2

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

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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

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.

References

Alexandrov, H. (n.d.). A group relations conference in the context of social transition. Human Relations, Authority and Justice. [On-line]. Retrieved 28 March, 1999 from the World Wide Web: http://www.human-nature.com/hraj/hara.html.

Cock, J., & Nathan, L. (1989). *War and society: The militarisation of South Africa.* Cape Town: David Philip.

Casement, P. (1985). *On learning from the patient.* London: Tavistock.

Figley, C. (1985). From victim to survivor: Social responsibility in the wake of catastrophe. In C. Figley (Ed.), *Trauma and its wake: The study and treatment of post-traumatic stress disorder* (pp.398–416). New York: Bruner Mazel.

Gibson, K. (1990). Organised violence and its clinical effects. Keynote paper presented on behalf of the Organisation for Appropriate Social Services to the International Conference on Organised Violence in Southern Africa, 4 to 8 September, 1990, Harare.

Gibson, K. (2000). The emotional experience of working with troubled children: A psychodynamic approach to organisational consultation. In D. Donald, A. Dawes, & J. Louw, (Eds.), *Addressing childhood adversity* (pp.225–243). Cape Town: David Philip.

Gibson, K., Sandenbergh, R., & Swartz, L. (2001). Becoming a community clinical psychologist: Integration of community and clinical practices in psychologists. *South African Journal of Psychology,* 31, 29–35.

Gibson, K., & Swartz, L. (2000). Politics and emotion: Working with disadvantaged children in South Africa. *Psychodynamic Counselling,* 6, 133–153.

Gray, A. (1994). *An introduction to the therapeutic frame.* London: Routledge.

Hamber, B. (2000). Have no doubt it is fear in the land. An exploration of the continuing cycles of violence in South Africa. *Southern African Journal of Child and Adolescent Mental health, 12*, 5–18.

Kleintjes, S., & Swartz, L. (1996). Black clinical psychology trainees at a 'white' South African university: Issues for clinical supervision. *The Clinical Supervisor, 14*, 87–109.

Marks, S., & Andersson, N. (1990). The epidemiology and culture of violence. In N.C. Manganyi, & A. du Toit (Eds.), *Political violence and the struggle in South Africa* (pp.29–69). Hampshire and London: Macmillan.

Manganyi, N.C. (1991). *Treachery and innocence: Psychology and racial difference in South Africa.* Johannesburg: Ravan Press.

Mokutu, M. (1998). *Black clinical psychologists in the Western Cape: Their perspectives on their work.* Unpublished master's thesis, University of Cape Town.

Nuttall, S., & Coetzee, C. (Eds.) (1998). *Negotiating the past: The making of memory in South Africa.* Cape Town: Oxford University Press.

Orford, J. (1992). *Community psychology: Theory and practice.* Chichester: John Wiley & Sons.

Parekh, A., McKay, A., & Petersen, I. (1997). Non-governmental organisations. In D. Foster, Y. Pillay & M. Freeman (Eds.), *Mental health policy issues for South Africa* (pp.32–54). Cape Town: MASA.

Straker, G., & the Sanctuaries Team (1987). The continuous traumatic stress syndrome. *Psychology in Society, 8*, 48–78.

Summerfield, D. (2000). Childhood, war, refugeedom and 'trauma': Three core questions for mental health professionals. *Transcultural Psychiatry, 37*, 417–433.

Swartz, S., Dowdall, T., & Swartz, L. (1986). Clinical psychology and the 1985 crisis in Cape Town. *Psychology in Society, 5*, 131–138.

Swartz, L., Gibson, K., & Swartz, S. (1990). State violence in South Africa and the development of a progressive psychology. In N.C. Manganyi & A. du Toit, (Eds.), *Political violence and the struggle in South Africa* (pp.234–264). Hampshire and London: Macmillan.

Young, A. (1995). *The harmony of illusions: Inventing post-traumatic stress disorder.* Princeton: Princeton University Press.