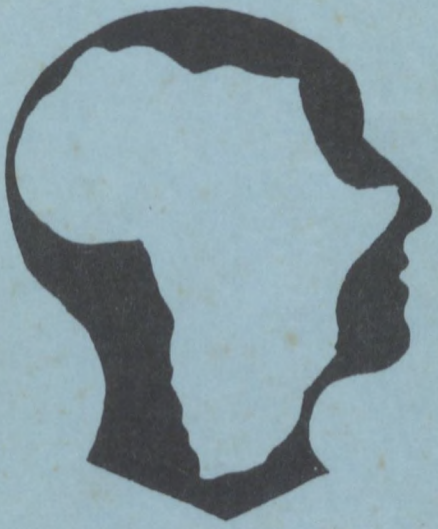
PSYCHOLOGY IN SOCIETY



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PSYCHOLOGY IN SOCIETY NUMBER 11 DECEMBER 1988

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EDITORIAL

This issue, put together by the Cape Town editorial group picks up, in each of the contributions, themes which have been aired in earlier numbers of Psychology in Society, providing a picture of some continuity in areas of discussion for those concerned with a progressive view of psychology. If there is a common theme in the papers constituting Issue No 11 then it is to be found in a perspective of conceptual unravelling. Most of the papers are concerned with attempting to think more clearly about the terms and concepts which have already emerged as cornerstones of a more critical and socially concerned psychology in South Africa.

Kottler takes up two important concepts of professionalization and African medicine and does good work in examining the discourse surrounding them. Solomons looks behind the descriptive category of post-traumatic stress disorder in detainees and starts to theorise about dynamic mechanisms. A "community psychology" approach has been widely tossed about as a "solution" to the overemphasis upon individualistic and clinically orientated perspectives: Seedat and Cloete offer some useful unravelling in this important area. Bulhan's book on Fanon and the psychology of oppression has already been well received in South Africa. Couve offers a probing and critical analysis of this book and also raises significant questions regarding this central topic. Shefer continues the theme of providing comparative views on mental health models, while Bentley gives strong views on what cross-cultural psychology in South Africa should be about in a review of Alexis Retief's recent book.

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Professionalisation of African Healers: Apparent problems and constraints

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INTRODUCTION

There is much talk afoot about the professionalization of African healers (or African medicine) but there is little evidence of any attempt to deconstruct the notions involved. I will examine the terminology and the assumptions embodied in a question which is commonly posed: What constraints are encountered in attempts at professionalization of African medicine? I then present three different positions from which to view African medicine, postulating that unless the different positions are acknowledged it remains impossible to address the question. Finding difficulty too with the notion of professionalization, I describe various ways in which the concept is viewed. Only after this 'deconstruction' do I attempt to directly discuss some of the problematics raised by the question. By this stage it will have become obvious to the reader that there is no single answer. Instead there are possible answers from each of the positions I outline. I point to a possible view that members of the 'western' medical profession perceive African medicine as 'matter out of place' and briefly outline this perspective. I suggest that, from this position, the solution to the 'problem' is found in the idea of professionalization - i.e. in cleansing and purifying the polluted. My final thesis is that the process of professionalization is a rite of passage. This paper highlights that attempts at professionalization of African medicine involve not only a range of positions but also some hidden agendas.

From a particular position, the question I examine can be seen as encompassing unselfconscious dogma. Anyone occupying the position from which it originates conveys that they know, and know that the reader knows

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what they are referring to; 'African medicine' is something clearly identifiable and the people who practice it are not professionals. This concept is generally used unselfconsciously. As a consequence, anyone who asks about constraints encountered in attempts at professionalization presumes that there is no doubt in anyone's mind that there exists a concrete, discrete and clearly bounded system of practices which comprise African medicine. The implication is that anyone to whom the question is addressed will know exactly what is meant by African medicine and that as such it is something only 'Africans' can experience and perform. Such a position might also imply that the system could be extended to apply also to 'traditional','tribal', 'non-western', 'irrational' groups of people found outside Africa. What I am drawing attention to is the argument that asking such a question is suggestive of an ethnocentric bias. It tells us more about the position from whence it comes than it does about African medicine. The wording of the proposal to professionalize is suggestive of stereotypic and dualist thinking - of the kind suggested by Sharp and West (1982).

The meaning of professionalization is assumed to be quite clear and the move is assumed to be an obvious and natural route for progress. There is an insinuation that the people who practice African medicine are resisting (ignorantly?) this obvious and desirable path to 'advancement'. Implicit in the idea is Durkheim's extremely problematic stage theory of human development - of the childish, irrational and superstitious belief in magic (primitive science), followed by the priestly and politically fraudulent belief in religion and finally the mature, rational belief in science (Douglas, 1966).

Suggestions for the professionalization of African healers come from not only a belief in this last so called mature and rational phase, but also with the belief that it is quite natural to be firmly rooted in such a system. The notion of 'professionalization' is a construction; the word describes the process whereby legal sanction is given to people assumed to have 'specialist knowledge' which entitles (forces?) them to membership of the society (profession). The end result is one in which the profession is able to monopolize members' 'services' (Helman, 1984). It seems to me that professionalization is a method by which boundaries are set up with the result that certain people are defined in or out. This also has significant implications for later discussion.

The issues to be discussed must be seen from at least two perspectives - though there are possibly other positions from which to view this "landscape" (Sless, 1986). One outlook would seem to subscribe to the ethnocentric thinking I have suggested. A second would not. My choice here is to move between these two positions and attempt to comment on the range of views expressed. My chosen stance means that much of what I posit will reflect my own interpretation of what has been said by the various authors from whom I have drawn. It is mostly informed by two seemingly distinct positions, neither

of which I am happy to discard.

My position is influenced by the literature available and by the positions taken by the anthropologists I have encountered. Much of the literature originates (not surprisingly) from within institutional frameworks. This is not unproblematic because much of it subscribes to unquestioning notions of "norms" based on samples of white middle-class college students, scientific thinking, professionalization, and progress.

One of the positions referred to above attempts to be value free. It is relativist and stems from within institutional walls and is informed by "mainstream" theories. It respects the various methods of healing and sees them as relatively separate, different and discrete (e.g. Last and Chavunduka, 1986). I shall refer to this position under the heading of "differences". The second perspective also originates from within institutional walls but its focus is different. It looks for similarities rather than differences. It argues that Western medicine is not devoid of ritual nor is it scientific. It argues that medicine is tied into the social system and reflects and perpetuates the 'norms' of the social system. It is skeptical of the idea that there are two separate systems arguing that non-scientific explanations of misfortune are found outside Africa and African medicine. Examples would draw from Comaroff's (n/d) study of the explanations given by the parents of children with leukemia. The "similarities" position postulates pluralistic medical systems and in viewing them, takes serious account of the actions of those who use the services offered to the patient (Janzen, 1978). It is noteworthy that much of the literature ignores this detail. We cannot assume that patients see discrete systems of medical services, something for which there is little (if any) evidence (Boonzaier, 1985).

Thus far I have attempted to illustrate that there are two ways in which the question could be viewed. Each in isolation appears logical but to attempt to take account of both becomes hugely problematic. This is a significant point in the field of the social sciences S.A. today, where these polar opposites are continually meeting physically but not intellectually. The issue is important for psychology and some resolution must be worked out. Without access to this kind of debate, researchers and students will have to tap dance between the two positions. I now focus on the next problematic concept: what is African medicine and what are African healers?

To answer such a question depends on the position from which one speaks. It therefore depends on who you ask. There are a range of perspectives from which to view this kind of medicine, but because Western medicine seems to be viewed as the dominant 'system', attempts to define African medicine immediately sets up distinctions - 'theirs' and 'ours'. In spite of what is suggested by much of the literature, African medicine is not something which

can be easily systematised. The term has been used to describe a range of healing practices. Most often the differences between such practices and western medicine have been described at the expense of the similarities, hence a distorted picture has been presented. Furthermore, as a result of interaction with different systems there have been modifications to African medicine but such changes have often been ignored in the literature. Looking at some examples elsewhere it is noteworthy that Janzen (1978) describes how whenever he returns to Zaire he is impressed by the apparent transformations but that a few "conversations with old acquaintances usually suffices to persuade (him) that little has changed at all" (p.xvii). Also, transitions do not necessarily move in the direction of Western medicine. Ngubane (1986) points to dramatic changes in the social structure which have resulted in increased ritual killings in Swaziland, a practice which is by no means similar to that of Western medicine. Such information has persuaded me to resist over-emphasising similarities at the expense of differences.

THE "DIFFERENCES" POSITION

Descriptions of African medicine can be broken into at least three main postulates. The first suggests that it is wholly different to Western medicine (seen as 'professional' medicine). It would probably classify African medicine as that which falls within Kleinman's (1980) folk sector. This covers all those practitioners who are not given full legal status or sanction in any given society. It is suggested that in this sector the practitioner and client share the same views, beliefs, values and explanatory models (Helman, 1984). Patients generally speak the same language as the practitioner who is generally known to them and works in familiar settings with whole families involved, i.e. therapy management groups (Janzen, 1978). This view is not uncommon but is problematic. It can lead to either a romanticized view of African medicine (e.g. Buhrmann, 1980) or one in which it is seen as inferior, ignorant and based on a belief in the supernatural (in Wilson, 1980). Discounting evidence of this in their own society (in e.g. Comaroff, n/d), supporters of this essentially Western position would argue that within African medicine (and only African medicine) explanations are given in terms which are magical, primitive and irrational. Such a dichotomy is a product of Western thought. This is clearly demonstrated in a recorded conversation between an Mbundu rainmaker and Dr. Livingstone (Janzen, 1978, p.38-40).

The terminology (I refer only to English texts) used by proponents of this position includes notions of for example, 'witchdoctor' - generally value-laden and used incorrectly (Ngubane, 1988a). It is thus unacceptable from any of the positions I describe later. An alternative word is a 'diviner' - again problematic because of the wide range of such healers. Ethnographies have attempted to distinguish between the 'diviner' and the 'herbalist' suggesting that there are two kinds of categories. One is either psychic or natural, the other good or evil. The diviner is both psychic and good; the herbalist is

natural and good; the witch is evil and psychic and the sorcerer is natural and evil. Clearly this view is problematic - something which is pointed out by those subscribing to the second view which I portray later.

