Community psychology: Panic or panacea

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The litany of pseudoscientific justifications for oppression aside, this elite (professionals) remembers the oppressed only when "the natives" are restive and violence is in the air, when smoldering rage and fire can no longer be contained within the bodies and neighborhoods of the oppressed. It is then that they rush like firemen to put out or contain what threatens the prevailing structure of privilege and dominance. But once the oppressed are 'pacified' with violence, the threat of violence, drugs, or some reforms, this elite, with the exception of a few whose concern with social justice is genuine, rushes back to its accustomed comforts and amnesia (Bulhan, 1985; pp. 271 - 272).

The growing social upheaval and intensifying tensions in South Africa have by their very nature evoked concern and panic among mental health professionals. In an attempt to alleviate the concomittant anxiety and appear to be more responsive to the majority, many psychologists have boarded the community psychology wagon to cross the great divide between the comfortable consultancy room and the masses. In assessing whether community psychology is the appropriate vehicle for crossing the rubicon, we will start with an overview of different models of community psychology focusing on their different conceptualizations of mental illness and how each model sees the role of the psychologist in the context of psycho-social change.

The community psychology movement developed in the U.S.A. during an era when there was growing concern about both the lack of resources and

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treatment facilities and the impact of social systems on the human psyche. Psychologists and other helping professionals began to take note of the effects of social variables like poverty and alienation on mental health (Iscoe & Spielberger, 1977).

This theoretical shift in emphasis which represents a concern about where to locate the seat of pathology, was accompanied by a critical re-appraisal of the philosophy underlying the conception and treatment of mental illness. This concern generated controversy and debate around the dominant intrapsychic model in psychology. Many writers criticised the strong intrapsychic orientation of mainstream psychodynamic therapy, for its "elitist" and "exclusivist" nature which automatically excludes the poor (Ryan, 1973; p.23). They questioned its selectivity in that it appeared to ignore the more serious and yet socially relevant problems like substance abuse, crime, violence and women-battering (Heller & Monahan, 1977). They also questioned the extent of its efficacy subsequent to Eysenk's spontaneous remission thesis (cited in Zax & Specter, 1974). The point here, nonetheless, is that even if psychotherapy is effective, it appears to be elitist and selective in nature, in that it does not seem to address the needs of the majority in society. Instead, community psychologists appear to stress issues that pertain to the community and its collective destiny, rather than those of the individual subject.

In attempting to address the collective, four models of community psychology have been developed; mental health, social action, ecological and organizational. We intend to explore only the first two because they may be considered to represent the polarities of the continuum in community psychology.

THE MENTAL HEALTH MODEL

The mental health model, which has its roots in the community mental health movement is based on the explicit intention to prevent mental illness and its consequent disruption of the usual patterns of living. It seeks to strengthen, conserve and develop human resources in order to prevent mental disorder (Dorken, 1969; Hobbs & Smith, 1969; Hunter & Reiger, 1986; Shore, 1974). By increasing the coverage and impact of services, and the possibility of more people receiving help sooner, this approach seeks to alleviate the ever-mounting pressure on mental hospitals. This represents a shift from the waiting-mode of mainstream psychotherapeutic practice (Connery, 1968).

Preventative efforts move beyond the exclusive treatment of individual patients towards various ecological levels that include entire populations or small groups and organisations within them (Heller & Monahan, 1977). The efforts include not only the mentally ill, who may or may not avail themselves for treatment, but also the healthy (Caplan & Grunebaum, 1979). It is designed to alleviate harmful environmental conditions, avoid unnecessary

psychic pain and to strengthen the resistance of communities to inevitable future stressful experiences. Rather than merely redressing deficit and pathology, it focuses on the development of competencies and coping skills. Prevention may be utilized to plan and implement programmes for reducing: the incidence of mental disorders of all types in the community (primary prevention); the duration of a significant number of those disorders which do occur (secondary prevention); the impairment which may result from those disorders (tertiary prevention) (Caplan, 1964; pp. 16-17).

