Psychology in society (PINS), 1994, 19, 31-44

CRITICAL PSYCHOLOGY AND THE PROBLEM OF MENTAL HEALTH

Victor Nell
Health Psychology Research Unit
University of South Africa

PART 1 - A CRITICAL REVIEW.

In December 1977, Noam Chomsky delivered the Johan Huizinga lecture in Leiden, Holland, in memory of the man who wrote **In the shadow of tomorrow** (1935), and **Homo Ludens** (1938), and was held under arrest during the Nazi occupation of Holland. In the lecture, Chomsky cites **The crisis of democracy**, a document produced in the 1970s by the Trilateral Commission, a private organisation of the elites of the United States, Western Europe and Japan set up by David Rockefeller to urge "moderation in democracy".

The Commission distinguishes between two kinds of intellectual. On the one hand, there are "the technocratic and policy-oriented intellectuals, responsible, serious, and constructive", and on the other "the value-oriented intellectuals, a sinister grouping who pose a serious danger to democracy as they devote themselves to the derogation of leadership, the challenging of authority, and the unmasking and delegitimation of established institutions ... while sowing confusion and stirring dissatisfaction in the minds of the populace". (Chomsky, 1988:13, citing **The crisis of democracy**).

In the perspective of thirty more years of postmodernism, this sombre warning against "sinister" intellectuals might better be read as an injunction that defines what intellectuals ought to be doing, prefiguring, for example, the anthropologist, Nancy Scheper-Hughes (1990), who calls on critical medical anthropologists to play the court jester in order to achieve a "carnivalesque turning of medicine inside out" (p191), "for the tumbling of received wisdoms and of privileged epistemologies!" (p195).

Predictably, social scientists have preferred to play the part of Lord Chancellor (if not better) than bob around in the cap and bells of the jester. The complicity of South African psychologists in supporting apartheid capitalism is well known. Other such complicities abound. For example, Seymour Sarason (1981:x) writes: "Psychology serves the social order, a stance that exposes how well psychology has been socialised into the social order, thereby rendering it unable to take distance from it."

In 1917, Robert Yerkes, then 41, proclaimed in his presidential address to the American Psychological Association, "Psychology in Relation to the War": "Today, American psychology is placing a highly trained and eager personnel at the service of military organisations. We are acting not individually but collectively on the basis of common training and common faith in the value of our work. At the first call American psychologists responded promptly and heartily." (in Sarason, 1981:106). Nor was this empty rhetoric. Yerkes (who was a major in the US Army Sanitary Corp because he could not be admitted to the Medical Corp) led the US Army testing programme, applying the Army Alpha and Beta to 1 726 000 men, the largest intelligence testing programme in history.

The imperative "to expose the interests which are served by uncritical psychological theory and practice" (Dawes, 1986:34) is at no time more painful and more necessary than in the aftermath of a great social revolution.

"The nature of political change is that ideologies come and go ... but the subterranean machinery of power, the armed forces ... and the immense civil service bureaucracy that translates policy into governance ... remains unchanged. ... Part of this process of co-option is that the most vigorous and best-informed critics of the old order become the intelligentsia of the new; in the process, yesterday's patriotism becomes today's treachery.
As the clock of political change ticks toward the dawning of Paradise-on-Earth, and the new government loads its suitcases onto the trucks that will soon depart for State House, the cynics will whisper a dreadful warning to one another: *Duck! Here comes Utopia!* (Samuelson, 1994:6).

These are heterodox and discomfiting thoughts at this time of redemptive politics and high hopes for a new South Africa. Is continued guardedness an appropriate stance for the progressive (1) psychologists who supported the Organisation for Appropriate Social Services in South Africa (OASSSA), many of whom are now members of the African National Congress, and have contributed through regional debate to the formulation of the mental health component of the recently published ANC health policy document (ANC, 1994)? Or would it on the contrary be more fitting to become "responsible" intellectuals who ally themselves with the process of reconstruction, accept the reality constraints demanded by this process, and deliberately refrain from the initiation of a new and disputational polemic?