I have sketched a perspective which focuses on the differences and on the disasters, failing to acknowledge that others systems share similar practices and also disappoint. The view I have described however, persists in asking questions of the efficacy of African medicine. For example: do any of the techniques work? Is there any formal training? What do practitioners charge? How much time do they spend with patients? Can practitioners recognise obvious diseases and do they refer patients to practitioners of Western medicine if they are unable to help? Why is it that African women consult with Western doctors only when they have advanced states of cancer? Many of the questions are biased in favour of Western medicine; the answers will locate it in good light. Evaluation is difficult and answers to each of these questions will vary, depending on the position held (Sless, 1986). There is a difference between for example, the efficacy of the contraceptive pill as against its lack of effectiveness in a country such as S.A. (Cochrane, 1984). Further, Western medicine has been known to appropriate and synthesize herbal remedies used elsewhere, e.g. quinine. There is no recognition of problems of availability of practitioners, transport costs and services (Westcott, 1979) or the notoriously bad treatment given to African women in the hospitals (van Selm, 1984). Neither is recognition given to the perception that many Africans who have been treated by practitioners of Western medicine have died (Ngubane, 1988b). But, such answers can be misleading in that they could be interpreted to suggest that African perception is different - a dangerous notion for the servants of apartheid who can use the idea to support the commonly held belief that ignorance is related to 'race' (Colman, 1987). What is overlooked is that there are many non-Africans who fail to keep appointments or who choose not to undergo chemotherapy and radiation treatment because they believe it will substantially reduce the quality of their life.

There is a need to look not only at the patient's perspective, position and prior experiences but also to ask how the various 'systems' distinguish between empirical ills and social ills (Ngubane, 1988a). The following scenario might help to illustrate my point. Practitioners of African medicine do recognise obvious diseases, for example tuberculosis. But, which of Western or African medicine can treat it more successfully? Western medicine can treat it in the short term by dispensing appropriate medication and giving sufferers the rest and food they need. However, in the long term the condition will recur. The symptom has been cured but not the cause. What might African healers do? It has been suggested that a practitioner might claim that the disease is a punishment for the misdemeanors of the father (who is unemployed and drinks heavily). Since families are involved in treatment (Janzen, 1978) it is

plausible that the father will stop drinking. As a result he might obtain employment which means that the family might have more money and consequently more food etc. This then suggests that African medical practices might provide a better long-term solution or cure (Frankenberg and Leeson, 1976). In this way, contrary to Western practices, African medicine is not taking lifes problems and medicalising them (Kennedy, 1980).

What I have been arguing for is the obvious need to ask different kinds of questions. For example, why is there a range of healers available and why do people consult them as they do? Such questions are asked by those who subscribe to the "similarities" view and bear significant relation to the question of professionalization or integration.

THE "SIMILARITIES" POSITION

This position would suggest that rather than look at the differences, the strengths and weaknesses of the particular systems should be considered (Boonzaier, 1988). Explanatory models, i.e. how people interpret illness and to what extent the healers explanation differs from that of the individual patient should also be studied (Helman, 1984).

In this second position African medical practices would probably also be classified within Kleinman's folk sector. The healers are not seen as homogeneous nor as professionalized to the same extent as they are in viewing Western medicine. There is a vast range to be identified and the kind of terminology mentioned earlier is again a problem for similar, but also for additional reasons. The terminology does not allow for the recognition of continua of types of healers. Practices are not seen as discrete. Further, as well as being value laden the terminology tells us more about the user than that which is observed; divisions are seen as attempts to divide according to problematic notions of for example, 'western', 'rational' and 'scientific'. As a consequence it is argued that there is a whole range of exaggerated and misleading images of African medical practices.

This position argues that the practices of African medicine are not static. It points to the many changes which have been observed, for example those found within the practices of the Prophets and healers within African Independent Churches (West, 1975). It also points to the danger of focusing narrowly on the healer and then generalising from this to the whole, e.g. Buhrmann (1984) who studied only "the Tiso school". This is an extremely small group of indigenous Xhosa healers (amagqira, translated as "indigenous healers") from which Buhrmann generalizes to such an extent that she draws comparisons with Senghor in West Africa. Such a position does not take account of the possibility that individual practitioners could differ in the way they practice. It also fails to consider the importance of looking at what patients do (i.e. consult different kinds of healers).

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As one of the few authors who does acknowledge patients' roles in this landscape, Last (1986) describes African medicine as "medicine of whatever kind available to the patient in Africa" (p.5). By definition it includes "not only all the varieties of 'traditional medicine' but all the varieties of non-traditional medicine, too, whether Islamic, homeopathic or 'Western' ... (which is not a) .. strictly disciplined system (nor are) its practitioners ..part of a single hierarchically-organised profession ..." (p.5). Clearly there is no doubt in Last's mind that medical pluralism exists. As such, there are in all societies differently designed and conceived medical systems (Janzen, 1978, p. xviii). Boonzaier (1985) and Last (1981) have suggested that patients will have consulted with each at some point, distinction between 'systems' is clearly made mainly by healers and scholars; boundaries are easily transcended by patients. Surely then, whether or not the 'system' is professionalized is not of major concern to the patient, most of whom I suggest are generally not even aware of the implications of professionalization. Few are aware of their rights or of the ethical codes and duties of members of the profession.

This second position also warns that there might be negative consequences as a result of the professionalization of African medicine. An example of such dangers is given by Boonzaier (1988) who argues that Western medicine might react by re-structuring their field in such a way as to choose their domain more specifically. This could involve a failure to take responsibility for firstly, the whole patient, suggesting that certain aspects would be better handled by the practitioners of African medicine. This is already true of Western medicine relative to e.g. social workers, physiotherapists etc. (Comaroff and Maguire, 1981). Secondly, Western medicine might attempt to deny responsibility for African patients, justifying this by arguing that African patients should seek medical advise from practitioners of African medicine.

A THIRD POSITION

Displaying commonalties with both positions discussed so far, there is a third position which does not derogate African medicine, nor is it romanticized. The position acknowledges similarities between African and Western medical practices but points to the differences, presenting the practices in a manner which suggests that they are relatively static and clearly bounded systems. In this sense then this position is similar to the first but in opposition to the second. This view does not seem to attempt to classify African medical practices in terms of Kleinman's (1980) three health sectors. Instead it sets out distinctively different kinds of healers. Chavunduka (1986) lists eight main categories of traditional healers in Zimbabwe. Ngubane (1988a) refers to five in Southern Africa (as compared with Buhrmann's (1984) suggestion that they are all the same - igqira, meaning "indigenous healer"). They are as follows: there is first the diviner (also known in the literature as a sangoma). The diviner is "pure" and does not use "death medicines". She is always a

woman, is a custodian of morality and might be compared with a western priest. She deals with spirits and, to the extent that she understands "medicine" in an empirical sense, she is a doctor. She is also a psychologist, in that she talks with the patient at great length. Ngubane (1988a) describes her as a theologian (or philosopher, sage, or wise woman); she "interprets the world". She is innovative in terms of the interpretive nature of her skills which adjust to the changing times and social practices of the people with whom she works.

A second kind of healer is known as an Inyanga who is trained only in "medicine". The training does not incorporate any rites of passage as is found in that of the diviner (Ngubane, 1977). Inyangas work in a competitive way as individuals. They do not share their knowledge and therefore would, according to this position, be difficult to professionalize (Ngubane, 1988a).

A third type of healer is that which is referred to as the specialist Inyanga, e.g. *inyanga yomhlabelo*, the *inyanga* who deals with fractured bones (Ngubane, 1986, p.191). The required knowledge is passed on to "chosen" family members through generations and is based on straightforward "scientific" information. Professionalization will involve a need to patent these skills if such healers are to continue to play the same kind of role in the medical system as a whole (Ngubane, 1988a).

A fourth practice is that of Faith Healing. Connected with religion, such healers work with the social practices of the people who consult them. They therefore deal with problems encountered in the social lives of the patients. They do not give up their religion to become for example, Christian. They use mostly white medicines, wear a lot of white but they also use and wear other colours, for example, red, green and blue. Each colour signifies something depending on their strength or intensity, a notion dealt with by Ngubane (1977). For example, red softens black and leads towards white. If too much white is used it points to abnormality because there is a suggestion of too much purity. Green and blue (in Zulu the same word) are used therefore to soften white (Ngubane, 1977). These aspects are clearly distinguishable to those who know what to look for.

There are clearly so many differences and similarities that to professionalize would surely change the very nature of the whole set of practices (Fyfe, 1987, pp.5-17). These issues are discussed in the sections which follow. First, there is another concept to be looked at closely.

WHAT IS "PROFESSIONALIZATION"?

Members of a profession are given legal sanction within the society in which the profession is formed. In India and China traditional medicine has been given legal sanction; it is therefore professionalized (Helman, 1984). In

Southern Africa, Western medicine is professionalized and like the medical profession everywhere it is in fact the epitome of a profession (Foster and Anderson, 1978). This is a significant point because professionalization is controlled and has certain implications for the society in which it occurs (Freidson, 1970b). There are therefore different ways of viewing the concept 'professionalization', each of which depends again on the theoretical notions to which the viewer subscribes.

A first descriptive position might highlight that to gain membership involves particular skills and prolonged training in which a specialised body of abstract knowledge is imparted (Helman, 1984). This suggests that the profession itself guarantees certain minimum fees and salaries to its members. Professions also form associations or governing / controlling bodies and establish for themselves codes of ethics. There is an orientation towards service; members provide skilled services or advice but no products. Finally, most members are of the opinion that their work is a "fulltime, lifelong undertaking" (Foster and Anderson, 1978).

What the descriptive position fails to consider are the various characteristics associated with professions in general. Firstly, the profession decides its own standards of education and training (Helman, 1984). Student professionals go through a very extensive socialisation process over and above the professional training (Helman, 1984). For example, medical students learn how to conduct themselves as medical students, how to dress appropriately etc. Lectures are given to them on these subjects. Medics can only practice if they are registered with the controlling body - in S.A., with the S.A. Medical and Dental Council. This body also controls a range of other professional bodies (Louw, 1986). This fact is one which Boonzaier would presumably insist on being considered in discussions relative to professionalization of African medicine. This is because he argues that professionalization of African medicine might only occur on terms dictated by Western medicine who will therefore take control (1988). The notion of control is significant also to the fourth characteristic which suggests that most of the legislation affecting the profession is shaped by the members of that profession and which is, in S.A. given Statutory powers (Louw, 1986). As a consequence it is logical to argue that the occupation gains in income, power and prestige (Freidson, 1970a).

A vicious circle ensues. The profession attracts a 'higher calibre' student (in effect a member of the privileged few who have been appropriately schooled for such professions), only the best of whom meet the required standards (set by the profession). This justifies the argument that the training requires a 'better' student - a powerful mechanism to exclude certain people from the profession. These facts have significant implications for the 'professionalization of African medicine'.

A functionalist view of professionalization might argue that the profession is located within a wider social system and that it provides vital functions within the society as a whole. Proponents to the position would argue that the profession evolved because it is the natural and only way. Expert knowledge is essential and is used in the interest of society to prevent exploitation. The control of such a profession is necessary for its commitment to the maintenance of health and it is in the interests of patients. It is because the services of the profession play such a vital role that the status and the financial rewards are high; members are fulfilling their natural role in society and because the responsibility is great so too should the income be high.

