of the healthcare workers also represented a request for emotional support for themselves. In this need for support, however, healthcare workers vacillated between an open expression of their needs in relation to us and a kind of disconnected withdrawal which appeared to be a defence against this.

Language and power issues were also central between facilitators and participants, hardly surprising considering their salience in the broader South African context. Facilitators had the powerful backing of history, holding the privileges of white apartheid South Africa. Because they came from an English academic institution, they held the power of a language which has historically been associated with the formal production of knowledge. Driving into the township from our plush suburban surroundings gave us a sense of crossing worlds, and we always came back feeling hungry – as though in some way we had taken in the sense of deprivation.

Group members, however, had the power to reject or shame facilitators or the workshop process. Perhaps even more powerfully, group members could exercise control through expressions of their ambivalence, positioning facilitators in the less powerful position of trying to guess how to respond appropriately. The multilingual context became a further site of exercising resistance, since participants could actively cut the non-Xhosa-speaking facilitator out by not allowing access to what they were saying. These language issues, however, did not always define the direction in which power operated. For instance, a Xhosa-speaking facilitator was criticised by the Xhosa-speaking group for speaking a different dialect. Conversely, on occasions when differences seemed most marked, real dialogue happened despite these.

The interaction between emotional responses and the operation of power generated a complex process in which we were repeatedly reminded that 'communities' are not homogenous, and consist of people. The simple idea that people can be asked what they want and then empowered to get it misses out a range of human resistances, uncertainties and shifts in power. Instead of resorting to fixed ideas about the way in which an intervention should be undertaken, we found it more helpful to adopt 'a listening position on the boundary between conscious and unconscious meanings' (Halton, 1994, p.12). Our listening within this had to encompass both emotional expression and fluctuations in the dynamics of power. This opened up the possibility of utilising psychodynamic ideas along with a more politically based body of knowledge. The usefulness of drawing from these two sets of knowledge in combination is explored in the following section through a detailed analysis of a single session.

Emotion and politics come together

In our third session together, one participant tried to introduce a case she was dealing with where a father and daughter were apparently having sexual relations, leading to the daughter attempting suicide. The healthcare worker was quickly silenced by the group and seemed later to be singled out for special criticism from her colleagues. In the next session, the same worker spoke again about her difficulties with this case and our workshop plan was derailed as the group became emotionally engaged in discussing the details in what seemed to be a blaming and rejecting way. The discussion centred around who was to blame for this sexual relationship, which was conceptualised as a wilful act on the adolescent daughter's part and never referred to as abuse. The child's mother was blamed for driving the father to seek satisfaction from the daughter because alcoholism made her unavailable to him and because she lazily gave her daughter too much responsibility in the running of the home. The daughter was blamed for being seductive and behaving immorally. Participants were worried about the father, because he was not being taken care of by his wife. No-one blamed the father, in spite of his drinking problems and, surprisingly, no-one appeared worried about the daughter, despite her suicide attempt.

As facilitators, we found ourselves in a moral dilemma about how to respond to values radically different from our own. We thought about introducing input on the effects of sexual abuse designed to encourage the healthcare workers to take up a more empathic and less persecutory stance in relation to victims of abuse. With some thought, however, we decided that this rather impulsive reaction was motivated primarily by a need to contain our own anxieties and express our own judgement in relation to the health workers. We were concerned that this kind of response might in fact close down the possibility of exploring the group's difficult feelings in more detail. Following psychoanalytic understanding, we believed that if we were able to tolerate the feelings long enough to reflect them, and provide sufficient containment, it would be possible to bring about change (Halton, 1994). In the following session, we provided little formal structure, and participants spoke more about the case. Two new pieces of information were introduced into the discussion and prompted the healthcare workers to shift from a blaming position to one which registered shock and distress at the abuse. We were told that the daughter was 14 years old and not 18 as they had originally thought. We were also informed that she had in fact made two suicide attempts. Anger began to be expressed towards the father but the predominant feelings appeared to be hopelessness and sadness. The hopelessness was partly provoked by the lack of available structures and the poor services the few resources offered. The social workers were perceived as unhelpful and the police as corrupt. At the end of the session, we were offered coffee for the first time. We interpreted this as a form of nurturance to soothe our pain and thankfulness that we had been able to tolerate the difficult feelings they had expressed in a caring and non-blaming fashion.

In retrospect, a psychoanalytic understanding of this interaction raises a number of issues. By understanding the healthcare workers' initial reaction as part of a process involving the necessary expression of anxiety, aggression and splitting, we avoided criticising their responses and thus opened space for the exploration of these reactions. An intrapsychic and interpersonal understanding cued us to wonder whether their rejection, and later anger, may in fact have been related to their own experiences of abuse. A local women's organisation estimated in 1994 that in South Africa one woman is raped every 34 seconds. Further, more diffuse forms of sexual and physical abuse are a pervasive feature of township life where women often find themselves at the bottom of the ladder of oppression. These experiences would be compounded by the very high levels of crime and violence in this community and the structural violence of poverty and historical oppression.

