Towards a model for a South African clinical psychology

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Apartheid and mental ill-health are inextricably linked in South Africa (Vogelman, 1986). A radical transformation at the structural level remains a prerequisite for appropriate change. In this context neutrality by psychologists is a myth and the choosing of sides an inherent necessity (Dawes, (1985). The clinical psychologist who acknowledges this need and does so is faced with a difficult problematic. How, in attempting to resolve the broad structural issues of societally produced mental ill-health and make him/herself relevant to this task, does the psychologist use his or her skill as a psychologist ? In other words, how do we resolve the tension between the clinical psychologist dealing with the individual or system clinically and the need to address the issues of the community or society. Two issues arise:

1. Are clinical skills useless in embarking on a "community psychology" path - how do we make ourselves clinically relevant to the community we serve ?
2. Can any activist not do the task of the "community psychologist" with equal efficiency ?

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Prior to tackling these fundamental issues which will begin to provide us with a conceptual model for attacking the problematic, an important myth needs to be dealt with. Many psychologists in attempting to deal with the problems outlined above and make themselves relevant, have opted for a community psychology approach, one which is posited to begin to broach the tension between individual and community.

This approach looks beyond the individual and attempts to treat the system instead by empowering communities or sections of it to change their circumstances. The primary area of focus is in the broader community. According to Heller and Monahan (1977) community psychologists are interested in the health and well-being of all members of a community.

> "The work of community psychologists is focussed on improving community life for all citizens, preventing disorder, and in promoting psychological well-being in the population. Unlike most clinical psychologists, community psychologists do not restrict the scope of their concern to those with established disorders" (pp. 4-5).

Amongst the roles defined by Heller et al for the community psychologist is helping citizens organise to more effectively accomplish their goals by being interested in improving the health and well-being of community members through research and action oriented toward producing significant social change.

In a paper by Lazarus (1986) dealing with community psychology in South Africa, the prime focus of community psychologists in South Africa revolved around interracial tensions, education system, resources, social class inequalities, public policy (such as Apartheid structures) and the preparation for a future South African society. The

empowerment and social action perspective were considered the basis of community psychology interventions in South Africa.

Rappaport (1980) argues in his model of empowerment that "we will need to be more a social movement than a profession..." (p. 1), and work towards the social empowerment of individuals through our work. Shinn (1985) has argued that community psychologists should focus on efforts at collective empowerment in a broad array of settings.

In all these approaches, the community psychologist takes on the cloak of social activism and begins to disrobe the clinical persona of professional skill. It may be contended, however, that there is a conflation of issues in applying this model to the South African context which needs to be disentangled prior to being able to formulate a coherent exposition of the latter.

In the first instance, the notion of a separate branch of community psychology within the framework of applied psychology needs to be challenged. Clinical psychology evolved as a branch of psychology operating within the mainstream of applied psychology in the USA and became oriented to serving the needs of the "community" as opposed to the individual. According to Rappaport (1977) community psychologists have come to recognise that the paradigms of individual psychology fail as a basis for community change.

In attempting to serve the "community", community psychology implicitly assumes that mainstream psychology does not serve the community. At its crudest level, the community which community psychology aims to serve and empower becomes defined as the working class community, poor community, "needing of intervention" community, or needing of empowerment community. In short, psychology is assumed to serve the individual - with community psychology constructed

as a separate branch within the field to serve the "community". This may be construed as an ideological myth.

According to Dawes (1986) the development of community psychology in the United States carries with it a similar humanistic imperative that is largely uncritical in any radical sense of the structural determinants of many of the problems which it attempts to address. It may be seen, he argues, as an "exemplar of relevant practice within a liberal humanist framework" (p. 32) that gives rise to political pressuring and calls for a "better deal" for disadvantaged sections of the citizenry, doing so within an unchanged liberal capitalist framework.