There is no choice. Governments may change, but the critical imperative to tumble received wisdoms and privileged epistemologies remains. It is necessary to ask whose interests are served by the mobilization of progressive psychologists to formulate a "mental health policy". Is it the cause of wellbeing, or will critical examination show that it is the medical profession or the state itself that is better served by this policy than the recipients of these services? And, if so, should the critics feel well satisfied that their critique is cogent, or would they be obliged, in terms of the high principles of human service they espouse, to become practical, like politicians, and propose an action prospectus?

STATISM SUBVERTS POPULISM.
One of the most revolutionary manifestos of recent times was adopted on 12 September 1978 in Alma-Ata, then the capital of the Kazakh Socialist Soviet Republic.

The declaration "reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not only the absence of disease or infirmity, is a fundamental human right." (WHO, 1978). Chapter 10 of this document commits the World Health Organisation and the United Nations Childrens' Fund to attaining "an acceptable level of health for all the people of the world by the year 2000" - the programme that has since become known by its acronym, HFA/2000.

"Health For All" in the sense of the "complete wellbeing" envisaged by the Alma-Ata Charter presupposes a worldwide social justice revolution that will *inter alia* address the fundamental causes of psychopathology which George Albee, founder of the Primary Prevention of Psychopathology movement, identifies as follows:
"(a) emotionally damaging infant and childhood experiences;
(b) poverty and degrading life experiences;
(c) powerlessness and low self-esteem;
(d) loneliness, social isolation and social marginality." (Albee, 1986:891).
Albee (1986:893) argues that the public health focus of "mental health" initiatives has led to overstatement of genetic and pharmacological factors, and a narrow, clinic-based approach to mental health rather than attending "to the truly massive and widespread emotional damage" produced by these four factors. Similarly, Kamin's (1993:7) scathing critique of the medicalising approach the United States' science establishment adopts toward violence prevention is also a call to resocialise and de-medicalise psychopathology: "The solutions, if such there be, lie in the social, economic and political realms."

The role of psychology, and with it the other human service professions, is in the first place to overcome the attitudinal barriers to a just society, which Albee (1986: cf 894-896) identifies as the belief in a just world, in which people get what they deserve (or what God thinks they deserve); belief in social Darwinism and, by implication, that the world's oppressed people are impoverished and exploited because they are naturally inferior; and a radical fatalism which says that there's not much people can do to change their lot.

Once powerful groups in a society have accepted that social justice is an attainable goal, and therefore that the four principal causes of psychopathology can be attenuated, the next phase of the struggle is to set in place local and national accountability mechanisms that will ensure that government does the one thing, the only thing, that justifies its existence - creating the social circumstances within which individuals, communities, cities and nations can attain the state of complete wellbeing envisaged in the Alma-Ata Declaration.

Of course, this quest must be prefaced by the realisation, as Noam Chomsky puts it, that there is no such thing as a good government. In consequence, the United Nations and its agencies, including the World Health Organisation, whose members are governments, can never be the agent of the social revolution that will produce social justice.

Ordinary people are the agent.

But populist agency is subverted by the worldwide tendency of governments to depoliticise health care, using the powerful medical profession to co-opt and

subordinate the smaller, nonmedical health care professions. Moreover, as Navarro (1984) has argued, the class determinants of the distribution of resources are ignored, and an "atheorectical pragmatism" is instead proposed as a solution to the problem of health. In this way, suffering caused by social injustice is medicalised and health, which, if it is to be attained, must be a site of struggle, is contained within professional power structures which can readily be manipulated by a ruling elite.

This process of subversion requires that government-based international agencies need to be seen to be addressing issues of poverty and the inequitable distribution of wealth in a technological and ostensibly apolitical way (Navarro, 1984), so that governments can use a rhetoric of community participation "to perpetuate the illusion of representative democracy, while large segments of the population are systematically denied access to the political process." (Morgan 1990:212).

At the same time, governments can direct community participation programmes and in this way extend their control over rural communities. Costa Rica for example initiated a rural primary health care programme in 1973, in which the community participation component lasted only four years, from 1978 to 1982. In 1978, the year of the Alma-Ata Declaration, President Carazo and his Minister of Health set up networks of active, state-funded health committees, which began spearheading community social movements. For example, one committee analysed each infant death in the canton, concluding that infant mortality was closely associated with poverty and unemployment. Local elites were alarmed, branding community participation as "social agitation" - a view readily endorsed by the new government that took office in May 1982, cut off state funding, and declared that the health committees were "political" and "ideologically dangerous." At canton level in Costa Rica, doctors were concerned that their professional control would be threatened by paraprofessionals, while political organisations suspected their opponents of using community participation in health care to fortify their own rural political strongholds (Morgan, 1990).