On an inter-group level, their blaming was also related to the broader dynamics of shaming and blaming each other. Several interactions involved group members publicly shaming each other or us. It seemed to us that the healthcare workers were communicating their own feelings of shame, which are an inevitable part of oppression (Fanon, 1961). On an organisational level, it is interesting that the group colluded in initially projecting blame onto the mother, particularly since the organisation itself and most of its clients were made up of women, most of them mothers. Their representation of the mother as responsible in this situation seemed a way of managing the reality of the constraints on women's capacity to exercise power in this community. They may have also felt that it was necessary to show us the worst aspects of themselves and their community to see whether we would survive.

Perhaps not surprisingly, the open expression of feelings in this session manifested itself in the following sessions with the emotional withdrawal we had come to expect. We expected them to be overwhelmed by their feelings and thus to retreat to a point of rejection, and this is what happened. The healthcare workers began to express a frustration about the lack of easy answers to questions arising in mental health work. What was most striking, however, was their rejection of us. We were accused of withholding knowledge. They wanted the workshop to end early and we were approached by a few people afterwards and told that they had wanted us to set up a clinic and do mental health work for them. They felt that we were cheating them by not doing this.

The feelings evoked by the experience of the work clearly had begun to enact themselves within the context of the consultation relationship. One of the processes this may illustrate involves what could be termed the political transference. In the face of deprivation and helplessness, we had in phantasy taken on the depriving and withholding features of the parent state which had failed to provide for their nurturance needs and perpetrated gross acts of abuse against the community. Perhaps a psychoanalytic listening to the projection of anger onto an unproviding social-work and police force in the previous session would have helped us to hear their anger towards us as well. Because of the difficulty in accusing or retaliating against the political parent, they responded to us transferentially since the feelings being evoked were reminiscent of continuing and formative experiences of abuse in their communal experience, much like individual continuing and formative experiences are repeated in individual therapy (cf. Stolorow, Brandchaft & Atwood, 1987).

The notion of the 'political transference' must also incorporate recognition of reality as well as phantasy. While we may have become withholding because of the projection of feelings of powerlessness and abuse, there was also a strong reality component in that their current community needs were not being adequately met. Anger directed at us may therefore have been projective anger as well as realistic anger which found few channels for expression elsewhere. In this example it is possible to see the way in which the psychodynamic metaphor of 'spitting out' may, in an addition to its intrapsychic defensive function, also represent an enactment of power, demonstrating a resistance to our authority. This kind of understanding enables us to recognise the interaction of emotional, social and political issues on a number of levels to avoid reducing complex issues through either a purely psychodynamic or a purely political approach.

Growing pains: implications for psychoanalytic community psychology in South Africa

The approach advocated in this paper discourages a non-critical application of psychodynamic concepts in a community intervention. Given that this area is new in South Africa, it is imperative that we engage in a continual process of self-reflection in order to extend the utility of our work. We need to recognise the practical, social and emotional complexities of a multicultural community setting and the implications for its interaction with psychoanalytic theory, which is itself complex and often experience-distant (Stolorow et al., 1987). Reflecting on the process of this intervention and on what we struggled to and needed to recognise, I draw some implications which may aid self-reflection in future psychoanalytic community work.

Recognition of power relations

Issues of power and difference which were salient throughout the intervention have been continuously alluded to. Active exploration and reflection of such issues is advocated, since they cannot simply be wished away. It is also suggested that a unidirectional understanding of power fails to consider that, as Foucault (eg., 1975) argues, power is differentially held and all players have access to powerful practices. A diffuse understanding of power helps practitioners to recognise participants' assertions of power. Further, such recognition may offer a place in which the emotions attached to such issues can be worked through in new ways. For example, a participant physically kicked one of the facilitators in the second-last session. A traditional psychodynamic understanding would draw on processes of aggression and rejection as part of the work of the termination phase. Another layer, however, may have involved an acting out of a reversal of power relations: the township was kicking out the educated outsiders before they had a chance to kick out the township. If such a possibility can be explored and rendered visible, spaces within the matrix of power may be widened for acts of resistance against coercive power.

Since psychoanalysis is itself a powerful discourse, it is equally important to recognise that the language of psychoanalysis may provide yet another point of division and potential enactments of power between facilitators and participants. Psychoanalysis has often been criticized as 'elitist, irrelevant and oppressive' (Maw, 1996, p.80) and can easily be misused to construct the participant's understanding as subjective and the analyst's as fact (Schwaber, 1983), thereby imbuing the analyst with the power of knowing all. For example, the notion of resistance, which Klein (1927 in Hinshelwood, 1989) refers to as the avoidance of a relationship for transferential reasons, may be misused to label appropriately rejecting actions. At one point in our intervention, we provided a handout which was thrown away by most participants. While this may have had something to do with an avoidance of relationship with us (in line with our 'spitting out' metaphor), such an interpretation positions us as powerful holders of 'the real reason' and could easily have prevented further reflection. A more likely explanation was that the handout was in English and the metaphorical meaning of the act may have had more to do with a legitimate rejection of the power of English as a transmitter of knowledge.

