Briefing

Clinical Psychology and the 1985 Crisis in Cape Town

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Crises tend to bring into relief both the strengths and weaknesses of a system. They are also potential catalysts for change. In this report we discuss the effects that the 1985 State of Emergency in South Africa has had on clinical psychology as practised and taught in Cape Town, and specifically at the Child Guidance Clinic of the University of Cape Town. We also consider some of the implications of our experiences for the development of relevant training and practice in the South African context.

Some introductory comments on training and practice in clinical psychology at UCT and in the Cape Town area will be useful to contextualise developments. The important issues are to a certain extent generalisable to training and practice in the rest of the country. Professional training takes place at a post-honours level, and is concentrated into a two-year period, with a year of broad-spectrum teaching and training at the Child Guidance Clinic, a year of internship in the Valkenberg/Groote Schuur Hospital context, and a thesis requirement.

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Training at the Child Guidance Clinic falls within the general ambit of British/American models, consisting of courses in psychiatrically oriented assessment, psychometric assessment and basic training in psychodynamic psychotherapy, family, behaviour and group therapy. Students apply all of these approaches in the course of their training, but the predominant model, reflecting the orientation of the majority of Cape Town therapists, is psychodynamic and tends towards developing therapists who will primarily work on a one-to-one long-term psychodynamic basis, generally with relatively affluent middle-class patients. Inevitably, work in a child guidance clinic requires students to work with a broader spectrum of clients, using a spectrum of behavioural or family therapy techniques on a short to medium term basis; but the overall approach is reactive and individual/family based, and the hospital internship tends to reinforce the one-to-one psychodynamic approach.

Community-oriented work has not been wholly absent from Clinic training. For several years Clinic staff and students ran behaviourally-oriented parent training groups through the UCT Centre for Extra Mural Studies, and Clinic students are given some practice in giving public lectures in the community. The Child Guidance Clinic also provides facilities for community service organisations such as Rape Crisis, in which many of our trainees have been active. However, this kind of work has been relatively marginal to the main thrust, which involves psychiatrically-oriented differential diagnosis and one-to-one psychodynamic work.

There are substantial strengths in a formal course of this nature, in that our trainees are readily conversant with the concepts and developments in mainstream "western" clinical psychology, and are able to draw on these resources. However, for some time it has been clear to us that there are

also substantial limitations, arising in the delivery of appropriate services to great numbers of South Africans living in third world conditions. The state of emergency brought about conditions that caused us to focus on the needs of this section of our client population and accelerated the process of attempting to address those needs, initially in the service which we were providing, and then necessarily in the structure of our training programmes.

Although stress was felt in the entire population during the state of emergency, black communities suffered very severely. Black residential areas were virtually occupied by security forces, and individuals, including children, were vulnerable to arbitrary arrest, detention, assault, injury and even torture or death. The education system was severely disrupted, and movement on the streets was frequently hazardous. Detention, injury and deaths in the community led to a range of crisis reactions, and many families were split by conflict over these events. It is also true, of course, that many individuals and families were strengthened by the development of unprecedented solidarity in their communities, but these people do not tend to come to the notice of clinical psychologists, for obvious reasons.

The State of Emergency led to a re-examination of attitudes in many sectors of the UCT community, and became a time of crisis for the Clinic's staff and students. There were personal and professional reasons for this. On a personal level, increasing involvement in the crisis took its toll on the ability of both staff and students to give their work undivided attention. A sense of being distanced from regular work routines added to an increasing awareness of the lack of fit between the role traditionally taken up by clinical psychologists in South Africa and the immediate needs of the community the Clinic is intended to serve. The crisis in Cape Town also highlighted

a number of professional problems. It became clear that the traditionally-adopted "neutral" stance of the clinical psychologist was becoming difficult to maintain, for two reasons: firstly, clients frequently wished to discuss political activities and viewpoints in therapy, often in the context of asking for support during a time of considerable stress; and secondly clinicians were feeling increasingly the need to make a public stand on political issues, either as individuals, or as a group. Further, many clients found themselves unable to keep appointments because of the situation; school work was extensively disrupted and this affected a substantial proportion of the Clinic's interventions; and a widening rift in the opinions of parents and their children made family-based interventions more and more complex.

Initial meetings between staff and students at the Clinic established the outlines of the problems and proved to be an important means of ventilating anxieties and channelling efforts towards coping efficiently with the new demands being experienced. Soon after this it was established that clinical psychologists in private practice were undergoing similar difficulties, and a number of them were drawn into a loose group of clinical psychologists and trainees who decided to meet regularly in an attempt to address the issues that were being raised.

The meetings held at the Clinic during this time debated the following major topics: the role of the clinical psychologist in South Africa especially with respect to the current political and economic situation; the need for a revision of the training of clinical psychologists so that their skills would be better suited to particular conditions in South Africa; the effects of the crisis on particular clinical interventions, including individual psychotherapy and family therapy; and specific ethical problems arising from

clinical interventions at times of political upheaval. The larger group was divided into smaller working groups to explore these issues further.