This humanistic effort employs a false inference for its foundation. That myth is that mainstream psychology does not serve a community. According to Hayes (1986) there is nothing wrong with therapy and the various therapeutic approaches. Therapy has specific origins, arising out of the dynamic crises facing bourgeois society. Therapy (and clinical psychology as a whole) is not according to Hayes (1986) a transhistorical problem for humanity, but rather a specific historical practice related to identifiable social problems. Psychology evolved to meet the needs and problems of bourgeois society.

Clinical psychology as it stands, has been broadly constructed within the parameters of white, western, middle class values and infused with the ideology of this backdrop. If we accept that middle class western society, of which white South Africans generally form part, is individualist, competitive, isolated and non-social in character, then a helping science such as clinical psychology constructed to serve the "composits" of this system, is in effect serving a community that contains these elements. Mainstream psychology, treating middle class problems of the individual or family unit, is nevertheless serving a community - the

white middle class community.

> "So when I say that there is nothing wrong with therapy, in some senses I am saying that bourgeois therapy for bourgeois individuals is okay ! We might not like it, but it certainly has a class consistency to it" (Hayes, 1986: 2).

Community psychology, however, is constructed to serve the needs of some other community, a community construed as needing of rescue and empowerment. Working class problems are conceptualised as social problems which are unamenable to therapy and this conceiving of working class psychological problems as social ones operates at a subtle and complex level which arises from the "contradiction of bourgeois ideology" (Hayes, 1986).

It seems possible, therefore, to understand mainstream psychology as a community psychology oriented to the needs of a particular community. To create a division within this mainstream from the framework of a middle class liberal humanistic discipline aimed at addressing the needs of a working class community is, therefore, an ideologically loaded venture which obscures the fact that psychology as a whole serves the community (albeit a western middle class one).

We have to therefore move beyond a narrow definition of community and begin to consider the application and reorientation of clinical psychology with the skill it offers, beyond a limited framework of application towards a broader, more relevant one. Mainstream psychology **as a whole** needs to become more relevant to the oppressed community - towards becoming relevant to the community as a whole.

At the bottom of this argument lies the notion that

attempting to construct a socially progressive psychology from the framework of a socially reactive psychology is inherently problematic. It is not so much the clinical skill that needs redirection - it is rather the ideological foundation that instructs to whom, and how these skills are applied that requires attention.

The conflation of social activism and psychological practice which this approach tends to evoke, is an unstable construction which negates the very foundation of applied clinical skill and makes psychology no more relevant to a community that has psychopathology and psychological stress and requires intervention at this professional level. In effect, it perpetuates the myth that working class people do not have psychopathological problems and turns working class individuals' psychological problems into social ones (Hayes, 1986). It implies that oppressed or working class people do not require skilled intervention to deal with their problems.

Against the backdrop of the above issues let us briefly return to two initial questions :

1) Are clinical skills useless in embarking on a "community psychology" path ?

2) Can any activist not do the task of the "community psychologist" with equal efficiency ?

Let us deal with the first part of this question and dispose of it in order to attempt to answer the second one which lies at the heart of a reconceptualisation of clinical psychological practice as it may become relevant to the oppressed South African community.

1) According to Berger and Lazarus (1987) the heightened level of political conflict in this country has highlighted

the dilemmas of the practicing professional, and "thrown many psychologists into a state of insecurity, confusion and self-doubt" (p. 6) regarding their relevance and role in South Africa. Their training perpetuates an elitist professional ethic based on uncritical, decontextualised and imported "non-African" psychology, that "psychologises" the causes and cures of human functioning and neglects political, cultural and ideological factors as well as structural conditions.

Swartz, Dowdall and Swartz (1986) argue that training (in Cape Town) falls within the general ambit of British/ American models with the overall approach reflecting a reactive, individual/ family based, one-to-one psychodynamic approach with those trained generally ending up working with affluent middle-class patients.

Does this make psychological training incorrect and clinical practice irrelevant ?