In the Dominican Republic, primary health care is dominated by a powerful medical establishment that has close ties with the ruling party. Whiteford (1990:221) writes that despite huge investments in a clinic infrastructure, "rural Dominicans face crumbling clinics, missing or expensive medications, and bored or absent physicians" - the consequence of introducing an inappropriate and politically motivated model of primary health care.

The other side of the coin is presented in a story told by David Werner, the keynote speaker at the 1989 congress of the National Medical and Dental Association (NAMDA) in Port Elizabeth. Werner is founder and president of the Hesperian Foundation, a lifelong proponent of community controlled health initiatives, and the author of the most demystifying of health care manuals, **Where there is no doctor** (1977), which teaches lay workers the basic techniques of medicine and surgery and has sold millions of copies.

In Port Elizabeth, Werner related how his village health care project in Mexico had first mobilised villages around health, which inevitably turned people's attention to the under-nutrition of children, which is an endemic problem for landless peasants. Finally, a group of peasants marched from Ajoya, in the Sierra Madre, to Mexico City to reclaim village land that was rightfully theirs in terms of Mexico's constitution.

THREE PROPOSITIONS FOR RESOCIALISING ILLNESS.

Why is the medical establishment such a powerful ally of ruling elites and their supporters (all of whom subscribe to what Galbraith, 1992, calls "the culture of contentment"), and how might this alliance be deconstructed so as to demonstrate its workings and allow appropriate counter-action which recognises that the attainment of wellbeing requires the resocialisation of illness?

The cutting analyses of modern health care systems that have emerged in the new discipline of critical medical anthropology introduced in 1986 by Baer, Singer and Johnsen, are especially helpful. Since then, two issues of the journal, **Social Science and Medicine** (No.2 of Volume 23, 1986; and No.2 of Volume 30, 1990) have been devoted to the propositions about social power and control advanced by this discipline. These propositions resonate at a national level with the political problems facing health care in South Africa and other countries, and also with the particular professional problems of nonmedical health workers.

Critical medical anthropology holds that biomedicine maintains its dominance by the co-optation and subordination of other professions. Baer et al (1986:181) draw attention to "the nonmedical behaviours of medicine, including its political manoeuvring to eliminate competitors and gain social status and power."

Scheper-Hughes (1990:192) suggests that an unexpected side-effect of the disease/illness dichotomy (2) is that "it has allowed physicians to claim both disease *and* illness, curing *as well as* healing for the biomedical domain." The first of her three propositions for a critically applied medical anthropology is therefore "to reduce rather than expand the parameters of medical efficacy, a call for a more humble model of doctoring as 'plumbing', simple 'body work' that would leave social ills and social healing to political activists, and psychological/spiritual ills and other forms of existential malaise to ethnomedical and spiritual healers .... Physicians ... are not the best guides for the mortally ill [life itself is one long terminal illness] toward their inevitable contract with death."

The second proposition is to develop "non-biological forms of healing in terms of their own meaning-centred emic frames of reference" (ibid:193), and in any case, "A great many patients are dissatisfied and 'noncompliant' because they continue to hold out for an explanation and a theory capable of linking their symptoms with their experiences, their lives." (ibid:194).

The third and most revolutionary of Scheper-Hughes' propositions is for a radicalisation of medical knowledge and practice, using hospitals and clinics as "a locus of social ferment, of revolution ... that begins by linking the suffering, marginality, and exclusion that goes on within the hospital with what goes on outside in the family, the community, the society at large. ... Many illnesses that enter the clinic represent tragic experiences of the world." (ibid:194).

PART 2 - AN ACTION PROSPECTUS: DEMICALISING HUMAN SERVICES.

In this light, what intellectual and policy-making programme might be followed by critical South African psychologists who seek to address the existential ills that erode wellbeing - poverty, degradation, powerlessness and isolation (Albee, 1986) - and develop ways of getting "individuals and families [to] assume responsibility for their own welfare" (WHO, 1978)?