According to Bloom (1968; cited in Heller & Monahan, 1977, p. 117) primary intervention efforts may take on three different forms; the population wide approach; the milestones model; and the high risk group approach (Barker & Perkins, 1981). Secondary prevent aims to, "identify and treat at the earliest possible moment so as to reduce the length and severity of disorder" (Bolman, 1969; cited in Heller & Monahan, 1977, p. 116). By way of early detection, it promotes growth-enhancing programmes that are geared to reduce problems before they become severe. It is really a treatment based strategy that strives to make available more services to the community. For this process to gain momentum, it must also be accompanied by an increase in the utilization of services by the community (Mann, 1978).

Tertiary prevention strives to minimize the degree and severity of disability by preventing relapses among recovered patients. It endeavours to ensure that ex-patients are offered maximum support for rehabilitation and re-integration into the community. It attempts to reduce obstacles that may hinder the full participation of ex-patients in the occupational and social life of the community. Half-way houses and after-clinics all aim to foster tertiary prevention (Caplan & Grunebaum, 1970; Mann, 1978).

Rappaport (1981) cautions that prevention programmes "may not change our current social institutions but might add on to them ... and I might add with little evidence that they actually prevent anything" (p. 18). Prevention programmes can also become a new arena for colonialization with people being forced to consume the goods and services of the psychologists. Prevention efforts assume the existence of universal values in the catchment area, but ignores how such consensus about these values may be reached (Mann, 1978).

Promoting prevention requires a conceptualization of mental health that moves beyond a mere semantic shift. The new definition does not simply equate mental health with the absence of mental illness. Instead, it moves beyond individuals so as to take cognisance of the broader social and economic stresses created by their contexts (Albee, 1980; Heller & Monahan, 1977). According to White (1952; cited in Mann, 1978; p. 84) any such definition transcends beyond using the concept health as a metaphor. Despite

differences in outlook, all definitions entail some conception of growth and development, of autonomy and individuality as well as some conception of relatedness to one's environment (Mann, 1978).

In keeping with its emphasis on prevention and positive mental health this approach superficially attempts to understand people within their total personal and social environments rather than as isolated human beings (Connery, 1968). However, it does not attempt to underplay the role of the individual's psyche and trauma. It asserts that mental illness is the product of an interaction of both individual and environmental factors. In essence, the model attempts to locate the seat of pathology at the interface of the interaction between individuals and their environment. Thus far, it has failed to provide a theoretical base for such a conception of pathology. Consequently it has to revert to established explanations of mental illness based on the individual model. Without a theory of pathology, it is almost inevitable that its treatment strategies are conventional crisis intervention and consultation.

Consultation refers to the provision of technical assistance by an expert to individuals or groups on aspects pertaining to mental health (Lachenmeyer, 1980). It is essentially an indirect, "within systems" strategy which aims at modifications, renewal or improvement of existing social institutions or environments. It seeks to create some remediation and basis for change in the environments represented by consultees, in a manner that fosters the positive mental health of clients.

This approach, according to Caplan (cited in Mann, 1978) contains the potential of maximizing the limited amount of person-power available. This can be achieved by fully exploiting the roles of the natural care-givers in the community. Natural care-givers include people like health nurses, teachers, parents and ministers who are physically and psychologically available. Based on a geographical conception of community, this model is committed to rendering mental health services to an entire community through a community mental health centre (Mann, 1978). The role of the psychologist in this setting is that of a professional, rendering expert services to a client population.

In summary, the main contribution of this approach is its identification of the limitation of mainstream curative individual therapy. It represents an attempt to make scarce psychological services available to more people within a given 'catchment' area by making the clinic more accessible to individual community members through reducing travelling costs. The service is still rooted in the individual model with all its limitations, which we explore later in this article.

THE SOCIAL ACTION MODEL

The social action approach, which has its foundations in the "War on Poverty" strategy (Nazzi, 1978) arose out of discontent with structural inequities and the unresponsiveness of the political apparatus of American society. Like the mental health approach it is initially aimed at prevention, but from a radically different perspective.

Located within the Community Action Programme, the poverty-programme addressed itself to the needs of the poor and to the complex nature of interrelated social problems. Thus, in its endeavour to equalize opportunities for upward social mobility, it sought to make available more social resources to the 'poor'. It simultaneously attempted to alter the social and psychological characteristics of the poverty-stricken in order to prepare them for more meaningful participation in society.