Arguing strongly against this is a more radical position which disputes first that professionalization is a natural or rational outcome of knowledge. There is no natural evolution; the medical profession is the outcome of a historically specific process in which there was conflict of power among a number of different interest groups, for example the developed versus the underdeveloped and the urban versus the rural. Since the interests of the dominant group are served by the medical profession, this is the one which is given legal sanction (Doyal and Pennell, 1979). Historically, there have been other perhaps less obvious sources of conflict involved, for example groups of psychologists, nurses, physiotherapists, naturopaths (Louw, 1986). I suggest that the practitioners of African medicine could be added to this list. The postulation is that in the light of the existence of these 'alternative' practices, medicine itself becomes an interest group struggling for status and wealth. From this position, the dominant elite and the State are seen to have given autonomy to Western medical practices. The profession then, is a way of organizing in a manner which reflects the dominant values and power structures in society. The training is necessary to limit the numbers of practitioners. The kind of knowledge imparted creates a distance between the practitioner / producer and the patient / consumer (Doyal, 1979). Language is mystified unnecessarily (Klein, 1979). As a consequence the doctor is seen to occupy a relatively more powerful position. Further, because the organised profession acts as one body, individual patients are powerless when it comes to complaints against practitioners. The medical profession is free from the control of the lay person (Doyal, 1979). Malpractice suits require evidence from another practitioner but in terms of the codes of conduct it is unethical to criticize another member (Kennedy, 1980). A member of the public therefore stands little chance of succeeding in such a suit. The profession then serves to re-enforce the positions of power, wealth and status of its members, not necessarily the health of the society at large (Doyal and Pennell, 1979). It is with these thoughts in mind that Boonzaier (1988) argues for special consideration when discussing the professionalization of African medicine. There is surely no benefit to be had for anyone but the members of the profession if these negative characteristics are taken on board uncritically.

A materialist approach to the concept of professionalization might suggest that the power of the profession is intimately tied up with the requirements of the economic system. To be successful it is dependant upon clientele and operates then on the principles of supply and demand. But it also has the ability to perform functions of social control (Doyal and Pennell, 1979). It can validate a person's subjective feelings by issuing a sick note (Klein, 1979). In S.A. this aspect is important because Western medicine translates collective political and social problems into biological, individual ones. This is illustrated in the distribution of disease in the country (Goldblatt and London, 1981). Many of its less enlightened members persist in arguing that disease is caused by germs which act independently of any socio- political factors. The implication of this kind of thinking is that the rampant ill health of many in the 'townships' (WIP, 1982) is caused by ignorance and dirt. Since all the inhabitants of the 'townships' are African, the next insinuation is that all Africans are ignorant and dirty. This is what gives rise to the common belief that disease in S.A. does not strike at random, but along certain colour lines. This opinion is clearly absurd and dangerous.

WHAT CONSTRAINTS ARE ENCOUNTERED IN ATTEMPTS AT PROFESSIONALIZATION OF AFRICAN MEDICINE

I have touched on this question in various ways. I have indicated that the question posed forces a position from which to view the landscape - from the perspective of someone who subscribes to a belief in the justifiable dominance of Western medicine, to the notion that African medicine should be professionalized and which believes that for some inexplicable reason, its practitioners are resisting it. This is a paradoxical situation because professionalization is argued to offer its members more advantages than disadvantages. It is therefore logical to expect that decisions to professionalize would come from within the ranks of those entitled and not from without - the literature highlights the struggle many professions have had to gain recognition (e.g. Napoli, 1981). But, what has been overlooked in this view is that the proposal for professionalization has come from the dominant elite. Why should this be so? I suggest that it might be because control is slipping away - their boundaries seem to have been transcended by other healers and it has become evident that patients do use other systems. In S.A. the professionalization of psychologists illustrates a similar history (Louw, 1986).

The discussion around professionalization of African medicine is also curious because in much of the literature on Africa there is evidence of organizations of groups of practitioners of African medicine which are similar to those of a profession. I do not want to make the mistake of over-generalising but point to evidence in Africa of associations, companies and / or co-operatives of African medicine (Semali, 1986; Chavunduka, 1986). In parts of S.A.

professional conferences are held to discipline and supervise what might be referred to as 'professional activity' (Ngubane, 1986, p.199). And, according to some discussion at the Medical Conference (1988) there is a register of 'traditional healers' kept by the Department of Labour in Pretoria. Whilst I acknowledge that this does not on its own, denote professionalization per se, I am still not clear as to the meaning of this term and there remain unanswered questions. Who wants to professionalize who and what exactly do they mean by this? Chavunduka suggests that professionalization is probably necessary for traditional healers not, as is expected, to improve their status, training etc., but for tactical reasons. He suggests that such a move would help prevent a situation in which traditional healers "remain politically powerless within or alongside a much more powerful system, and accept direction from planners, government and other 'full' professionals" (1986, p.267).

By now it should be obvious to the reader that constraints to professionalization (if there are any) depend very much on the position from which the landscape is viewed. I propose a particular argument which views the question from the position in which I probably feel most comfortable. I have also chosen to take a leaf out of Ngubane's (1986) book and present an argument which illustrates an extreme point.

My explanations thus far have indicated that there may well be resistance on the part of 'African' healers to be incorporated into the professional hierarchy of Western medicine and used to perform the more menial tasks at lower levels of status, pay etc. (Feierman, 1986). There is another way of looking at this situation which makes use of the literature on the subject of pollution and the notion of "dirt" put forward by Douglas (1966).

Applying Douglas' ideas I have suggested elsewhere (Kottler, 1988) that practitioners of Western medicine see African medicine as ambiguous and anomalous. In Douglas' terms Western medicine sees it as "dirt" in that it is "matter out of place". As such, African medicine makes practitioners of Western medical anxious. Since it cannot be ignored (because patients use it, because of the population explosion and because of the lack of resources) I suggest that there is a concerted effort on the part of Western medicine to change African medicine. An extreme way of doing so is to force on practitioners a particular process of professionalization - that of undergoing Western medical training. In terms of my argument, this will move African medicine out of its polluted state. I suggest that this will involve three phases: separation, margininalisation and incorporation. Those familiar with the ideas of van Gennep will recognise that I am referring to a process involving a rite de passage. Looking at medical training in this way has revealed striking similarities between this and the process of initiation described by Turner (1967).

This notion offers a somewhat unorthodox analysis of motivations to professionalize African medicine. An obvious consequence of this argument is to suggest that there are no constraints to professionalization of African medicine. Whilst there is an innocent suggestion that its professionalization is an appropriate move forward, one which is for the benefit of the practitioners, the people, and the country as a whole, this is not the whole truth; there is something else at play. My paper attempts to highlight that each of the concepts involved can be seen differently and that the arguments proffered by proponents of these positions can be used for different purposes. I have advocated that the issues which arise as a result of discussions about therapeutic services in a country should be looked at with less bias. Questions about professionalization of African medicine hide assumptions which have to be addressed.

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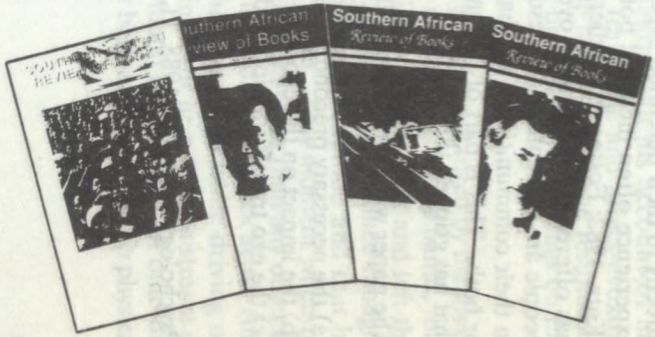

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A contribution to a theory of the dynamic mechanisms of Post-traumatic Stress Disorder in South African detainees

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INTRODUCTION

The theoretical formulations in this paper are derived from clinical experience in the Detainees Counselling Service in Johannesburg. This service is provided voluntarily by trained psychotherapists for people who have been detained on political grounds. The service emerged as a result of the growing realization that a significant proportion of ex-detainees suffered from debilitating and serious psychological sequelae which could be attributed directly to their detention experience. (Rasmussen, 1982; Lunde, 1982). This experience often included both physical and psychological forms of torture (Katz, 1982; Foster & Sandler, 1985). Over the past three years, the service has offered counselling to over 500 affected people. Increasing numbers of people are presenting as a result of traumas sustained outside the prisons and in their communities at the hands of security forces, rival political groupings, or both. This is part of the pattern of escalating political and social violence that has gripped the country.

The paper will examine the following:

(a) the necessary preconditions for the development of PTSD;
(b) the impact on the ego of serious trauma;
(c) the ego transformations induced by the trauma.

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Necessary Preconditions

The American Psychiatric Association's criterion for PTSD is a stressor that would evoke significant symptoms of distress in almost anyone (DSM III 1980). For Freud the element of surprise and a state of unpreparedness were essential factors in the development of a traumatic neurosis (Freud, 1920). Bluhme describes the density of the trauma and its degree of unexpectedness as determining the power of the trauma to cause effects (Bluhme, 1948). While these are no doubt accurate, local experience has shown that additional qualities of the stressor are invariably present among the ex-detainees with PTSD we encounter.

(a) In virtually all cases, ex-detainees reported feeling and thinking that the traumatic stressor was going to kill or severely and permanently damage and maim them. This sense of impending death was experienced at some point during the traumatic episode and not necessarily during the peak of pain.

In one young man who alleged to have been savagely beaten, the moment when he felt his imminent death came after the beatings. He was lying on the floor of the interrogation room, recovering from the beatings. He overhead a casual conversation between two of his interrogators in which they were discussing the pros and cons of killing him and disposing of his body. One interrogator was arguing in favour of killing him, the other was disagreeing and pointing out the inconvenience of an inquiry and the resultant publicity. It was overhearing this casual polite discussion that evoked in the detainee the sense of not just a significant stress but of his own imminent death. He realized how easy it would be for him to be killed and how close he was to that state (of his death). In his account of his experiences, this was the single most traumatic and affect-evoking episode, even more so that the multiple beatings that had resulted in breakage and loss of teeth, and severe bruisings and swellings on the rest of his body.

In another instance a detainee was allegedly immobilized by means of leg-chains. His interrogators placed a metal object in his hands, told him it was a bomb, then flicked a switch on the object and left the room saying the "bomb" would soon explode. The detainee thought that his end had come, that the bomb would explode and that he would be suffocated to death by toxic gases. This moment when he realised that he was about to die haunted him more than any other of his detention. A further instance is of a middle aged truck driver (the "truck driver") who was attacked by heavy gunfire while driving on business. While lying under his truck in terror he noticed a stream of blood on the road ahead of him. The blood was running off onto the side of the road. Although he had not been shot and had no physical

injuries, he felt as though it were his blood on the road, that he had been shot and that he was dying.