Swartz et al., (1986) go on to argue that there are substantial strengths in a formal course outlined above, in that trainees become readily conversant with the concepts and developments (and clinical skills) of mainstream "western" clinical psychology and are able to draw on these resources.

In their work in dealing with "unrest interventions" at a clinic in Cape Town, they found the pattern of problems emerging from these interventions falling into three groups: unmanagable levels of anxiety or depression as a result of prolonged exposure to stressful situations; Post traumatic stress disorders with its consequent array of symptoms; and an exacerbation of problems existing prior to the crisis (for example chronic marital conflict, alcohol abuse, psychotic breakdown, and prolonged depression intensified in some cases as a result of exposure to stress). An examination of the

presentation of these problems highlights their "non-social" nature and the necessity of providing appropriate clinical skill in intervention. Such intervention cannot ignore the clinical expertise that may be required for this purpose.

Dohrenwend (1975) argues that they know enough now to realise that some of their more extreme speculations about the influence of socio-cultural factors are not supported in fact. He cites the example of the once popular hypothesis that psychopathology is simply different in cultures other than their own. That western nomenclatures are inapplicable is contradicted by actual psychiatric research in those cultures. Whilst environmental factors in communities may increase the severity and intensity of psychopathology, the treating of psychiatric disorders remains a necessary clinical task in the community.

It thus becomes clear, that rendering working class community psychopathological, emotional and psychological problems to the dungheap of "community intervention" (i.e. socialising the treatment of these problems) is a reductionism of necessary symptomatic treatment to partly responsible structural causes. Treating individual white middle class patients with these disorders would not pose a clinical identity crisis in progressive therapists. Why then should it do so with black working class patients ?

A number of issues arise in the application of clinical skill to working class communities and the transformation of psychology towards becoming more relevant to the broader South African community:

It bears repeating, that the structural inequality visible throughout the provision and maintenance of mental health resources for the black (i.e. african, coloured and indian) community needs fundamental restructuring and redistribution (De Beer, 1986; Floyd, 1986; Vogelman, 1986). The structural

transformation of Apartheid remains a prerequisite for such a modification which in turn depends on the broader socio-political and economic struggle being waged in the country and psychologists may participate in this struggle as activists. In doing so, they may not be doing so under the umbrella of their profession.

Whilst psychologists (**as** psychologists) can have a role in pressurising the state to symptomatically part remedy the situation by providing better services, this remains a peripheral, though important part of the clinical psychologists function. Organisational participation in bodies such as OASSSA, or pressurisation from other professional bodies may go some way towards this task. But what of clinical skill and psychopathology ?

Berger and Lazarus (1987) in their study of the views of community organisers on the relevance of psychological practice in South Africa, found that such dimensions as political consciousness, attachment to a trusted organisation, collective use of resources, counteracting public wariness of psychological services, dissemination of skills, establishment of trust, credibility and accountability, and alignment with, and support of other progressive organisations within the democratic movement were considered necessary components of a relevant psychological practice.

Nowhere is the application of trained clinical skill negated. Nowhere is the psychologist expected to throw off the tools of expertise that the psychologist of necessity is equipped with.

> "Involvement in the struggle for a new social order does NOT preclude the need to address people's more immediate problems" (Berger and Lazarus, 1987: 20).

Hayes (1986), despite being critical of the ideological content of therapeutic practice, does not intend, he argues, to "damn all therapies on this account" (p. 46). Rather, we need to work toward affecting their possible transformation in making them more relevant.

Turton (1986) in explaining the failure of a community project in an african community (based on Rogerian type counselling) argues that of the many factors which contributed to its failure, the organisation's attempt to apply its counselling to african working class clients in an unmodified form was of most interest. The skills per se are not negated. Rather, elements of modification and transformation to them need to be affected. In this regard Straker (1987) has outlined a treatment programme designed to be of use in the current climate of crisis and involves the compression of intervention strategy into a single therapeutic interview. It also involves the reconceptualisation of Post Traumatic Stress Disorder (PTSD)(APA, 1980) into The Continuous Traumatic Stress Syndrome. As Straker argues:

> "The term post-traumatic stress syndrome is a misnomer in the South African context. Individuals living in South Africa's black townships are subjected to continuous traumatic stress" (p. 48)(emphasis in original).