This model criticizes traditional psychology's individualist orientation that locates pathology solely within individuals. It asserts that it is imperative to take cognisance of the structural inequities of society, which may include factors like inadequate housing, overcrowding, the absence of free speech and political powerlessness (Brown, 1978; Reiff, 1968, cited in Mann, 1978). The shift is from prevention to empowerment. Rappaport (1981) argues that empowerment should be "the call to arms". While prevention is founded on the needs approach, empowerment is based on a "rights" model. Accordingly, Rappaport asserts that because many competencies are already present in people, what is required is a release of potential. "Empowerment implies that what you see as poor functioning is a result of social structure and lack of resources which make it impossible for the existing competencies to operate" (Rappaport, 1981; p. 16).

By including power in its explanatory model, the emphasis shifts from "blaming the victim" to implicating the social arrangements of society. This means that a pre-requisite for empowerment is a redressing of social inequalities. This model conceptualizes community process and inter-group relations in terms of conflicting interests between groups. Accordingly it argues that the poor do not have any power, influence or control in the society. Since the dominant group have vested interests in maintaining political and economic inequities, differences are not easily reconcilable. Logically then, social action advances the mobilization and organisation of an "appropriate constituency" to exert pressure on the ruling elite (Heller & Monahan, 1977; Reiff, 1968, cited in Mann, 1978). In the South African context it would probably involve organizing the unenfranchised, with a view to shifting the power balance and instituting structural changes.

By arguing that health is not possible in the context of repression and domination, social action programmes address themselves to issues of finance, power, increasing resources, education and community development. Reiff

(cited in Mann, 1978) asserts that self-determination must be an integral part of any social action programme. The acquisition of power is a pre-requisite for the fulfilment of human needs. For him, the powerlessness of the poor renders self-actualization unrealistic. It is imperative that the working-class experience themselves as being able to determine what happens to them, both as individuals and as a group (Hoffman, 1978; Reiff, 1983; 1977). some theorists have pointed out that in order to advance and maintain this process of self-determination, community psychology should be a social movement rather than a professional enterprise (Rappaport, 1981). Confirmation for this position is provided in the added thrust that community psychology gained from being juxtaposed with a series of civil rights and youth protest actions during the 1960's in the United States of America (Mann, 1978).

In accordance with its view on the acquisition of power, this model stresses and encourages community participation and equality in community relations, relying on grass-roots support for its programmes. Establishing a power base and commanding grass-roots support are vital, for as Alinsky (1972, cited in Heller & Monahan, 1977) implicitly points out, the disempowered cannot achieve their goal without struggle.

In accordance with its tenet of self-determination and community control, this model has devised various strategies to foster a sense of power and community participation. This is achieved by increasing community morale, tapping community resources, developing social skills and generating opportunities for promoting local leadership (Lewis & Lewis, 1979; Mann, 1978).

As part of its intervention strategy, the social action approach capitalizes on natural support systems. It employs the services of "indigenous" non-professionals and attempts to mobilize consumers of services to assume control of the activities of the programme (Mann, 1978). Given the assumption that non-professionals are fairly sensitive to the needs of the community, they are considered to fulfill a good liaison function for the professional services. They are able to provide valuable input for programmatic planning and are also in a position to encourage the community to utilize the services (Mann, 1978). It is argued that because they have the same social background as the clients, they are able to interact with a greater degree of therapeutic effectiveness. The amount of trust they receive and the emotional significance that they hold for the clients, allow them to render informal support and communication within the community itself (Guerney, 1969; Zax & Specter, 1974). Despite these advantages, experience the world over indicates that the professional/non-professional relationship is often unidirectional. Non-professionals are not always accorded equal status and are perceived to be in need of training and upgrading. The emphasis appears to be on incorporating the indigenous into a professional framework.

To foster independence, various multi-purpose, locally controlled, community development corporations (CDC's) were established in ghetto and rural areas all over America. Functioning on a non-profit basis, these CDC's have been able to promote economic and social development, as well as some degree of political power (Bower, 1973). They essentially provide a permanent source of income and collective power for the ghetto residents and for the community as a whole. If programmes like the CDC's are not an integral part of a broader movement, they run the risk of merely becoming little enclaves with greater scope for self-sufficiency and material advancement.