Here are my three propositions for critical South African psychologists, which are set out in order to counter the observation made by a critic of sceptical postmodernism who pointed out how easy it is to adopt a "systemic" view that allows one to drive a horse and cart through an opponent's position without the inconvenience of taking up a position of one's own.

PROPOSITION 1: RESOCIALISNG DISTRESS.

The first proposition is to oppose the medicalisation of psychological distress, and to promote its resocialisation. However, the South African reality is that distressed people, especially working class people, are for lack of alternative treatment modalities constrained to somaticise their illness experience and present at health clinics with a range of physical symptoms. Leading on the one hand to exceptionally high somatisation indices, as evidenced in the Soweto Community Health Clinic (Seedat, Butchart, & Nell, 1991), and on the other, to an (avoidable) expense burden for the medical health system.

The cycle of dependency.

There is a greater need for psychological healing in South Africa than in many other countries, in part because of what Hussein Bulhan (cited in Seedat and Nell, 1990:146), has called the "psychic mutilation" that arises from the self-hatred of colonised people. In South Africa, the traumatisation of the past five years of inter-organisational and ordinary criminal violence must be added. In reviewing the almost exclusively interpersonal, nonpolitical violence found in nine Johannesburg hospitals in 1986-1987, Nell and Brown (1991) hypothesised that among both white and black South Africans the internalisation and "horizontalisation" of the societal violence of a profoundly racist society, is the underlying factor that has given rise to the inordinately high rates of assault among blacks and of suicide among whites, making South Africa the most violent country in the world (Nell and Seedat, 1993).

Black communities in South Africa may lack legitimate leadership, or have contested leadership that does not represent large, subterranean elements in the community, and these problems have been exacerbated by decades of skillful destabilisation of black community organisations by the South African state. The consequence is that community organisation around the quality oflocal life and infrastructural issues is relatively weak, civic assertiveness is undeveloped, and there is little knowledge of the works of the mechanisms of accountability needed to give political teeth to such assertiveness.

Though there is a strong tradition of political activism through protest politics, and civic organisations in black communities have shown resilience in creating structures to bypass illegitimate local authorities and a distrusted criminal justice system (Scharf,

1989), there are no working community-based models for constructive engagement with the South African police in order to deal with escalating criminality, or to engage with local authorities on bread-and-butter issues such as street lighting, road kerbing, clean playgrounds or adequately staffed and equipped recreation centres.

The danger thus exists that the long apartheid tradition of government unresponsiveness to the needs of black communities will translate into a millennial expectation that a new democratic government will at once create responsive local government mechanisms that will, in an abundance of wisdom, energy and money correctly prioritise and then address a multitude of community problems.

Such expectations are unrealisable, and the rebound disillusionment with the new government will exact a high political price, whilst also giving rise to a new cycle of community despair and the withdrawal of competent community leaders from the local development arena.

The contribution of South African non-governmental organisations to addressing this fundamental problem of the perceived impotence of civil society to bring about beneficial change in local living standards has by and large been counterproductive. The establishment of a shelter for abused women or a youth club, however successful it might be, does not address the underlying problems that arise from the lack of civil society assertiveness and local government accountability. The task of the human services is to demonstrate through successful local programmes that individual projects can be rooted within a system of "circles of power" that create working accountability mechanisms through which local people, informed by citizen charters, can demand and achieve high-quality local government, including community-driven policing (for details of accountability and community safety proposals, see Nell 1993; Nell, Seedat and Williamson, 1993; Nell and Seedat, 1993).

Resocialising mental health.

In this context, the problem is not definitional but institutional. As a professional discipline, the content of mental health is admirably broad and inclusive of what was above termed "existential malaise". This is reflected, for example, in the newsletters of the World Federation for Mental Health and its current programmes, and in the frequency with which the term "mental health" is coupled with "psychological wellbeing" in 1993 - 1994 books and book chapters, as shown by a search of the CD-ROM version of **Psychological Abstracts**.