In both this modification of PTSD, and the transformation of the therapeutic process into one that is conducted over a single interview, where transference is not necessarily encouraged and where clinical skill is directed towards meeting the direct needs of those affected, does not involve at any point the negation of skilled intervention and therapeutic practice. It simply highlights the need to transform our clinical skill towards a more relevant practice in line with the political, cultural and socio-economic context in South Africa.

Swartz and Swartz (1986) in reviewing their intervention in workshops for pre-school teachers in Cape Town, found that their expertise was both demanded by the community members they were working with, and necessary in the context of having access to skill that others did not have. They argue that their experience suggests that we cannot simply slough off our expert role in a social hierarchy. Whilst needing to be aware of the problems generated by psychologists "expert" role, we also need to recognise its salience for an appropriate intervention.

Part of this process involves what has been described as the democratisation of knowledge and service (ESG, 1986). Rather than impose models and therapeutic practice onto the community, knowledge needs to be shared and democratised, "a process which tends towards an amalgamation of skills and ideas rather than a one-way "giving"" (ESG, 1986: 2). The failure of the community project outlined above which attempted to enforce a Rogerian model where this was inappropriate without dialoguing with the needs and context of those who it was designed to serve, highlights this point (Turton, 1986).

As described earlier, our therapeutic skills, whilst not useless or irrelevant, need to be modified and transformed to make them more accessible to the broader community. It is necessary in this process to be educated by the political and socio-economic dynamics of the society in which we operate. AS Swartz, Dowdall and Swartz (1986) argue:

> "Without some knowledge of the South African political economy, for example, clinical psychologists cannot hope to have an adequately contextualised understanding of the organisations, families and individuals with whom they consult" (p. 138).

It involves, as Hayes (1986) describes, the opening up of ourselves to the experiences and knowledge which working class people can give.

An additional component of this process involves a reconceptualisation of the myth of individual intervention reinforcing a "bourgeois" therapeutic practice. Many community psychologists, such as Rappaport (1977), have argued for the necessity of dealing with groups of people in the community rather than with individuals.

This argument involves, in part, a naive reductionism. It does so because it conflates the concepts of individualism versus working with individuals (Hayes, 1986). According to Dawes (1986), psychological professionals have utilised theories of personal psychological functioning which reflects an individualistic conceptualisation of the person. Dawes does not, however, reject the provision of individual assistance. What he suggests is a change from a view of the person's problem which emphasises the notion of the individual "locked into a psychic dilemma, to a person whose dilemma is understood in the context within which it occurs" (p. 34).

It is unnecessary to pursue the notion of group intervention being the alternative to individualist practice. Group therapy is relevant where people coming together have a common denominator that informs their psychological problem (for example, released detainees, or rape victims). However, the individual may often remain the primary focus of clinical intervention, taking into account the interactive context operating including the community and society. Contextualising the individual problem in which it occurs, remains therapeutically relevant.

Radford and Rigby (1986) argue that any attempt to make psychology relevant without taking into account the societal

context in which mental health occurs, "would be both dangerous and foolhardy" (p. 14). One way of accomplishing this task is to utilise the conceptual base of Systems Theory for examining the relationship between the community and mental health.

This enables an examination that goes beyond the one-way causality of the traditional model of positivist science "to include the mutual interaction of elements in an organised whole" (Radford and Rigby, 1986: 6).

Radford and Rigby (1986) use systems theory as the conceptual base for a relevant South African psychology because, they argue, it holds out the possibility of dealing with the interaction of a complex of elements, it enables an understanding that shifts the focus of psychological analysis from only that of the individual to include also the context in which the individual functions and finally because it provides an holistic view of the individual.