In summary, this model attempts to radicalize the conceptions of social problems. It represents an alternative perspective in that it proposes that social inequities, economic exploitation and political powerlessness may be responsible for the genesis of high visibility social and mental health problems. By so doing, it locates the causes of "problems of living" to be within the social arrangements of society and not within the catchment area. Thus, unlike the mental health model, which confines its preventative efforts within the catchment area, the social action model purports to attack the very societal structures that it considers to be causing social problems. It aims to mobilize the community into collective struggle. The implicit role of the psychologist is community mobilizer cum conscientizer. The social action model represents a more concerted attempt to move away from an individual conception by incorporating socio-political variables, with the aim of empowering communities. It could be regarded as one of psychology's first attempts to redress "social ills".

FREUD AND/OR LENIN?

From the foregoing discussion it is clear that both community psychology models have started a significant shift away from mainstream individual psychology. While acknowledging these positive contributions, it must be pointed out that they still have to theorize the "individual-society interface" (Duveen & Lloyd, 1986) and the role of the psychologist during collective intervention.

The shift from the individual to the community has not been accompanied by a theory of mental health that takes cognisance of the interaction between the individual and the collective. It is imperative to combine individual and community processes to arrive at an integrative perspective of community life. This is to prevent a one-sided approach in what is regarded as a dialectical problem (Mann, 1978; Rappaport, 1981).

The social action model, for example, tends to underplay the individual's subjective experiences, focusing chiefly on the antagonistic nature of the interaction between groups in society. It does not explicitly address the

specific ways in which psycho pathology develops. Rather it assumes that in the process of empowerment problems such as alcoholism, sex abuse and delinquency would be eradicated. The mental health model on the other hand has still not fully attempted to depart from the conventional individualized conception of pathology. It essentially overlooks changes which may occur with community processes, which the model assumes to be stable (Mann, 1978).

Because community psychology does not offer a theory about the genesis and process of mental health problems it is unable to say anything about what constitutes mental illness. Ryan (1971) has begun to address this thorny issue by suggesting that since ideological assumptions determine how problems are defined it would be much more fruitful to consider mental health as of social problems rather than as medical diseases. This issue is supported by proponents of anti-psychiatry like Szasz (1960) who claims that the concept "mental illness" is misleading and "serves to obfuscate the distinction between two entirely different kinds of problems" (Heather, 1976; p. 68). It confuses a neurological and physiological framework, with whatever "problems in living" people have.

In locating the causes of social problems to be within the socio-political arrangements of society, the social action model has attempted to move away from a biological conception. The basic tenet appears to be similar to Fanon's (1968) assumption that liberation from oppression removes the primary barrier to people's humanity. He asserts that through the process of political liberation people restore their sense of self and reconstitute their bonding. They reclaim their history and regain both their individual and collective identity. Fanon thus merges two questions: the liberation of the colonised from the agony of colonial oppression and the liberation of the individual personality for an autonomous existence (Bulhan, 1985).

Fox and Genovese (1980) argue against the merging of what they regard to be such disparate and patently distinct questions. They assert that there is no reason to believe that the revolt against colonialism represents a triumph for personal liberty or of individual autonomy over authority; except in the special vital sense that it removes the particularly debilitating element of racist degradation. It cannot resolve the conflict of the individual (and his/her claims to autonomy) with society (and its claims to order and submission). They further add that the revolutionary destruction of colonialism and the destruction of all classes and social oppression cannot psychologically liberate the human personality from dependency. This questions the validity of Fanon's conception of revolutionary violence as a totally transformative event for both societal and personal liberation.

This criticism is an indictment of the social action model which has not

theorized how psychological emancipation may be achieved through the process of political liberation and empowerment. In fact it does not even talk about political liberation; rather it talks about communities empowering themselves within the existing order. Although it locates the causes of problems of living to be within the 'social arrangements' of society, it does not challenge the prevailing economic order which to an extent determines the social relations within a society. Where 'social arrangements' are tied to the concept of inequality in society it simply enables communities to gain better access to the free market. While this is presented as empowerment it is actually a struggle for embourgeouisification.