The problem is thus not with the breadth and humanity of the World Mental Health programme, which is distress oriented rather than disease fixated. The problem is institutional. If services for psychological distress are located within the heavily medicalised health care system found in South Africa and other developing countries, somatisation is inevitable, with its attendant needless costs and continued client distress. In addition, the political disempowerment of and disrespect for the "little professions," and especially the loquacious discipline of psychology, will continue.

The problematics of mental health of which critical psychologists must be aware thus arise not from the discipline's potential to address distress, but rather from its assignment to the health sector and its consequent vulnerability to individualising medicalisation and desocialisation.

PROPOSITION 2: INSTITUTIONAL AUTONOMY FOR THE HUMAN SCIENCES.
The loquacious disciplines - psychology, social work, welfare, vocational counselling - do not prosper in clinic settings, though they are irresistibly drawn to the *klinikos*, the bed, where the silent medical gaze is supreme (Nell 1992). In consequence, in South Africa, as in other developing countries, these "little professions" (they are numerically insignificant in comparison with medicine and nursing) suffer under the stifling hand of medical supremacy which compels nonmedical professionals to work under conditions of disempowerment, and blocks opportunities to develop their professional skills in innovative ways that would better serve the health needs of South Africa's population.

Of these professions, psychology faced active antipathy within the previous government's health administration. In 1988, a provincial Director General of health services asked a delegation of psychologists, among them the present author, why it was that so many psychiatrists on his staff would say to him: "Please, whatever you do, don't appoint any psychologists in my unit!" (Nell, 1989). As a result, months or years may go by before vacant posts for psychologists are advertised or filled (see also Mgoduso & Butchart, 1992; Miller & Swartz, 1990; Nell, 1989, 1990, 1992, 1993; Seedat & Nell, 1990, 1992; Swartz, 1989, 1991).

The disempowerment of the nonmedical unit services in general hospitals and psychiatric settings takes many forms, among them the creation of false client expectations. Thus, in hospital settings, where clients observe white-coated figures rushing to save lives and take momentous decisions, and where the psychologist will very likely work in a clinic room with a curtained examination bed in one corner and a powerful lamp above it - the tools of the Foucauldian medical gaze - clients expect from the psychologist the same "quick fix," a pill or an injection, that they get from the doctors or nurses. Nell (1989) has recorded a "therapeutic" encounter at the Hillbrow Hospital Head Injury Outpatient Clinic staffed by the University of South Africa's Health Psychology Unit. A careful diagnostic interview was conducted with the family in which a young man had had a disruptive personality change after a head injury, and after 30 minutes (not a long time for such an interview), the mother, a fiery lady, burst out, "We came here to be treated, not for this workshop!", and stormed from the room with her family in tow.

Robbertze (cited in Nell, 1993) has noted that the Department of National Health has paid no more than lip service to psychology's supposed parity of status with medicine, pointing out that psychologists are represented by psychiatrists at management and head office level. Psychologists who have worked in psychiatric settings repeatedly complain that little professional credibility is given to their reports, vacant posts for psychologists remain unfilled, and no action is taken against psychiatric hospitals that are in breach of the internship training regulations laid down by the Professional Board for Psychology (Nell, 1993).

The position of welfare under conditions of medical domination is no easier. Freeman (1993:9) who has consistently advocated for a unitary department of health and welfare, within which he believes mental health services should be located, has frankly recorded the views of welfare worker informants, who expressed the view that "welfare workers are dominated in their relationships with doctors", and that "where there is one department [of health and welfare], welfare is seen to suffer."

These issues come to a nice focus in an anecdote that emerged from a Pretoria workgroup in June 1993 to debate a new mental health policy for South Africa. One of the psychiatrists present, having listened with increasing irritation to the views on the medical hegemony outlined above, turned on the writer with some heat and asked: "Who are these dinosaurs that you are hunting?" The flip answer would have been that as a long-time resident of Jurassic Park, he was excellently qualified to answer his own question. The serious answer is that the debate is not about dinosaurs and humanoids, or about "good" and "bad" doctors, but about a system so powerfully structured that it makes dinosaurs of the kindest people and the best intentions. The task is not dinosaur hunting, but the restructuring of a destructive system.