Recognition of the complexities of the transference relationship

A broadening of the concept of 'transference' is needed in order to incorporate the influence of the punitive parent state in the emotional lives of people. When, for example, workshop participants talk about the importance of 'really being listened to' for the first time, this concept allows the recognition of personal as well as political experiences of being silenced. Such understandings may prevent a psychoanalytic intervention from failure to interact with the realm of the political and from blindness to the need for social action.

Further, those community psychologists need to reflect constantly on what is traditionally called their countertransference reactions, and to bear in mind that they are not exempt from relations and responses to the punitive parent state. It is thus important to think about what motivates us to do community work and what our emotional reactions are to being (often privileged) members of post-apartheid South Africa's 'family'. In one workshop, for example, the white facilitator wrote in newsprint sitting on the floor, when in any other situation she would have done so standing up. This apparent attempt to minimise her power and authority in the workshop may be linked to feelings of guilt and a need to make reparation.

A further dimension of the countertransference involves the view that it provides a source of information about how the client is feeling. These feelings, however, originate in the context of a political history whose impact is constant on intrapsychic life.

Recognition of power in language

The multilingual setting is an important part of almost every community intervention in South Africa. Recognition of, and dialogue with, the differences created by this are central. The multilingual context in this intervention, as is common in this sort of work, was mediated by interpreters who take up a role as arbiters of power. Facilitators initially viewed the interpreters' function in a neutral technical light, paying little attention to interpretation as an interpersonal process (Drennan, Levett & Swartz, 1991). We soon realised, however, that the interpreters were not outside the transference relationship. They helped to shift and influence the power dynamics through joining with the participants, aligning themselves to the power of the psychologists or claiming their own power above both these groups. For example, at times, interpreters joined participants in using language as a means of exclusion by neglecting to translate into English. At others, in line with Drennan et al.'s (1991) assertion that interpreters may claim specialist knowledge about the 'true world' of the Xhosa speaker, they added to or adjusted what the English-speaking facilitator said to make it more 'true'. Further, interpreters found it difficult to be neutral non-participants and frequently used the space to make their own voices heard.

Recognition of the need to refine theory and practice

An important question regarding future psychoanalytic work in community settings involves asking what exactly psychoanalysis is. A relational approach has been drawn upon here and would benefit from further theoretical refinement in line with the needs of community psychology. Psychoanalysis is a heterogeneous theoretical discipline with different and sometimes contradictory understandings. It would be of benefit to strive towards refining theoretical understanding by exploring the way in which the more progressive developments in psychoanalysis might be used systematically to their fullest extent to explore political meanings (Rustin, 1991; Richards, 1989).

A second question regards implications for intervention. The preceding discussion included an illustration of politico-psychodynamic understanding. More exploration would, however, be useful regarding the translation of this understanding into techniques of intervention. Psychoanalytic literature itself is not in agreement on what constitutes appropriate intervention, particularly regarding whether change happens through interpretation or through experience of relationship (Stolorow et al., 1987). In this intervention, change was understood as occurring primarily through the containment provided by the relationship. We were reluctant to utilise explicit interpretations of our psychoanalytic understandings in this intervention, although in retrospect it may be that interpretation would have been possible and that we were prevented from using it by our own anxieties about the exercise of power. These issues need further exploration.

Can psychoanalysis meet empowerment?

While the differences between psychoanalytic literature and theoretical ideas in community psychology appear marked, there are in fact more areas of overlap than may initially be recognised. It is suggested that insights obtained from a psychoanalytic understanding, which gives salience to the emotional worlds of participants, can be subjectively empowering and that, further, an integrated political understanding can also go some way towards empowerment at a social level. Our purpose was to empower participants to deal with their own emotional worlds, individually and in response to their clients. It is also suggested, however, that a self-reflexive and politically aware psychoanalytic practice in community settings also opens possibilities for adding complexity to existing empowerment theory. A de-emphasis from ideologies of self-determination and agency undermines simple calls for people to empower themselves. This opens opportunity for recognition and dialogue with possible intrapsychic and discursive constraints to empowerment. Such recognition allows for more complex understanding and possible negotiation on personal, social and political levels.

Conclusion

Crossing the divide between the epistemological paradigms that have traditionally separated community psychology from psychoanalysis raises questions of both a political and a psychoanalytic nature. It has been suggested that a binocular focus on the interaction between conscious and unconscious levels, on the one hand, and the dialectic between personal and political meanings, on the other, proved useful in the integration of these various concerns into a framework that might adequately respond to the needs of community work. Examples presented from our case study, designed to provide a flavour of the complexities of such a focus, led us to arguing that a psychodynamic approach which explicitly recognises socio-political influences and articulates these with an understanding of intrapsychic, relationship, organisational and community dynamics, as well as a process of self-reflexivity, can provide this type of framework for community work.

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