In a smaller number of cases the fear is not of death but of serious permanent physical damage and disablement. One detainee was allegedly suspended in an upside-down position and assaulted repeatedly about his head and face. He had the sensation that all the blows to his head together with all the blood rushing to and accumulating in his brain would cause permanent brain damage and mental retardation.

(b) A second precondition has been found operative from observations of this affected population. In all cases, the phenomenon of anticipating pending death has been accompanied by a deep and reality-based sense of impotence to avert the massive threat. Ex-detainees have described feeling completely unable to influence the course of events which threaten them, that matters have passed beyond their control, and that they are powerless to avert or avoid the danger. This state of impotence arises from the reality of their situation whereby they are often physically weak and weakened by a combination of sleep and food deprivation, excessive exercise, physical beatings and other exhausting torture techniques. They are cut off from all sources of support, regeneration and help. They are at the mercy of torturers who exercise massive and sometimes unrestrained power over them. They are often humiliated and always outnumbered. They have no means of, and are cut off from any possibility of escape.

Torture may continue beyond the tortured person's supply of information. This then becomes gratuitous torture, the course of which the detainee is unable to even marginally influence since s/he has nothing more with which to co-operate. Torture may also be primarily gratuitous and intimidatory, again removing any possibility of influencing the course of the torture from the detainee, increasing the sense of helplessness.

A further quality of this impotence is passivity. The detainees are restrained and confined by the traumatizing environment with no outlet for actively dealing with it, withdrawing from or avoiding the dangers to their integrity. Their range of movement and activity is severely curtailed. This inability to act upon the environment leads to a passivity in the face of danger which consolidates the pervading sense of impotence. This combination of passivity and impotence, hopelessness and helplessness, contributes to the state of deep despair in which the possibility of being overwhelmed by death becomes a tangible reality. This thereby reinforces the sense of

inevitable and pending death or damage.

An example of impotence and passivity which occurred outside prison concerns a man who heard the screams of his friend who was being hacked to death by vigilantes. He was unarmed, outnumbered and unable to help his friend. He felt that he too was going to be killed and overhead the vigilantes talking of finding him next and doing the same to him. He felt unable to prevent that except by remaining out of the vigilantes' sight. His impotence to help his friend and himself when his own person, family and property was later threatened, attacked and partially destroyed, played a major conditioning role in the onset and evolution of his symptoms.

All the affected people reported on described in similar terms their feelings of powerlessness to alter the situation which confronted them and their passive impotence in the face of death-evoking dangers.

Impact on the Ego

Two stages appear to be involved in the manner by which the trauma acts upon the internal world and affects the ego.

(a) In the first place, the trauma itself leads to a withdrawal of libido from the object world and a redistribution of libido into the self. This process of libidinal retraction into the ego is something that probably begins before a life-threatening traumata are experienced due to circumstances preceding torture such as the arrest itself. This is reinforced by the degrading and often violent nature of the arrest and subsequent events which precede the interrogation. Detainees are sometimes pushed around, humiliated and beaten, even in front of their families, at the start of their detention experience. They are often arrested in the small hours of morning. Their experience of deprivation and restricted freedom may be initiated by their being refused opportunity to dress, take a change of clothing and or toiletries. This mistreatment in association with anticipated further discomfort, pain and threat to physical and emotional integrity, usually starts the process of libidinal retraction. It is primarily into the narcissistic core that the libido is withdrawn.

The process of retraction and re-allocation may occur either rapidly, or in a slowly progressive manner, depending on the circumstances which evoke the process of retraction. The process may or may not be complete by the time the life-threatening experience is confronted. In the case of the "truck driver", the libidinal redistribution occurred over the short space of time between his realising that he was under fire and his noticing the stream of blood on the road adjacent to him

and interpreting it as his own. In the case of many detainees, there may be a period of varying delay between the original detention and the subsequent life-threatening interrogation. S/he may then retain his or her libidinal attachments to the object world, although perhaps at a reduced level, depending on the intensity of the pre-interrogation experiences.

The mechanism of libidinal retraction into the self-preserving narcissistic core has been described by clinicians who worked with concentration camp survivors from the Second World War. It is viewed as an early adaptive defence against real threats from the external world, and therefore a normal response to an abnormally threatening situation or environment (de Wind, 1968); Bluhme, 1948). In the traumatic neurosis the libido is withdrawn from the objects in the object world with the objects remaining in the object world. This libidinal shift liberates the libido to concentrate its activities in the service of ego- or self-preservation by freeing it from other activities in the object world that have become superfluous under the new circumstances of danger.

(b) The next step towards the evolution of the PTSD after confronting the events which threaten destruction under the conditions of passive impotence is that the ego, into which the libido is condensed in the narcissistic core, is overwhelmed, and the defences surrounding the narcissistic core are ruptured. The rupture of the narcissistic defences leads to a deeply painful and often intolerable narcissistic injury (Freud, 1926). This injury constitutes the crux of the psychological damage which is central to the traumatic neurosis syndrome. The possibility of it occurring at all rests with the emergence of all the other preconditioning factors discussed earlier.

In the normal course of developmental events, the narcissistic defence is built up from the normal maternal (and/or paternal) nurturing behaviour (Freud, 1914). At the same time as meeting the infant's specific physical needs, this maternal nurturance conveys to the infant, by the very meeting of his needs, that s/he will not be abandoned to the terrifying inner impulses which threaten to destroy and annihilate him/her. It thus develops as a defence against infantile experience of annihilatory vulnerability. The infant thus builds up a defence against the inevitability of his/her own destruction and death. Initially the infant uses maternal or paternal supplies of narcissism to defend against vulnerability. S/he uses this until s/he has incorporated and internalized sufficient supplies for him/herself that s/he can maintain this death-defiance on his/her own. The defence modifies the unbearable reality of inevitable death

into a tolerable one and frees libidinal energy for other tasks of normal living into the world of objects which also, and in turn, feedback onto the narcissistic core by facilitating and enhancing its preservation. The trauma and ensuing narcissistic insult evokes a regression to this state that precedes the emergence of defence mechanisms against narcissistic anxiety.

The pertinence of these theoretical constructs was evident in the case of the "truck driver". Having noticed the stream of someone else's blood and sensing that it was his own and that he was bleeding to death (the pretraumatic events with the libidinal retraction into his narcissistic core), he was unable to restrain his growing anxiety and emerged from under the vehicle. As he fled off into the bush, a shot was fired at him which missed him, but something, perhaps the force of the bullet, caused him to fall to the ground. He fell and lay down for a long time, thinking that he was dead. When night fell, he stood up but still felt that he was dead. He described an extreme state of depersonalization and derealization. This state persisted over the next few days that it took him to rejoin his family and remained with him even then. He continued to feel depersonalized and that he was dead. This was so disturbing to his wife and children that friends went to fetch his mother from the town where she lived and brought her to him. When he saw her, which was ten days after the ambush, he instantly realized that he was not dead. His depersonalization and derealization lifted dramatically. This episode suggests the links between external danger, threat of annihilation and death, the narcissistic insult and defence and the origins of the latter in early maternal nurturing relationships.

Consequences of the Ego Effects

(a) The Emergence of Anxiety

The major consequence of the rupture of the narcissistic defence is the release of large amounts of anxiety. Anxiety is a response to danger (Freud, 1926). The danger under these conditions is one that threatens to destroy the detainee and threatens his/her very survival. This danger, implicit in the deep narcissistic insult is therefore of a primitive kind. It generates a primitive form of anxiety which can be regarded as narcissistic anxiety. The immediate fate of this narcissistic anxiety is unclear since in the subsequent evolution of events in the PTSD, its manifestation is usually delayed until the detainee is released from prison or the traumatising environment. What happens to this anxiety in the interim remains unclear. It has been suggested that while traumatised people remain in an actively traumatising environment, their psychic resources are mobilized fully

in the service of warding off the dangers, protecting the self from the continuing threats and of preserving the self. This necessitates an adaptive restructuring of the ego function with a restricted, distorted, deformed, weakened and impoverished ego state that focuses exclusively on survival in the immediate present (de Wind, 1968). This may well be the immediate consequences of narcissistic injury under these conditions with no functional or adaptive role for manifest anxiety.

Since the detainee is still engaged in the traumatizing environment, there is no purpose to be served by the signal function of anxiety as anticipation of future trauma is meaningless in a situation of acute and ongoing traumatic insults. Similarly the function of mitigating the trauma is also meaningless in a situation where the detainee has lost control over his ability to influence the traumatic events which are ongoing (Freud, 1926).

In contrast to the in-prison situation, as in the case of the "truck driver", narcissistic anxiety erupted immediately after the traumatic event and manifested as profound depersonalization and derealization.

(b) The Mobilization of Defence Mechanisms

Once the detainee is released from prison, the narcissistic anxiety emerges from whatever psychic structures that have been employed to contain it. This release of anxiety may be immediate or delayed. On emerging it mobilizes a number of different defence mechanisms as a way of dealing with the traumas and the memory residues of these traumas that provoked its emergence initially. Two particular defence mechanisms have been noted to be operative by authors writing of the PTSD in Vietnam veterans, namely the repetition-compulsion and the denial mechanisms (Horowitz, 1986). Experience with ex-detainees in the local setting has pointed to the activity of a third mechanism, namely the conversion-somatization defence.

The repetition-compulsion is a primitive defence structure which operates by repeating the traumatic events over and over again in the same format as they originally occurred. Its functional value in diminishing the intensity of the anxiety has been suggested to occur mainly by transforming the person from a passive to an active participant in the traumatic events. The victim of the trauma in this internal way regains some control over the circumstances that induced the trauma. There is also an innoculation effect whereby with each repetition the noxious effect is diminished as the person learns to anticipate the trauma, defuse it and become progressively

more immune from its traumatizing effects. In these ways, the original trauma loses much of its dangerous overwhelming qualities. It can then become incorporated into the ego as an integrated part of the personality (Freud, 1920).

The second defence mechanism of denial is also a primitive defensive function (Freud, A., 1936). Denial of a threatening external reality at the time is non-adaptive and may not be compatible with survival. Once the external danger has passed or become internalized, the denial defence becomes a convenient way for the ego to deal with overwhelming threats and impulses. Its more frequent application can be detected in relation to serious illness or sudden loss as a normal and early part of the process which precedes acceptance of the unpleasant reality or narcissistic injury. The force with which the trauma is denied is gradually lessened and the ego is slowly able to integrate the trauma. The more complete entrenchment of denial is usually incompatible with healthy integration of the trauma. Instead, this may lead to the person becoming detached from both the trauma and other areas of normal psychic functioning.

The third defence mechanism of somatization has impressed itself by the frequency with which ex-detainees point to its activity. In this mechanism, narcissistic anxiety is converted into certain body parts. The body parts affected are usually those which were significantly associated with events at the time of the trauma. By displacing the anxiety from the psychic structures, the ego is relieved from inner tension to alleviate what is felt to be overwhelming danger and threat. Conversion into somatic structures helps to externalize the stress which becomes less threatening to the ego. This affords the ego the opportunity to work through the stress at more of a distance and at less risk to itself (Hoppe, 1968; Eitinger, 1969).