Under these historical circumstances of the continual undercutting of nonmedical human services by the medical profession in South Africa, and many other countries, there is a powerful case for rejecting the health lobby's insistent arguments on spurious grounds of cost and client convenience for a unitary health-welfare-mental health department. Freeman (1993) has no evidence for his claim that one ministry will be cheaper than two; and given the computational infrastructure of modern states, the transfer of client information between departments no longer requires the use of tattered cardboard-and-paper files.

Wayne Holtzman (personal communication, 10 November 1993) notes that the development of a unitary United States federal government department of health and human services has been an evolutionary process. The state of Texas still has separate health and human service departments. Holtzman states:

"If you have a single department of national health and human services, including mental health, there is a real danger that the urgent health problems of the country will receive all the attention to the detriment of the equally important mental health and human service needs of the population. While it is true that eventually a single department may prove more effective at the central level, there is no reason that you should necessarily start out in this manner.
Evolution of mental health systems here and elsewhere generally follows a course that balances central funding and the promulgation of guidelines and standards with a significant amount of local control and initiative. Consumers (the general public as well as patients) must eventually participate in future planning. ... Central initiatives [must] recognise local diversity and control while using central funding to encourage the development of appropriate mental health services and standards. Neither traditional clinical psychologists nor physicians are likely to have the training, experience, and value orientation essential to sound community mental health initiatives. Leadership is more likely to come from community-oriented social workers, nurses, and others who have already had front-line experience.
Providing funds for matching with local initiatives and recognizing extreme diversity at the local level would also be politically sound at this stage in your evolution."

Comprehensive Help and Guidance Centres.
The creation after the April 1994 elections of a separate national department of welfare is probably to be attributed more to the strength of the social worker lobby within the African National Congress than to the ideological considerations set out above. Though this is a step toward achieving autonomy for nonmedical human

services, it fails to address the underlying problems arising from what might be termed the hypermedicalisation of the health care system, and the resultant skewing of service delivery to physical interventions even at the primary health care level.

The second of the propositions for critical psychologists is thus to advocate for the creation of a new state department of human services that is independent of the medical profession and does not by its name give primacy to one profession (such as social work) over others. This Department of Human Services will create a site of development and a central government source of matching funding for the widest possible range of nonmedical wellbeing services, which will include all traditional welfare services.

At the local level, I am proposing that these services be delivered through a network of Comprehensive Help and Guidance Centres (an alternative though less readily comprehended name might be "Comprehensive Human Service Centres").

These centres would be staffed by the widest possible range of professionals, some full-time and others on a sessional basis, for example, social workers; psychologists trained in the traditional modalities and also as community psychologists; vocational guidance and vocational rehabilitation specialists (some with experience in the reskilling of the unemployed); counsellors with special skills in mothering, parenting and abuse prevention; injury prevention experts; occupational therapists; skilled networkers able to build youth agencies and adult services; and paralegal workers who will channel access to the criminal and civil justice systems.

An essential component of the staff of the Comprehensive Help and Guidance Centres, to be established as free-standing institutions in urban areas, but attached to the existing health clinics in rural areas, will be primary health care nurses who will be able to refer frank disease manifestations to the nearest health clinic. In parallel, the screening procedure at health clinics will be informed by the range of services available at the Comprehensive Help and Guidance Centres, cross-referring so that the illness burden falls outside the health system. It is proposed that each Help and Guidance Centre serve some 300 000 to 500 000 people. The Johannesburg-Soweto Complex would thus have 4-5 such centres and each would have a referral base of 10-15 primary health care clinics, plus other referral centres in the community. Services would be targeted at non-psychiatric clients with life problems or crises. Such persons will probably also have marked somatic symptoms, but there will in addition be a clear burden of psychological distress. Referral source education will focus on the need to avoid exclusively physical treatment of such clients.

Once the initial screening by a primary health care nurse ascribed above has been completed, clients will pass to a Centre worker familiar with the skills of the various providers in the clinic. The initial interview will take place directly after intake to develop an intervention plan. Thereafter, individual treatment and counselling will be held to a minimum, and the client(s) moved to activity centres with group formats in which more effective use can be made of scarce skilled resources than in individual therapy.

The Centres will provide women and child abuse services including referral in acute cases to a shelter; activity and discussion groups for teenagers, the unemployed, single

parents, physically handicapped, and other target groups as required; small business development; and youth workers skilled at drawing on outside agencies such as scouts, high adventure groups, sports coaches, hobby teachers, and so on.