By remaining reformist within the system, community psychology has not endeavoured to theorize the relationship between madness and oppression. Bulhan contents that the problem of madness and oppression will "continue to elude us so long as the questions of inequity, power and liberty are evaded". This problem will be perpetuated as long as the individual and the society are construed as separate "immutable givens" (Duveen & Lloyd, 1986). As socio-psychological categories they are not independent categories, because there is no 'pure individuality' which can be understood separately from social relations (Duveen & Lloyd, 1986; Muller, 1985). Separating these two concepts is as futile as the nature-nurture categorization in the intelligence debate. This means that community psychology still awaits a Freud to develop a unification of the individual-social dualism. Since few theories have contributed so much to entrenching the individual - social split, it is highly unlikely that this will be achieved by a Freudian.

The second fundamental issue that faces community psychology is to develop an intervention method that will liberate the "patient" from psychological oppression. It is imperative to do so without reproducing conventional psychology's "therapist-patient" relationship which itself is "suffused with the inequities, non-reciprocity, elitism, and sadomasochism of the oppressive social order. What is needed in situations of oppression is a mode of intervention that bridges the separation of insight and action, internal and external, individual and collective. "The oppressed are economically and socially too pressed to wait indefinitely for an insight apart from lived realities" (Bulhan, 1985; p. 272).

This raises the issue of the relationship between the professional and the community. In the mental health model, the control is firmly vested with the expert who renders professional services to a client population that is a direct emulation of the hierarchical patient-therapist relationship in individual therapy. On the other hand, social action experts such as Rappaport (1981) argue that in the empowerment process the professional as an advocate of change should become a "collaborator". While this prescription aims to democratise the professional-community interaction, the differences in skills

cannot simply be resolved by the professional declaring himself/herself as "just another one of the people". Such a move does not contribute to an understanding of what is the appropriate place and function of expert skills. This can easily lead to what Gouldner (1979) would call an obfuscation of the role and the interests of intellectuals.

Taking Rappaport's (1981) suggestion seriously to start from the bottom up, Berger and Lazarus (1987) enquired from community organisers what they thought the role of the expert psychologist should be. With regard to professionalism, the participants considered expert knowledge and skills as crucial but felt that the problem lies with the monopolization of skills by an elite and the resultant dependency of the community. The activists also prescribed that professional services should be opened up and integrated into community support networks which would break down the demarcation of specialist functions and the mystique surrounding experts.

Rappaport and the community are thus in agreement. Whilst consensus is laudable and an important starting point, it does not contribute towards a greater understanding of the expert-community interface. This question will continue to plague us as long as professionals do not take seriously the suggestion of community organisers that psychologists should break out of the confines of a discipline which has an impressive theoretical framework for transference in individual therapy but no systematic theory of intervening in social change. This is one of the important reasons for the stagnation of the social action approach.

Community psychology may have to start looking at social theorists such as Lenin (1971), Gramsci (1971), Freire (1970), Habermas (1974) and Tourraine (1981); to mention but a few of the names that seldom appear in psychology texts. Familiarity with some of these theorists may enable psychologists to start responding to the demand of community organizers (Berger & Lazarus, 1987) for a greater political content and awareness in the subject matter of psychology.

It should also help to clarify the simplistic notions of community espoused by many community psychologists. Rather than defining 'community' in terms of catchment area or locality, it could start to perceive community work as part of the process of consent creation during the formation of a counter hegemony (Sayer, 1986). According to Gramsci (1971) hegemony "represents the advance to a class-consciousness, where class is understood not only economically but also in terms of a common intellectual and moral awareness, a common culture" (cited in Adamson, 1980; p. 171).

Becoming part of a social movement is imperative if the aim is to redress inequality. For social change psychologists to attempt to alter social relations

in isolation from a broader movement sounds like grandiose self-delusion. A good reminder is that in the U.S.A. the upsurge of community psychology coincided with the civil rights movement. The demise of this campaign also heralded the beginning of the retreat of many of the proponents of social action to the ivory towers and the conference circuits.

Alignment with a social movement is a crucial first step in the process of a collective challenge to the existing relation of exploitation and domination. 'Joining the organization' is not the panacea but only the beginning of the process of developing different functions and roles for the professionals while simultaneously forging cohesion.

It is far beyond the scope of this article to even begin to address the vast literature on the role of intellectuals or experts in mass movements. Rather, a brief illustration of two approaches will suffice to demonstrate the fruitfulness for looking outside of the psychological literature for a way forward out of the present impasse.