(c) Symptom Production

The next step in the evolution of the PTSD is the transformation of narcissistic anxiety by the above defence mechanisms into symptoms.

The major symptom of the disorder is the recurrent intrusive recollections of the traumatic event. This distressing symptom in which the narcissistic injury is relived in full detail of both event and affect occurs either in clear consciousness or in dreams where it often takes the form of nightmares. It can be provoked by stimuli that either resemble closely an aspect of the trauma, or only remotely and innocuously so. The combination of relived events and affects constitute the painful nature of the symptom. The neurotic, distressing or symptomatic part of this process is that these

recollections occur unconsciously, unbidden and beyond the control of the sufferer and cause significant distress. It is the frequent reliving of the traumatic experiences that is the clue to the repetition-compulsion being the implicated mechanism.

In some cases, the intrusive memories may dissipate over a relatively short period of time, the dissipation then coinciding with the person's coming to terms with the trauma. In this respect the ego-syntonic nature of the defence is demonstrated. It is when the person is plagued by these memories for a long period of time with no apparent defusing of the emotional impact, reduction of intensity or integration of the experience that these memories become disabling symptoms. Even here the attempt of the ego to work through the trauma can be detected. Its inability to achieve integration can be seen either as a result of the intensity of the original injury, unfavourable underlying narcissistic and ego organizations, an absence of other favourable and supportive factors or any combination of the above. In all cases of PTSD seen to date, each person has reported being plagued by recurrent intrusive memories of a particularly damaging moment during their traumatic experience. This moment has invariably been the one at which they experience their proximity to death and their helplessness in the face of this, the "traumatic moment". A number of additional symptoms typical of the PTSD flow secondarily from this. The states of hypervigilance, hyperalertness and the exaggerated startle response can be understood as conditions of heightened anticipation for the activity of the repetition-compulsion and the re-experiencing of the trauma. The characteristic sleep disturbance may be due to difficulty falling asleep after awakening from distressing nightmares. It may also be an avoidance of the loss of control inherent in sleeping and the fear of not waking up again or surviving this loss of control, all of which are so reminiscent of the original trauma.

The other major symptom characteristic of the disorder is the psychic numbing or state of emotional detachment. This is associated with impoverishment of and estrangement from previously healthy emotional, personal, social and occupational relationships, weakening of cognitive functions such as concentration and memory, constriction and numbing of affect, lowering of mood with concomitant increase in mood lability and diminished interest in previously significant activities. In this cluster of typical symptoms, the denial defence can be traced as the dynamically active factor since the cutting off from the surrounding environment implicit in the symptoms parallels the attempts by the ego to cut itself off from painful events and recollections of the precipitating trauma.

Denial occurs in relation to both the originally traumatic event as well as to these events being repeatedly relived via the activity of the repetition compulsion. It seems that when these other aspects of the person's life are affected in a symptomatic way, the energy required to dissociate from the original trauma and subsequent recollections is of such an intensity that it spills over into a denial of a detachment from the rest of their affective life. In addition, denial may function as a secondary suppression of affect so as to deprive any anticipated intrusive recollections of affective force, thereby preserving the depleted ego from further narcissistic injury. In the sense that denial shields the deformed and weakened ego from both the initial and repeated narcissistic injury, its function can be seen as protective and contributing towards the preservation of the self. With time it may weaken its hold over the narcissistic anxiety, releasing it in quanta for other psychic mechanisms to work through more productively. It may by the same token outstrip its utility as a protective device and become entrenched as a permanent defensive structure which gives rise to the persistent disabling symptoms outlined above.

In practice it is not uncommon to find that the two defence mechanisms of repetition compulsion and denial alternate in intensity in the struggle to control and contain the narcissistic anxiety. This manifests in a fluctuation of symptoms.

There is not yet sufficient clinical evidence to support an early and very tentative observation that when these two defences do not seem to occur simultaneously and that one or the other predominates, that the repetition compulsion seems to occur in people with a more integrated underlying narcissistic structure. Denial on the other hand then appears as the preferred mechanism where the underlying narcissistic core is less well developed. This tentative distinction will have to await further observation and elaboration.

Clinical experience has shown that the conversion somatization defence has been responsible for generating a number of other frequently encountered symptoms. Numerous ex-detainees suffer from headaches, often ill-defined and non-specific, and a host of other vague body aches, visual complaints, pains, paraesthesias and other unusual and uncomfortable physical sensations. In most cases, repeated medical examinations have excluded specific physical causes.

Therapy has sometimes then been able to reveal the psychological nature of the symptom. An example of this is the case of the young

man who feared becoming brain damaged and retarded whilst being physically assaulted whilst suspended in an upside down position. He complained of a vague, burning, hot, headache-like sensation over the side of his face, scalp and head. this was found to be associated with anxiety, awareness of his continuing state of vulnerability and memories of his detention experiences. Therapy was able to reveal that the headache sensation reproduced for him the fear of becoming retarded. The fear was associated with the physical sensation of his blood collecting in his brain during his forced inverted suspension and the pain in his head and face from the simultaneous beatings. The sensation of his presenting complaint was the same as that which had occurred at the time of his torture except that it was less intensely and painfully felt. Uncovering the association in therapy held him gain relief from the symptom. Not all somatic symptoms have been or can be so readily traced back to a particular moment during the traumatic experience.

It has also been found that the traumatic experience is not necessarily attached directly to the somatic symptom that develops. Instead, the trauma may merely mobilize an underlying conflict indirectly. This may then become entrenched as a somatic symptom under conditions of ego weakness and distortions set up by the narcissistic injury. A particular case which substantiates this observation is of a teenager who was pursued and shot at by the security forces. This persecutory situation evoked in him associations of his own neglectful, competitive and persecuting father who the teenager blamed directly for amongst other things, a serious and incapacitating illness in the teenager's young sibling. Soon after being pursued by the security forces, he broke down with visual hallucinations of his sick sibling, and concomitant seizures, both of which were conversion in origin and which responded well to therapy.

CONCLUSION

This model proposes that under conditions of significant external threat to life, when the threatened person anticipates his/her own destruction actively in thought and in physical circumstances where s/he is restrained and unable to alter the threatening environment, a regressive libidinal shift occurs from the world of objects back into the self-preserving narcissistic core. The threat to and anticipation of destruction is sufficiently severe to overwhelm the narcissistic defence and this gives rise to the liberation of free-floating narcissistic anxiety. Three defence mechanisms are mobilized to bind this anxiety, namely the repetition compulsion, denial and the conversion somatization mechanisms. Where these defences are unable to adequately defuse the intensity of the anxiety, they transform it into symptoms as a

further attempt at accepting and integrating the trauma. It is the symptoms produced by these defences that characterize the classical post-traumatic stress disorder or traumatic neurosis syndrome. These are the symptoms that are encountered clinically so frequently among ex-detainees who have presented for counselling at the service. This theoretical formulation has implications for an approach to treatment, which will be dealt with in a separate article.

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Mental health services in Nicaragua: Lessons for South Africa

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It is at present widely accepted among mental health workers and academics that South African psychology/psychiatry is in a state of crisis. In recent years we have seen the articulation of a challenge to the theory and practice of mental health from a large variety of sources, both inside and outside the country. It has been argued that mental health services are not only inadequate and inappropriate, but in many ways serve to legitimize and perpetuate the apartheid status quo in South Africa (for example: American Psychiatric Association, 1979; Dawes, 1985; Dawes, 1986; Dommisse, 1985; Dommisse, 1987; Hayes, 1987; Jewkes, 1984; Seedat, 1984; Vogelman, 1987a; Vogelman, 1987b). It has more recently been proposed that while the continuing critique of mental health services in South Africa is of obvious value, it is also necessary to examine alternative models of care (Vogelman, 1988a).

Arguments for a more appropriate mental health practice are popular in many circles, which has lead to the addressing of psychological concerns directly related to the apartheid regime and the repression inherent in the defence of this status quo. Organisations like OASSSA (Organisation for Appropriate Social Services in South Africa), detainees' counselling services and clinics, have been carrying out reparative work with victims of the system. Yet these attempts at an alternative have been largely responsive, dealing with the immediate psychological effects of apartheid and repression. There has been little focus on the future of mental health care in its wider context,

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although discussion within the paradigm of community psychology has been important in this respect (Lazarus, 1986; Vogelman, 1988b). Recently, Freeman (1988) has discussed mental health care in Zimbabwe and has pointed to some of the complexities involved in transforming services to meet the needs of a society in transition. Since radical mental health workers propagate social change as a precondition of mental health, it is evident that discussion about mental health care within the broader context of change in South Africa is overdue.

This paper arises out of research into an alternative mental health system - the Nicaraguan model. It aims to highlight aspects of the latter which we suggest are useful guidelines within the construction of appropriate, accessible and enlightened mental health services in South Africa, and hopes to build on a recent commentary on Nicaragua presented by Vogelman (1988c). It should be noted that the author has no personal experience with the Nicaraguan situation and that this paper relies on secondary sources.

Background to Nicaragua's mental health system

Nicaragua, like South Africa, has a history of oppression and exploitation of the majority of the population. It has emerged from the 45 year old Somoza dictatorship to construct a more equitable society with considerable achievements in the area of health, welfare and education since the Sandinista victory in 1979 (Melrose, 1985; Pickvance, 1987). There has been a particular focus on the provision of free, accessible and appropriate health services. Mental health has not been a priority, for obvious reasons in a Third World country, but it is clearly visible as a growing area of concern. Like the general health system, mental health services have been organised within a participatory democratic manner, challenging many of the classic problems of these services within both first and third world countries.

Before 1979, psychiatric and psychological services were scarcely accessible to the majority of Nicaraguans, but could only be obtained by a small elite grouping who were able to afford the private fees (Kroese, 1987). Those who were severely mentally ill were isolated in the psychiatric hospital in Managua. This hospital, the only one in the country, served as a "dumping ground" for those not considered worthy of rehabilitation (Personal communication - Varchevker). Substandard conditions existed with no attempt at therapeutic intervention. It has been claimed that psychologists during the Somoza regime served the interests of the status quo (Harris, 1987). For example, it is claimed that school psychologists would intervene with politically active students, treating them for behavioural problems. It is clear that despite the underdeveloped nature of mental health services in pre-revolutionary Nicaragua, there are many similarities to the more sophisticated South African system.