Implications of the proposal.
Medical gatekeeping to human services will be replaced by a system better able to avoid physical treatment of psychological distress. Clients of the helping professions are too often infantalised by professionals, whereas, on the contrary, they soon learn their way around the available systems. It is anticipated that clients will increasingly self-refer themselves to the medical health care system or to the new Comprehensive Human Service Centres as appropriate, and that such self-referral will in most cases reflect well-informed and correct choices.

At the same time, a broad base will be established for the development of a full range of human services, within which non- governmental organisations could be accommodated.

Cost-offset benefits will accrue through the avoidance of expensive medical treatment and the reduction of client loads at clinics. No accurate cost data on health services in the public sector are available in South Africa, so that it is not possible to calculate cost-offset data, that is, the net saving to the system that arises from raising a debit for the introduction of new services and crediting against it the cost savings that result. United States cost-offset data (available on request from the author) show that the introduction of psychological services (and by implication, other human services) to medical health care settings results in substantial savings to the health budget. In South Africa, similar evidence on the cost benefits arising from the introduction of psychological services to two Health Maintenance Organisations in Port Elizabeth is available (Vernon Sack, personal communication, January 1994).

PROPOSITION 3: TO REMAIN A SINISTER INTELLECTUAL.
The third and last proposition is always to remain sceptical of state power and the perceptual transformation wrought by power in those who accede to it. Science is not a value-free enterprise, and the old distinction between science and politics (for example, Biesheuvel, 1987) no longer holds. However, Chomsky's Bakuninian warning against "responsible" intellectuals who place their science-knowledge-power at the service of state power has great weight in a post-revolutionary society, but in a strictly limited sense. The promises made in the name of redemptive politics (it is hope that makes revolutions) deserve to be, and must be taken seriously. That there will ultimately be a betrayal is beyond question - the mechanisms of greed and power are in the end irresistible, especially in the developing countries which lack any serious understanding or application of political accountability.

But until betrayal comes about, redemption must be given a chance. For that purpose, a state needs responsible intellectuals who may not refuse when called upon to serve the cause of the greater good. The limited sense in which Chomsky's warning must be heeded is that when intellectuals enter political service, as advisors or as office holders, they are constrained to lay aside their critical mantle of intellectual autonomy, openly acknowledge that they have become "responsible intellectuals", and that they now operate in the world of the possible, constrained more than liberated by power. *The*

failure to perceive that this dizzy transition from autonomy to responsibility has taken place explains an episode at a meeting of progressive psychologists in Johannesburg to debate mental health policy, at which one of the old OASSSA soldiers, who has played a major role in shaping ANC mental health policy, and had listened with increasing irritation to the views set out in Propositions 1 and 2 above, finally burst out: "This stuff is maverick nonsense! We're trying to make policy here!"

So does responsibility silence the sinister voice!?

This third proposition thus requires that the sinister intellectual - literally, those who choose to remain perpetually to the left of government - forcefully, and if necessary, rudely remind those who have become responsible that they no longer speak with the critical voice of autonomous intellect.

Notes.

1. Guided by a human welfare value system that consciously favours the social underclass.
2. Disease is a physical condition produced by identifiable pathogens, while illness is the person's subjective sense of the absence of wellbeing.

REFERENCES.

African National Congress (1994) A national health plan for South Africa. Johannesburg: Author.

Albee, G W (1986) Toward a just society: Lessons from observations on the primary prevention of psycho-pathology. **American Psychologist, 41**, 891-898.

Baer, H A, Singer, M & Johnsen, J H (1986) Toward a critical medical anthropology. **Social Science & Medicine, 23**, 95-98.

Biesheuvel, S (1987) Psychology: Science and politics. Theoretical developments and applications in a plural society. **South African Journal of Psychology, 17**, 1-8.

Chomsky, N (1978) **Intellectuals and the state.** Leiden: Het Wereldvenster.

Dawes, A R L (1986) The notion of relevant psychology with particular reference to Africanist pragmatic initiatives. **Psychology in society, 5**, 28-48.

Freeman, M (1993) Governmental structure for mental health: A proposal. Unpublished paper.