One model sees knowledge and skills as having been separated off from the working class and becoming located within the middle classes (Abercrombie & Curry, 1983). Seen in this light, the question becomes how to reinstitute the expert as "handmaiden of labour, and of other subordinated groups" (Muller & Cloete, 1987; p. 13). The professional is obliged to 'hand back' knowledge to the movement. In the forceful words of Lenin, "you intellectuals must give us political knowledge. You can acquire this knowledge and it is your duty to bring it to us ..." (cited in Wexler, 1982). For Lenin the problem is a technical one: you have the knowledge, we need it, so hand it over or popularise it. While 'handing back' knowledge is both desirable and inevitable, it is also not without problems. One of the issues is that the autonomy of knowledge is left unquestioned and the divisions of labour into specializations affirmed. The problem is not whether the skill of the expert is legitimate, but that the technical division of labour becomes married to social relations of domination and subordination. The 'handing over' suggested by Lenin tacitly acknowledges the professional as the sole authoriser of knowledge and therefore reproduces inequality between professionals and other client groups (Muller & Cloete, 1987). In this sense the Leninist model radically underestimates the politics of knowledge (Muller & Cloete, 1987). Currently, this does however seem to be the dominant approach and what many organizations demand of experts.

The critical theory model, in contrast, posits that the split between expert knowledge and liberatory practice needs to be mediated and not simply "collapsed". In describing the dialectical mediation of theory and practice, Habermas (1974) insists on distinguishing between three different processes. The first is the collection and formation of critical knowledge: the domain of

the experts or intellectuals. The second is the organizational process of enlightenment or education, where this knowledge is tested against the forge of the actual experiences of actors in social struggle. This necessarily involves a dialectical process between experts and actors in organizations. The third part is the selection, application and re-evaluation of appropriate strategies. In such a situation the expert's role is to be part of the process of movement and strategy formation, not to initiate or to control it (Muller & Cloete, 1987).

The above concerns itself with different forms of participation, but does not elucidate the knowledge content with which the psychologist will participate. The issue is not only to become an activist, but a mobilizer with certain knowledge. There is for Gramsci (1971) a direct link between organizational form and knowledge; a certain organizational process of participation will privilege certain types of knowledge while a certain content will contribute to gaining access to participation. A good example is Tourraine's (1983) sociological intervention during the strategy formation phase of the Solidarity movement in Poland.

Community psychology is construed as the community division of psychology, which means that like industrial or clinical, it has to take relevant content from psychology and apply it to the social. However, if this content is generated from within an individualistic paradigm then the fundamental contradiction of the enterprise becomes apparent. The obviousness of the contradiction raises the question as to whether panic has blinded the adherents or whether it is a calculated tactic to keep the discipline intact within the individual paradigm while pretending to be concerned about the majority. The contradictory class location of intellectuals enables them to signal support to the oppressed while continuing to enjoy the privileges of the class that they are helping to maintain (Disco, 1979).

The contradictory position can be maintained through the medium of language, particularly if the language helps to pacify the oppressed while not really posing a threat to the regime. Terms such as "empowerment", self-determination, community, struggle and social arrangements" conjure up images of appropriateness and relevance, concern for the majority and even radical social transformation. It should be remembered that the noted 'encounter group' advocate, Carl Rogers, also used very similar terminology. Perhaps it is exactly because it is only at the level of talk that neither Rogers nor community psychology have been associated anywhere in the world with progressive movements during the process of change. Instead, they have been much more conspicuous as 'guests of the system' during social upheaval.

Community psychology is a 'red herring' which fulfils different functions for different constituencies. As has already been indicated, it demonstrates a concern for relevance and a possible tacit joining with the oppressed, who feel

that even if the professionals are not quite there yet, they are at least on the right track. Certain foxy psychologists on the other hand know that the herring will enable them to appear relevant while simultaneously keeping open the 'passage' to Australia and the Americas. It is not only individuals who benefit from such a tactic, but also departments who continue to theorize and teach within the mainstream individual paradigm while allocating a few junior staff members to hoist the community flag.

While it is easy to expose those who are deliberately trying to divert attention, the more difficult issue that confronts those who are "genuinely concerned with social justice" (Bulhan, 1985; p. 272) is to develop a psychology that will take cognisance of the psychological processes of oppression and liberation. We think that lifting one of the masks psychologists wear during social upheaval constitutes a start in the development of an alternative praxis.

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