In post-revolutionary Nicaragua, the aim of the health system, including mental health, has been to provide free, accessible and decentralized services, with a focus on prevention rather than mere cure. Nicaragua has received advice and material support from a wide range of countries and groupings, but a major influence within the area of mental health is the "Mexico Group", now called the "Marie Langer Internationalist Group" (Kroese, 1987). As part of the reconstruction of Nicaragua the new government invited this group to work and teach in Nicaragua (Hooks, 1983). Since 1981, 2-3 members of the group, which is based in Mexico city, have been visiting Nicaragua every month for a period of 10 days (Hooks, 1983). They have been involved in the training of students, in research projects, in assessment of government projects and in teaching therapeutic techniques (Hooks, 1983; Pickvance, 1987). They have worked with the Faculty of Medicine and Psychology, with the Psychiatric Hospital and the Ministry of Health (Hooks, 1983). The team has a radical psychology tradition, drawing from psychoanalysis, systems theory and Marxism, with the assumption that psychological practice cannot be separated from political practice (Pickvance, 1987). Their stated goal has been the democraticization of mental health services (Pickvance, 1987).

The Mental Health System in Nicaragua

We have construed the structures dealing with mental health within three different categories; at the tertiary level is the psychiatric hospital and psychiatric wards in general regional hospitals; at the community level are psycho-social centres (CAPS), children's centres, and psychological services within the school and work-place; and at the popular level are support structures, which are not normally termed mental health services but obviously function as such, like the brigadistas (see below) and mass organisations (in particular AMNLAE, the women's organisation. These various levels of mental health services span the continuum of curative to preventative intervention. They also illustrate the incorporation of both professional and non-professional mental health care workers.

1. Hospitalization

There is still only one psychiatric hospital in Managua which is described as lacking facilities and under-staffed, but still a vast improvement on pre-Sandinista days (Hooks, 1983). There is strong de-emphasis on institutionalization with admission to the psychiatric hospital being a last resort (Hooks, 1983). In an attempt to challenge the social isolation of mental illness, patients will firstly be placed in general hospitals and will be admitted to the psychiatric hospital only under strict diagnostic criteria. These include emotional or organic psychosis, severe epilepsy and severe alcoholism (Hooks, 1983). Within the psychiatric hospital a ward has been set up for acute cases where intervention is carried out as soon as possible so as to return the patient back to society (Hooks, 1983). The Mexico group has tried to infuse the psychiatric hospital with a critical awareness of the implications of psychiatric

labelling as well as a skepticism of the traditional medical model (Hooks, 1983). More recently, the Italian model of Basaglia, which totally rejects institutionalization of psychiatric patients, has begun to have an influence at the psychiatric hospital (Pickvance, 1987). Electro-shock therapy is not present in Nicaraguan psychiatry at all and there is a cautious approach to the use of drugs (partly because of ideological reasons, but also because of the U.S. embargo on medical supplies to Nicaragua) (Kroese, 1987).

2. Community Mental Health Services

The primary unit for clinical psychology/psychiatry at the community level is the psycho-social centre (CAPS) of which there were about 17 throughout the country by 1986 (Personal communication - Varchevker). In that these are decentralised they go some way towards making mental health services more accessible to all members of the community. These centres function as day centres. Admission groups occur on certain days, so that a new client will attend an introductory group session in which diagnosis will take place (Personal communication - Varchevker). If necessary referral will follow, for example to a neurologist. Otherwise the new clients will then meet in a group for about twelve meetings. Short-term psychodynamic group work follows. The staff of a CAP is usually made up of four psychologists, a social worker and a psychiatrist (who may be a visiting one). The staff usually spend some time on research, self-education, training of other health workers and staff meetings. It is clear that a great deal of self-reflection and evaluation of their work takes place. The team members also travel to healthposts in villages close to the CAPS. During these visits they will train and supervise brigadistas, hold clinics, make home visits and collect statistical information. Following the emphasis on group work and the understanding of psychological problems in social context, most of the therapeutic intervention happens in a group setting with individual therapy being a rarity (Kroese, 1987).

Another level of psychological intervention within the community setting are centres for children, including residential and day centres. The emphasis on multi-disciplinary work within the entire health system is evident within these projects. An example of a residential centre for children is the I.N.S.S.B.I. (Social Security and Welfare Ministry) centre for "Protection and Prevention" in Managua (Kroese, 1987). This is for children who have been abused, abandoned or who have special needs (mental, physical or sensory handicaps). There are four psychologists employed in the centre, which houses about 100 children, who assess the children, develop individual programs and advise residential staff and teachers (Kroese, 1987). There are also 23 therapeutic day-centres in Managua to cater for children between 6-15 years from deprived backgrounds. Again a multi-disciplinary team of teachers, psychologists, social workers and art therapists is evident. The centres also attempt to organise parents' groups in order to advise them on child

management and family problems (Kroese, 1987).

Mental health work is also visible within the general health structure. Through the Mexico Group, doctors, nurses and other medical staff have been trained with psychological skills and knowledge. They have been involved in initiating a "Work and Study Programme" which incorporates a focus on mental health (Hooks, 1983), through a praxis-based approach to training (i.e. students spend time in the community attempting to integrate theory with practice). Thus there is a strong emphasis within the general health system on the emotional aspects of physical health. Another example of this is the involvement of psychologists in rehabilitation work with the large numbers of physically disabled war survivors (Kroese, 1987; Britten & Stenfert-kroese, 1988). Psychologists are found within a multi-disciplinary team at the Aldo Chevarria Rehabilitation hospital, the only rehabilitation hospital in Nicaragua. They undertake group assessments, run psychotherapy groups, provide individual psychotherapy and give psychosexual counselling. They are also involved in the Equipo Mobil (Mobile team) which serves the whole country and functions to reintegrate the patient back into his/her community. Home visits are made to the family and support work is carried out with them as well (Kroese, 1987; Britten & Kroese, 1988). It is evident that victims of the ongoing military defence against the contras are treated with sensitivity to their psychological needs. A war victim with psychological problems will receive priority at the CAPS and other mental health services (Kroese, 1987).

Psychological services are also present within community institutions, like schools, factories and rural productivity centres. Industrial psychology with a very different flavour to its First World Western counterpart, is a growing area (Harris, 1987). At the work place, psychologists are involved in the selection and promotion of personnel, as well as the provision of clinics dealing with stress and other mental health problems (Harris, 1987). In rural productivity centres, the Ministry of Agrarian Reform has been employing psychologists to work with rural peasants (Harris, 1987). The rural economy has been reorganised into co-operatives, but the ideological framework necessary for successful functioning has been lacking. Psychologists are part of a multi-disciplinary team of agronomists and others, in training farmers for co-operative farming (Harris, 1987).

3. Popular Mental Health

Popular mental health structures which perform a largely preventative function and are primarily carried out by lay people are evident within Nicaragua. In this respect popularization of mental health knowledge and skills as well as de-professionalization is occurring. The major vehicle for this level of mental health is the brigadista (voluntary health worker based in all communities at local level). Brigadistas have been extremely valuable within the general health system and have been largely responsible for projects like

mass immunisations (Melrose, 1985). More recently brigadistas have been trained in para-psychological skills and knowledge, like relaxation exercises, setting up of self-help groups and the problem of "frozen grief" (the somatization of unresolved bereavement) (Kroese, 1987; Personal communication - Varchevker). The Mexico group has been involved in the programmes for the trainers of brigadistas, with input on family therapy, crisis intervention, theories about the development of the personality and problems that may arise, etc. (Personal communication - Varchevker). Brigadistas view themselves as "multipliers" of knowledge who should pass on their skills and knowledge to those that they work with. The ideology of "multipliers", that is the spreading of knowledge, is an important part of the popularization of medical and psychological knowledge and services to demystify the traditional elitism attached to these bodies of practice.

Emotional support at the mass level is evident within the national women's organisation (AMNLAE) and it's projects (Personal communication - Hunt). The most important project in this respect is the support groups with mothers and companeros (comrades) of soldiers at the front or those who have been killed. AMNLAE has also set up offices for "the protection of the family" whose main work is to support, emotionally and practically, women who have been abandoned by the fathers of their children (Personal communication - Hunt). They have also set up a legal office for women in Managua which deals with domestic violence, rape and incest (Personal communication - Hunt). Although these projects are not identified as mental health services, in that they are dealing with problems which have psychological sequelae, they naturally provide emotional support as part of the service they provide.

The Nicaraguan Association of Psychologists (ANIPS) organises popular programmes on mental health on TV and radio, which makes knowledge accessible to a wider audience (Harris, 1987).

Conclusions

This paper has presented the model of Nicaraguan mental health services as they have developed since 1979 when the Saninistas came to power. We do not consider this to be a fully comprehensive picture given the dynamic nature of the country and limitations in collecting resources.

There may be some skepticism arising out of the fact that the Nicaraguan model is very young and unsophisticated. In contrast there are many aspects of the South African system which are very sophisticated and developed. The Nicaraguan model is one which is putting into practice principles of participatory democratic mental health which is the goal of mental health workers throughout the world. Some of the most inspiring aspects of the Nicaraguan model are exactly those which South Africa lacks: a free, accessible, decentralised service; participation of the community within their

own service; popularization and demystification of psychological knowledge; de-professionalization and the widespread use of lay people; avoidance as far as possible of isolation of psychiatric patients from the rest of the community; the emphasis on prevention rather than cure; the understanding of psychological problems within the social context; and the emphasis on group intervention rather than the individualisation of the problem.

We are by no means claiming that Nicaragua has put into effective practice all that they are striving for. This would be impossible in the short space of time and the advancements that have been made are constantly undermined by the Contra aggression. Nonetheless the Nic araguan goals and proposed structures for a more appropriate and equitable mental health service provide a useful site upon which to begin our own journey of reconstruction of South African mental health services. If nothing else the Nicaraguan model facilitates inspired thought about the possibilities of a better alternative.

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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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The politics of colonised subjectivity

A critical review of H A Bulhan's "Franz Fanon and the psychology of oppression (1985)

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The published studies of the work of Franz Fanon in the last twenty years reveal a glaring paradox. Despite the fact that Fanon was a trained psychiatrist and practising psychotherapist, hence deeply influenced by a range of psychological theories amongst other, critical studies remain dominated by historians, political theorists and biographers. The Fanonian legacy has occasioned a mere trickle of serious appraisals by psychologists themselves despite its wide ranging appeal amongst black intellectuals and its considerable influence on American and South African Black Consciousness movements. H. Bulhan's book is thus a particularly welcome contribution to Fanonian scholarship as it constitutes the first major attempt by a trained psychologist to systematise Fanon's psychological writings. It is clear that Bulhan sees himself both as the guardian and continuator of Fanon's work, truncated as it was by his untimely death at the age of thirty-six.

The nature of Bulhan's appraisal of Fanon's work may best emerge by briefly contrasting his project with that of another recent Fanon scholar : J McCulloch in his "Black Soul, White Artefacts" (1983). Starting from the assumption that Fanon's prolific but brief career has left us with a set of fragmentary and unsystematic sketches drawing from paradigms as diverse as Negritude, African Socialism, Hegel's philosophy and various psycho-analytic psychologies, McCulloch proceeds to painstakingly tease out the underlying epistemological structure which gives unity to Fanon's work and which allows us to grasp its dominant and contradictory tendencies. His book focuses more specifically on the difficulties and points of tension which emerge out of Fanon's effort to work in that intermediate terrain where the sciences of personality and society converge.