A second purpose for the meetings was found as the number of interventions related directly to the "unrest" increased. Clinic staff and students, as well as clinical psychologists in private practice began to see individuals and families who had been affected. These included people who had been detained, families involved in violent confrontations with the army or police and families more indirectly affected who were feeling unsettled and badly stressed by the degree of upheaval within their immediate surroundings. Regular meetings at the Clinic then became an appropriate setting in which to discuss both the pattern of problems emerging in our interventions, and possible responses to them. It also became clear that clinicians needed to talk regularly, and in a supportive context, about their own anxieties and confusions in dealing with unrest interventions, and the Clinic's meetings provided that context.

The pattern of problems emerging from these interventions fell largely into three groups:

1. unmanageable levels of anxiety or depression as a result of prolonged exposure to stressful situations;
2. post-traumatic stress disorders, including memory impairment, poor concentration, survivor guilt, sleep disturbance, flashbacks, recurrent intrusive dreams of a traumatic event, and detachment or numbness following a stressor such as a period in detention, or a violent confrontation with physical injury; and
3. an exacerbation of problems existing prior to the crisis - for example, chronic marital conflict, alcohol abuse, psychotic breakdown, prolonged depression intensified in some cases as a result of exposure to stress.

It was also found that severe economic hardship, lack of support within families or from friends and organizations, and isolation increased people's vulnerability to stress.

Documentation on children's responses to the unrest also began at this time. Some of their problems were very similar to those of adults and adolescents; others, like enuresis, were specific to younger age-groups. Children seemed to cope with stress partly through playing out traumatic scenarios in games. Those with absent or very anxious parents, or with family members physically injured by confrontations with armed forces or in detention seemed more vulnerable to acute stress reactions.

Interventions with individuals and families was only one part of the evolving series of interventions which were moving increasingly towards meeting with and counselling groups rather than individuals. It is both efficient and therapeutically useful to run groups for people whose predicament has a common denominator because of the support group members are then able to offer to one another. Clinic staff and students have been involved in a number of groups for children with parents in detention, parents with children facing charges of public violence, for the children facing those charges, and for ex-detainees.

Another aspect of the response to the crisis has been the involvement of the Clinic and other clinical psychologists in workshops designed to assist community workers, counsellors, teachers, and clergy in crisis intervention work. The role of clinical psychologists in this type of work is partly didactic and partly to provide back-up clinical support for front-line workers.

Developing parallel to the increase of these interventions was the degree of organization in the group making the interventions. After a

series of meetings it was decided to affiliate to the Organization for Appropriate Social Services in South Africa (OASSSA), a Transvaal-based organization comprising progressive psychologists, psychiatrists, social workers and other individuals interested in relevant social and health services. The Cape Town group has thus become a formally constituted organization with OASSSA's constitution. Informal connections exist with other organizations such as NAMDA and the Detention Treatment Team. The group has also been expanded to include social workers and psychiatric registrars, and it is hoped that further diversification of interests and qualifications will take place as membership increases.

Although clearly there will be further calls on social services to do the kind of crisis intervention work described here, this is perhaps an important juncture at which to plan beyond times of crisis, to restructure training programmes and to reconsider the role of clinical psychology in relation to South Africa's emerging needs. The experience of the past year has highlighted the value of workshops as a forum for debate and dissemination of skills, and as a source of support and affirmation for teachers, counsellors, nurses, clergy and community workers of all kinds.

For years to come South Africa is going to be in a situation in which there are too few psychologists to meet the community's needs, and workshops will go some way towards alleviating the consequences of that shortage. Front-line workers will evolve appropriate means of dealing with common problems within the community; attention will be drawn to more serious problems where gaps in facilities exist; and hopefully clinical psychologists, working closely with community workers, will become more responsive to their immediate needs.

This has important implications for training. During the coming year,

the Clinic's trainees will have a regular commitment to attend and participate in workshops, to become familiar with principles on which to plan, run and evaluate workshops, and with the process of community consultation. There will be a parallel shift in the orientation of clinical intervention towards group work and away from the traditional model in which intervention with individuals has a central role.

Part of the challenge we face - and this is a challenge for our profession as a whole - is to develop a mode of practice truly appropriate to our environment. This means more than being reactive to circumstances of crisis, and requires us to reassess our training and practice at every level. We believe that we have made some progress on the issue, but also recognize the necessity for continuing change and development. A rigorous and robust approach to theory is also required. Without some knowledge of the South African political economy, for example, clinical psychologists cannot hope to have an adequately contextualized understanding of the organizations, families and individuals with whom they consult. The isolation of clinical psychology as an academic discipline needs to be countered in tandem with the growing involvement of the profession in community issues. Of necessity, we have to make ourselves more open to input and criticisms from non-psychologists and non-professionals. We shall need, in effect, to give up some of our formally-constituted power so that we can be effective in a broader sense than we have been in the past.