One conceptual system that seems to begin to provide such a basis of understanding, is Ecosystemic Therapy. It is founded on the principles of human ecology and systems theory and is a multi-level treatment perspective focused on the context of interaction among individuals and their environment (Stachowiak and Briggs, 1984).

This context is composed of a series of interlocking system levels. Physiological and intrapsychic processes interact with dyadic and family dynamics all within a network of social relationships, role responsibilities and community-cultural (general environment) influences. The person-environment context is taken to constitute the totality of relationships among individuals and their environment (Stachowiak and Briggs, 1984).

Whilst the application of therapeutic intervention may still

be at individual level, the conceptualisation of the individual takes on an ecological perspective, overcoming the problem of individualism whilst not necessarily socialising all pathology or psychological needs of working class people. It allows for appropriate clinical intervention with individuals without becoming entrapped in an individualist construction that remains outside of the broader South African reality.

From the matrix of systemic interactions, relevant elements are selected from each level that allows for an appropriate and effective intervention specific to the case concerned. Environmental forces as they effect the individual, for example, can be modified through intervention at any other level given the interactive nature of the systems involved. Central to this, therefore, is the notion that intervention at a specific system or systems will depend not on a prescribed pattern, but on its relevance to the problem situation. Even when treating the individual, the conceptualisation of the problem may remain operative at the ecosystemic level.

This distinction, finally, frees us from the myth of clinical practice being irrelevant and leaves clinical skill a necessary and important function of psychologists where this practice is informed by the context, and such notions as democratisation and choosing sides. Psychological skills remain useful in the South African context and clinically relevant in serving the broader community.

2) Rephrased, if community psychologists play a role of conscientisation, mobilisation or empowerment (for example, Shinn, 1985), then why can any activist not serve this function as adequately or more so ?

In answering this second question at hand, i.e. whether any activist can not fulfil the task of the community

psychologist with equal efficiency, a reconceptualisation begins to take place towards the construction of what is an attempt at a model of relevant South African clinical psychology.

This search for a socially relevant psychology, for alternative or appropriate practices which respond to the needs and concerns of the majority of South Africans in the building of a future democratic society (Berger and Lazarus, 1987) leads to the construction of a model that attempts to distinguish the function of the psychologist as psychologist in rendering an appropriate clinical service to the community, from the role of psychologist as activist wherein the cloak of function as clinician is shed.

It is implicitly obvious that this separation artificially isolates what are essentially interactive functions. This is so, it appears, for two reasons:

a) because as activist one may still be a psychologist and
b) because as psychologist one may still be an activist.

Let us briefly examine these in turn:

a) Political experience in South Africa has demonstrated the efficacy of belonging to the group that one is trying to organise, mobilise or work with. Organisational functioning has tended to isolate the roles of organisation in focussing on specific population needs and membership. Hence, the proliferation of youth groups, women's groups, worker groups (unions), civic groups specific to a community, "white" groups (such as the End Conscription Campaign or Pietermaritzburg Democratic Association, PDA), "indian" groups (such as the Natal Indian Congress) etc. In each case, the focus, although not perpetuating ethnic division, has been relatively specific in its membership aims, despite contextualising issues within the broader democratic struggle.

In other words, in choosing to be an activist one may not necessarily be operating from the perspective of one's professional identity. In belonging to a political, civic or woman's organisation, for example, one's role as psychologist would be irrelevant. Any activist from the relevant community of focus would probably be able to organise and empower people, groups of people or communities of people with greater competence than any psychologist.