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McCulloch, writing from a neo-marxist perspective, is by no means unsympathetic to Fanon's overall aim of producing a sociogenetic psychology. His final evaluation, however, is that this intention is not realised. On the one hand, he argues that Fanon's reliance on the analytic categories of race/culture and nationality at the expense of that of class entails that what he presents as a general psychology of colonial oppression is in fact restricted to a specific class: the educated petty-bourgeoisie. Further, the contours of Fanon's fundamental psychology of colonial oppression, mapped out in his first text (Masks, 1952), is more relevant to the socio-existential experience of the educated elite than to the Algerian peasantry or the dispossessed peasants (the 'Wretched') which Fanon privileged as the truly revolutionary strata in the Algerian struggle for national liberation.

On the other hand, McCulloch argues, that Fanon, by virtue of his emphasis on psychological theory, tended to over-psychologise the concept of alienation and oppression at the expense of a more elaborate political economy and class analysis of colonial society. This tendency thus led him into a series of errors both in regard to his theory of revolutionary struggle and in his political strategy. If Fanon privileged the peasantry in the Algerian revolution it was not so much because of their position within the relations of exploitation, the labour process and their actual political consciousness. Rather it was due to their having retained a strong mode of cultural attachment to indigenous culture. It is this mode of cultural attachment which Fanon viewed as a radical source of oppositional identity and which allowed him to assert that individual and collective liberation fuse into an identical project : the anti-colonial struggle for national liberation.

Bulhan's book by contrast contains none of the critical distance which McCulloch sustains throughout. Disregarding the relevance of the race-class debate in an evaluation of both Fanon's sociology and of his psychology (see Bulhan, 1985:13), Bulhan remains at heart, and in theory, a Fanonian. His espousal of Fanon's framework leads him to assert three major interrelated theses.

In the first instance Bulhan asserts that Fanon's psychology contains an implicit break from much of eurocentric psychology (1985:ch.4,6). He further argues that this break is predicated upon the successful development of a socio-genetic paradigm in psychology (chs.6,7,8,9). Finally, this socio-genetic perspective ensures the way in which participation in political struggle, which Bulhan subsumes under the undifferentiated heading of collective liberation, also becomes a mass therapy for socially induced psychopathology (ch. 7,12).

In my opinion Bulhan's attempt to argue that Fanon's theses and his development of the latter herald a new paradigm in psychology is not

convincing precisely because it does not pay sufficient attention to problems inherent within Fanon's work itself, such as those suggested by McCulloch. In addition it appears that the feasibility of a project such as that of producing 'A Psychology of Oppression' should include a more thorough discussion of the dilemmas which have marred such ventures in the history of psychology itself. It is unfortunate that Bulhan shows a overhasty tendency to dispel almost all of psychology as eurocentric as if psychology, in this highly undifferentiated state, could fruitfully be approached under the ethnic headings of 'WASP' or 'Jewish' trends in psychology (1985:ch.2).

I am referring here more particularly to the significant history of the marxist-freudians (Reich, Fromm & Marcuse) which, although undeniably western in its focus, nevertheless reveals the impasses inherent within the project of reconciling a theory of mind/personality based on intrapsychic divisions and conflicts with a sociology based on class divisions and conflicts. This history (Gabriel, 1983; Coward, 1983) reveals that what was gained in terms of sociological and historical relevance was lost in terms of psychological complexity. For example, the uncritical slide between the psychoanalytic concepts of REPRESSION and the sociological concept of OPPRESSION is a notable feature of these psychologies. Conversely, the inclusion of a theory of personality to complement an otherwise reductionist and economistic marxism and to articulate the subjective or ideological components of social oppression never managed to convince those who espoused a radical sociological perspective. It seems that Fanon's work which emerged from within the post-war intellectual conjuncture of the 1950's as it were, bears many similarities with and faces a variety of dilemmas germane to the history of freudo-marxism.

A work of thorough comparison between Fanon and the marxist-freudians would take us far beyond the scope of this review. However, it would take into account three considerations, which I can only briefly enumerate here.

In a first instance the model of mind or personality operative in Fanon's psychology of colonial neurosis seems to owe its main theoretical allegiance to Alfred Adler's individual psychology. Fanon rejected Adler's notion that the sense of inferiority is inherent within the human condition (Fanon, 1952; Bulhan, 1985: ch.4) and proceeded to root the creation of the sense of inferiority amongst the colonised in the history of colonialism itself. Colonialism is thus responsible for a 'sacking' of indigeneous culture and the imposition of a manichean racist ideology which devalues black physical and cultural identity. The division within colonised subjectivity, however, rests centrally on the conflict between this internalised sense of inferiority and the compensatory manoeuvers to combat it: that is, the setting up of an ideal guiding fiction. In Fanon's psychology this Adlerian 'superiority complex' or 'masculine protest' takes the specific form of the 'desire for lactification'. It is

the desire for salvation through an identification with white values which is productive of alienation since it is discrepant and incongruous with a more fundamental black identity which the colonised attempts to disown.

The lineage between Adler and Fanon is in itself interesting given Adler's historic position as the first dissenter or deviationist in the early psycho analytic movement (Jacoby, 1975). Furthermore, although the deviation is often presented as emanating from a divergence in political outlook - Adler was a socialist and Freud not - such a presentation masks a more complex theoretical issue and this is that Adler was in fact the first formulator of an ego-psychology (Jacoby, 1975). As Jacoby points out, in Adler's work one witnesses a general theoretical drift which was to come to full flowering within the chorus of humanistic post-Freudians : "the replacement of an instinctual dynamic by social factors or interest, repression and sexuality by insecurity and goals, depth psychology by a surface psychology" (Jacoby, 1975:23). Thus Fanon's basic model of colonial alienation relies centrally on a division between a basic self-concept and an ideal-self fashioned by the ideological apparatuses of colonial society and within the fragmented mirror of racist ideology. In a nutshell it is a psychology of how the ego-ideal is socially constructed through the process of internalisation. It leaves untouched and untheorised the very notion of a basic self or that as to how there emerges a divison between a basic-self and an ideal one at all.

It is at this juncture that the comparison between Fanon and the marxist-freudians becomes interesting. As Gabriel points out, both W. Reich and E. Fromm in their respective attempts to introduce the missing historical dimension in psycho-analytic theory and conversely the human factor in marxism only managed to do so by reintroducing the notion of a core personality at the center of their respective psychologies (Gabriel, 1983). Reich replaced Freud's complex unity of psycho-sexuality by a genital sensuous being, dominated by biological forces and immanently striving towards non-neurotic harmony through the achievement of full orgastic potency. In contradistinction Fromm, standing at the opposite pole of the body-mind spectrum, introduces the notion of a deeply symbolic being in constant pursuit of meaning, identity and freedom. In both psychologies, underneath the oppressed layers of the personality there emerges 'a view of the individual over-integrated in his/her alienation, just as their imageries of a personality core entail a view of the individual over-integrated in his/her freedom' (Gabriel, 1983; 191).

I would like to suggest that Fanon's psychology is also built on just such a notion of a basic core identity or self. This basic self is intimately tied up with the notion that the culture of the colonised survives despite its atrophy owing to colonial domination. Although Fanon was critical of the concept of an African personality with its idealised attributes dating to the pre-colonial era

as put forward by Negritude poets and African Socialists, he nevertheless assumes the basic notion of a self formed in an other culture. This basic self is conceptualised as the overall product of an ensemble of cultural practices. Despite the fact that this cultural self acts as a source of oppositional identity both in Fanon's psychology and in his political analysis, his psychology leaves unchartered the process of its construction and development. As a result, despite the assertion that this self is a socio-cultural product capable of new definitions in the course of anti-colonial struggle it functions theoretically as a unitary category in Fanon's work.

It is at this point that the three psychologies of Fanon, Fromm & Reich reach their paradoxical similarity. For although they reject the individual-society dualism, they in fact rely on the notion of a core identity as a psychic infrastructure which lurks underneath the alienated layers of the psyche formed in an oppressive society. In Fanon's psychology more specifically it can be pointed out that it is just such a notion of a non-alienated, harmonious and unitary subject which feeds and sustains his utopian vision on the psychic valency of participation in counter-violent struggle. To quote Fanon himself: "Illuminated by violence, the consciousness of the people rebel against any pacification. From now on the demagogues, the opportunists, and the magicians have a difficult task ... the attempts at mystification become practically impossible" (Fanon, 1967:95). Having thrown off the mask of the falsely constructed superstructure of the self decolonised man restores the truth of its subjectivity with truth as its essence.

The variety of themes introduced above warrant a more thorough discussion but my main aim is introducing such themes has been to counter Bulhan's sustained assertion that Fanon's psychology heralds a successful sociogenetic perspective in psychology. I would argue that, while Fanon's psychology promises an interesting articulation of psyche and society and one which is important where national liberation struggles still loom large on the historical agenda, it is not without major dilemmas. Furthermore, I am also suggesting that Bulhan's knee-jerk ethnic approach to the history of psychology obscures potentially fruitful avenues of comparison which would assist in the analyis of the conceptual dilemmas at play within Fanon's work. This work of comparison, however, would stretch far beyond the scope of this review.

The value of Bulhan's book in my view lies not so much in his success at sustaining his claims of an epistemological break but rather in the rich variety of interrogations, considerations and materials he presents in his overall attempt at sustaining his major claim. I will enumerate only a few which I found particularly useful.

As mentioned earlier the book has the overall beneficial effect of integrating Fanon's psychology within the psychology discipline and thus of rescuing it

from the uncertain and inaccessible position in which it had been lingering for the last two decades.

Bulhan's first chapter on Fanon's biography is a crisp treatment of the highlights which marked his remarkable trajectory from his modest petty-bourgeois origins in Martinique to his status as consultant-in-chief in Algeria and his direct involvement with the Algerian Liberation Front. It provides some revealing background detail which suggests ways in which Fanon's first book (Masks, 1952) can be seen as a theoretical distillation of the conflictual elements which marked his own experience prior to settling in Algeria. Fanon's astonishingly early enrollment in the French Army as a result of De Gaulle's call to liberate 'the Fatherland' from Nazi occupation indicates the manner in which Fanon himself was interpellated into colonial ideology and of the power of such interpellations. This biographical detail resonates closely with Fanon's poignant description of the identification process at play in the subjection of the colonised child to the dominant ideology marked by its symbolic (manichean) divisions: "The young Negro ... invests the hero, who is white, with all his own aggression - at that age so closely linked to sacrificial dedication, a sacrificial dedication permeated with sadism. An eight-year-old child who offers a gift, even to an adult, cannot endure a refusal" (Fanon, 1952:104).