Galbraith, J K (1992) **The culture of contentment.** London: Sinclair-Stevenson.

Kamin, L (1993) The temper of the times. Review of Reiss, A J Jr & Roth, J A (eds) "Understanding and preventing violence". **Readings: A Journal of Reviews and Commentary in Mental Health**, December, pp4-7.

Mgoduso, T & Butchart, A (1992) Authoritarianism and autonomy. 2. Power, politics, and alienated nursing care in a South African Primary Health Care System. **South African Journal of Psychology, 22.**

Miller, T & Swartz, L (1990) Clinical psychology in general hospital settings: Issue in interprofessional relationships. **Professional Psychology: Research and Practice, 21.**

Morgan, L M (1990) International politics and primary health care in Costa Rica. **Social Science and Medicine, 30,** 211-219.

Navarro, V (1984) A critique of the ideological and political positions of the Willie Brandt report and the WHO Alma-Ata declaration. **Social Science and Medicine, 18,** 467-474.

Nell, V (1993) **Toward community policing in South Africa.** Johannesburg: University of South Africa Health Psychology Unit, Technical Report 93/1.

Nell, V (1993) Structural blocks to a liberatory psychology in South Africa, in Nicholas, L (ed) (1993) **Psychology and oppression: Critiques and proposals.** Johannesburg: Skotaville.

Nell, V (1992) The case for an independent licensing board for psychology. **South African Journal of Psychology, 22,** 228-239.

Nell, V (1989) Health care and psychology in South Africa will be damaged by the introduction of middle level psychologists. Supplement to **Newsletter of the Psychological Association of South Africa,** 4/89, Pretoria.

Nell, V & Brown, D S O (1991) The epidemiology of traumatic brain injury in Johannesburg. II. Morbidity, mortality and etiology. **Social Science and Medicine, 33,** 289-296.

Nell, V & Seedat, M A (1993) **An Accountability Foundation for South Africa: Bottom-up and top-down accountability initiatives.** Johannesburg: University of South Africa Health Psychohlogy Unit, Technical Report 93/2.

Nell, V, Seedat, M A & Williamson, G (1993) **Community safety and community policing: Bottom-up and top-down accountability initiatives.** Johannesburg: Centre for the Study of Violence and Reconciliation, University of the Witwatersrand, Seminar No.6.

Samuelson, L (1994) Waiting for Dogot: 3. Apocalaphobia. **South African Journal of Science, 90,** 6.

Sarason, S B (1981) **Psychology misdirected.** New York: Free Press.

Scharf, W (1989) The role of people's courts in transitions, in Corder, H (ed) **Democracy and the judiciary.** Cape Town: IDASA.

Schepers-Hughes, N (1990) Three propositions for a critically applied medical anthropology. **Social Science and Medicine, 30,** 189-197.

Seedat, M A, Butchart, A & Nell, V (1991) Family therapy in primary health care: Skills training and outcome evaluation. **Contemporary Family Therapy, 13**, 143-163.

Seedat, M A & Nell, V (1992) Authoritariansm and Autonomy. I. Conflicting value systems in the introduction of psychological services in a South African Primary Health Care System. **South African Journal of Psychology, 22**, 185- 193.

Seedat, M A & Nell, V (1990). Third world or one world: Mysticism, pragmatism and pain in family therapy in South Africa. **South African Journal of Psychology, 20**, 141-149.

Seedat, M A, Butchart, A & Nell, V (1991) Family therapy in primary health care: Skills training and outcome evaluation. **Contemporary Family Therapy, 13**, 143-163.

Swartz, L (1989) Aspects of culture in South African psychiatry. Unpublished doctoral dissertation, University of Cape Town.

Swartz, L (1991) The reproduction of racism in South African mental health care. **South African Journal of Psychology, 21**, 240-246.

Werner, D (1977) **Where there is no doctor: A village health care handbook.** London: Macmillan.

Whiteford, L M (1990) A question of adequacy: Primary health care in the Dominican Republic. **Social Science and Medicine, 30**, 221-226.

World Health Organisation (1978) **Report of the international conference on primary health care, Alma-Ata.** (Declaratioh of Alma-Ata). Geneva: Author.