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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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