In being an activist, therefore, one is not necessarily being a psychologist. One is, rather, absorbing the role of membership to a particular grouping and functioning in a clinically "deroled" sense.

b) The second criticism weighs slightly more heavily. This is so because within one's professional role one may be taking on the task of organising the community of psychologists (for example, OASSSA membership). And indeed, in so doing one would be playing the role of activist. Such activism, however, still involves a clinical derobing in that one is not applying clinical intervention but involving oneself in a role of organisational membership on the basis of being a psychologist, rather than on the basis of applying psychological skill. Nevertheless, in this narrow sense the psychologist as psychologist may be construed as an activist. In the wider sense, however, the activism within a community that a psychologist may be involved in would be distinct from his or her role as a professional. As a professional health worker, the psychologist is serving the needs of the community rather than organising it. "The service groups are not organisers in the factories" (de Beer, 1986: 6).

It is argued, therefore, that whilst partially a synthetic division in reality, the conceptual separation of the role of the psychologist as psychologist and as activist is a

useful and helpful distinction so as to avoid conflation of issues (for example, the false role of community psychologist in "empowering" communities) and assists in attempting to build an appropriate model for South African psychology.

This does not however imply the depoliticisation of the psychologist. As Vogelman (1986), Dawes (1986), Hayes (1986), Radford and Rigby (1985) have argued, it is necessary to have a political understanding and to apply one's skill within a political framework.

It is clear that as activist, the psychologist may play any number of chosen roles in the community or broader society. As psychologist, however, the question of the construction of a relevant psychological practice remains. How, in other words, do we modify our therapeutic skill to be of relevance to the community ?

In the first instance, we need to evoke the notion of therapeutic priority. Therapeutic regression of an individual to resolve psychosexual fixation to bring about greater psychic integration in an individual who has just been released from detention and suffering consequent symptomology (Foster, 1987), or in someone living under conditions of chronic stress and suffering the Continuous Traumatic Stress Syndrome (Straker, 1987), or in someone whose stomach takes precedence over his or her head (Maslow, 1954 cited in Hilgard, Atkinson and Atkinson, 1979) is to be therapeutically inappropriate.

Turton (1986) in explaining the failure of a counselling service established in an african working class community near Johannesburg, makes the point that its primary emphasis was on helping clients to gain insight into their emotions or feelings rather than on helping clients to solve material problems. The counselling was designed to help

clients meet their "actualisation needs" rather than their "survival needs". Implicit in this design, Turton argues, "is the assumption that "actualisation needs" are the most pressing needs experienced by the clients" (p. 88).

This issue is an important part of the problem of an unmodified therapeutic practice. Anonymous (1986) attempts to address it by discarding mainstream psychology. He argues that "Eurocentric theories of human behaviour can never be relevant to South Africa where the majority is still concerned with "bread and land issues" (p. 83). Modification should not, however, equal negation.

Allwood (1985) cited in Radford and Rigby (1986) argues:

> "The people want concrete advice and direction - they want action not interpreted feelings... The need is for practical help for a community undergoing severe stress" (p. 5).

Implicit in Anonymous's arguments and explicit in those of Turton 1986) and Allwood (1985), is the notion of psychological or psychic prioritisation. Immediate, concrete psychological needs take priority over more emotional or intrapsychic ones. This does not render feelings or "actualisation needs" irrelevant to working class people. It simply places them at a lower level of the individual psychological hierarchy.

It seems fair to assume that once the "bread and land" issues have become less pressing in South Africa, the more abstract emotional, interpersonal and intrapsychic concerns will emerge towards the forefront of people's needs and the demands on psychologists may be towards meeting such evolving needs.

This prioritisation of psychological needs can be argued to

begin with immediate concrete needs (concrete life problems) corresponding to a broader structural or societal inadequacies and amenable to change via remedying these inadequacies. In other words, the more immediate the psychological needs, the more rooted will these needs be in the broader socio-political context and the more amenable to change via environmental change. In the therapeutic setting, problem solving therapy, for example, (or other behavioural interventions), may be relevant.

The deeper we move down the psychic model of needs, the more individual becomes the remedy and the more intrapsychic the intervention.

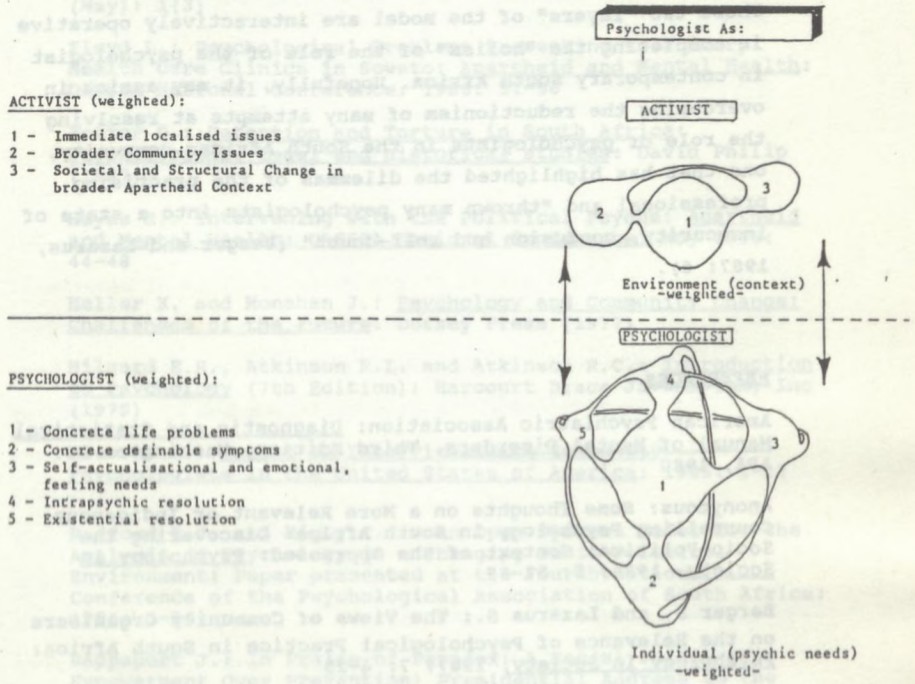
Second to the concrete life problems, can be placed symptomology of a concrete form. Stress responses, depression, sleep problems, and general outward symptoms that can be relatively concretely remedied lie at this level.

The third priority involves feelings, emotional needs, issues of self-esteem, self-concept and self-actualisation in the person's general life circumstance.

The fourth priority involves intrapsychic needs. Here, therapeutic regression to resolve intrapsychic fixations or impasses may be relevant with redicision work, early cathartic needs and unconscious resolution being the focus of therapy.

Fifthly and finally, the "existential resolution" may become the focus of therapy.
What we arrive at, is a model of psychological needs that is prioritised in form. It is clear however that a linear, hierarchical construction falls into a deterministic trap that is theoretically and clinically unsound.

It is obvious that concrete life problems may involve symptoms and feelings and that therapeutic intervention may therefore need to deal with symptoms and feelings interactively prior to, in order to, or as an adjunct to solving concrete life problems.



A linear conceptualisation therefore needs to be shelved in favour of an interactive model that nevertheless takes account of the prioritised nature of psychological needs. In so doing, a "weighted", interactive hierarchy that avoids the rigid connotation of prioritisation becomes useful.

This part of the model has to be constructed, however, together with the first issue dealt with previously - viz.

the role of psychologist as activist. By making these aspects interactive and weighted, we arrive at activism that involves primarily immediate, localised issues, secondly, that challenges broader community issues and finally that effects societal and structural change in the broader Apartheid context.

These two "layers" of the model are interactively operative in completing the "holism" of the role of the psychologist in contemporary South Africa. Hopefully, it may assist in overcoming the reductionism of many attempts at resolving the role of psychologists in the South African community, one that has highlighted the dilemmas of the practising professional and "thrown many psychologists into a state of insecurity, confusion and self-doubt" (Berger and Lazarus, 1987: 6).

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