Biographic details aside, Bulhan's book contains excellent summaries of both Hegel's Master-Slave dialectic and of O. Mannoni's work on Malagasy colonialism (1985:ch.6). But one of the paradoxes of Bulhan's argument that Fanon's treatment of oppression contains a break from eurocentric thought emerges clearly in this chapter. In my view, while it is true that Fanon rejected Mannoni's notion of a dependency complex amongst the colonised for its ostensible conservative political implications and for its eurocentric underpinnings, it is equally true that Fanon's overall framework is indebted to a particular amalgam of Hegel and Mannoni. Thus Fanon accepts the general Mannonian notion that colonialism has to be understood by unravelling a specific psychology at play within it. He accepts explicitly (Fanon, 1952) Mannoni's notion of a Prospero Complex amongst the coloniser: a basic personality which utilises the projection of unacceptable impulses in the formation of the Negro myth. Furthermore, this psycho-analytic treatment of racist ideology as a collective personality meshes with Hegel's Master-slave dialectic to support the second Mannonian notion that colonialism is an encounter of two personality types. It is with the help of Hegel that Fanon makes the bridge between the 'collective consciousness' of the coloniser (the Prospero mentality) and what it yields at the historical level amongst the colonised : the mask-neurosis.

It can thus be argued that Fanon's critique of Mannoni's analysis of colonial racism does not shift the ground radically from under Mannoni's feet. I

concur here with McCulloch's conclusive remarks that: "Although it is only in his first book that we find a lengthy attack on Mannoni, the shadow of Prospero falls across all of Fanon's writings. It was Mannoni who, more than any single figure, set the boundaries of his life work" (1983:214). More particularly, Fanon's indebtedness to both Mannoni and Hegel, takes the specific form of the treatment of racist ideology as collective mind or consciousness or personality which is to be understood primarily with the help of the psychoanalytic theory of projection. Fanon thereby, and Bulhan reiterates the same position, does not treat ideology as an objective instance of the social formation, as a practice of representation whose determination is established in terms of its articulation to the mode of production and to the political struggles between antagonistic social groups and classes. The analysis of racist ideology as a set of symbolic practices, whereby white is constituted as sovereign and black as its transgression (manicheism), gains the upper hand almost exclusively over a socio-political analysis of ideology and its functioning within an ensemble of relations. It seems to me that it is Fanon's substantial indebtedness to Mannoni and Hegel which allows him to portray colonial domination as if its central and most determining feature is the symbolic process of manicheism. If the utilisation of psychological theory gains ground in this treatment of an oppressive ideology it is at the expense of a more elaborate sociology and political economy of colonial domination.

Bulhan's chapters 10 and 11 give a thorough presentation of Fanon's less well known psychiatric papers. These papers of transition, written after 'Masks' (1952) and before 'the Wretched' (1967), allow the reader to trace Fanon's shift from his early focus on the individual form racial oppression takes to one in which there is a greater emphasis on institutional racism. Colonial psychiatry as a body of knowledge and as a set of practices is critiqued for its ostensible functions in reproducing colonial relations. Behind Fanon's critique of the Ecole d'Algiers, in its attempts to demonstrate the inferiority of the African brain and its 'baser' personality traits, lies a more subtle analysis of how psychiatric theory individualises and pathologises a range of behaviour which have a complex social and cultural determinants. Fanon thus shifts from an analysis of individual psychopathology (the mask neurosis) to one in which the very nature of colonial psychiatry occasions ruptures amd dysfunctions. Thus in the psychiatric institution it is the institution itself which functions in a pathological manner.

These papers reflect the drift in Fanon's thinking which led him to give up his post as chief-consultant to become more directly involved in political struggle per se. In my opinion, what is not sufficiently dealt with by Bulhan, however, is the question of whether Fanon did not carry with him his critical analysis of the micro-politics of institutions to the sphere of primary political institutions. For it seems that there is an abrupt slippage, whereby both Fanon and Bulhan

move from a social critique of psychiatry to one in which participation in broader political struggle becomes equivalent to a form of radical psychiatry and therapy.

Bulhan's chapter 7 entitled 'Violence and Manichean Psychology' stands out as a key chapter in his book. It contains a thought provoking critique of the conventional, legal definition of the violent act which rests on five criteria: the use of physical force, the intensity of emotions, the grounds to infer intent, the illegitimacy of the act and the extent of its effects in terms of physical damage. Although Bulhan acknowledges the importance of such a definition he goes on to show its obvious limitations and inadequacies in taking into account forms of violence which have an institutional or structural character. Such forms of violence cannot be gauged by reference to individual intentions but rather in terms of the consequences of the functioning of a system. Bulhan thus proposes a redefinition of the concept of violence: "Violence is any relation, process, or condition by which an individual or a group violates the physical, social and/or psychological integrity of another person or group" (1985:135). Although Bulhan does not answer the questions of how to define this basic integrity of a person or group his redefinition has the value of providing a more structural approach to the concept.

At a more theoretical level, however, it seems to me that Fanon's treatment of the question of violence (Fanon, 1968) has become the operative concept and the one which gives ballast to Bulhan's entire work. He states: "Thus to study oppression is, in the last analysis, to delve into the problems of violence in both its subtle and crude manifestations" (1985:131). In this context it seems important to raise a theoretical question. Fanon's fundamental of colonial oppression is rooted in his early book (Masks, 1952). The specific conflict of the 'mask neurosis' occurs at the level of the identification of the colonised with a manichean ideology which consecrates white attributes and devalues black ones. In other words, his early model rests on this notion of conflict engendered by contradictory identifications. In his essay on violence, however, Fanon (1968) shifts register and employs a model of mind which is purely energetist or economic and in which violence is treated as psychic force. As psychic force it can be directed against the self, lateralised against the fellow oppressed, or re-directed within counter-violent struggle against the oppressor. It seems to me that it is this shift from the register of identification to that of psychic energy which allows Fanon, and Bulhan, to reduce all forms of violence and violations be they physical, social, political, economic, cultural, symbolic and epistemic to one fundamental substrate, that of psychic force or energy. Thus theorised, politics and history become a question of misplaced or rightly placed psychic energy and more particularly of violence. What recedes in the background is the political treatment of armed struggle in terms of the goals and aims of a political vision and the appropriate strategies to achieve them. In other words, what disappears is

the very stuff of politics: ideology, programmes, organization and a theory of struggles, their aim and goals.

Despite Bulhan's attempt to trace a distinction between the notion of 'cleansing' and that of 'detoxifying' (1985:147) ultimately both notions boil down to the same construct and that is the direct or unmediated expression of damned up aggressive energy. From a psychological perspective it is highly dubious that catharsis can be considered a significant therapeutic agent. From a political perspective it is equally arguable that the decision to resort to armed struggle can be sustained purely on ideological and strategic grounds and in terms of political goals and aims and gains little by ascribing a therapeutic or regenerative valency to it. It seems to me that Bulhan's attempt to maintain a psychological justification for counter-violent strategy is based on a double reduction. On the one hand, it assumes that psychological processes at play in individual psychology can be transplanted wholesale to the relations between social groups. On the other, it assumes that such psychological processes can be reduced to a mental economics.

Thus when Bulhan resorts to Pinderhughes' thoroughly Kleinian explanation of how projective identification is always at play within an interpersonal violent situation his case is weakened rather than strengthened (1985:151). In such situations, where persecutory anxiety dominates, and splitting and projective identification are deployed, the most untherapeutic stance to adopt is to join in the vicious cycle of retaliation and counter-retaliation and thereby increase the amount of persecutory anxiety. But then the argument is purely rhetorical anyway for it is not convincing in the first place that the most salient feature of a situation of oppression is best understood in terms of the psychological concept of manicheism, projection and the violence it engenders. Such an approach treats ideology as collective mind which can then be understood in terms of neurotic or psychotic processes. By the same token, since ideology is a social force, the social itself becomes assimilated to a mass psychopathology.

This last point needs to be further explored for it relates to a major lacuna in Bulhan's book. By focusing on the psychology of political action Bulhan manages to by-pass the political vision and positions which collective liberation entails. Are we to assume that the psychology of liberation operates independently of the political vision of the various organisations which usually compete for hegemony amongst the oppressed social strata?

My major aim has been to the difficulties arising out of Fanon's attempts to work in that interstitial terrain where the sciences of personality and society converge. More particularly, I have focussed on the centrality which both Fanon and Bulhan accord to the analysis of racist ideology as resting on manichean processes and on the unitary model of mind operative in Fanon's

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psychology of colonial oppression. Bulhan's book however in so far as it reflects the diverse preoccupations which marked Fanon's brief but prolific career cannot be grasped in its totality. The value of the book in my opinion is that it renders possible for psychology students a more serious confrontation with Fanon's theses. For if Fanon is often invoked, given his emblematic position within the chorus of radical third world nationalist thinkers, he is less often seriously read.

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Book review

Method and theory in cross-cultural psychological assessment
by Alexis Retief

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One of the principle reasons for writing a book must be that the writer has something new to say or alternatively can say what has already been said in a better or more lucid way. In neither case do these apply to Retief's foray into the area of cross-cultural methodology. Several issues make this a disappointing book.

Firstly there is a lack of clarity as to who might find this book useful. For those who already have a passing interest in the area of cross-cultural research the book adds nothing new to the literature - much of what has been written simply summarises standard texts which have been available to the researcher for several years. The beginner in this area is alerted to some of the methodological pitfalls of the cross-cultural enterprise but when the going gets rough the writer bails out with an injunction to the reader to consult the primary sources. This leads us to question why we need have bothered with the book in the first place. Secondly, as a research report published by the HSRC investigation into Research Methodology one might anticipate a degree of novelty in the project or perhaps some new slant on the problems of cross-cultural psychology in a South African context. In both cases we are disappointed.

Many of the sections in the book are simply condensations of other more substantial approaches to the topic. The chapter on theory draws particularly heavily on Jahoda's account published in the Handbook of Cross-cultural Psychology. Further, in places the author appears to misunderstand the

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nature of the theoretical thrust being made, as is the case in the commentary on Miller's (1987) work on methodology and its critique of Cole and Scribner's view.

Although there is a need for a book which alerts the researcher to the nature of the problems in cross-cultural psychology it requires a more whole-hearted commitment to the diversity of the African experience than this volume has managed to portray. Examples abound in the daily experience of researchers actively engaged in doing research; these could have been used profitably to illustrate the problems and the solutions to cross-cultural issues. A more careful selection of examples with which to illustrate points and a more careful use of language with which to describe people from different cultures could have made. This would have begun to redress the balance in the way that people think about each other in the South African context. As Retief correctly points out in his introductory section on the history of psychological assessment this is one area where the legacy of racist psychology is particularly strong and therefore should have been countered more forcefully.

One cannot escape the feeling that this book was written with the author's head quite firmly turned toward a particular Euro-American tradition of comparative research. Indeed this is confirmed in the Afterword of the book itself where the author resorts to the very global characterisations of people in different cultures that cross-cultural methodologists have been trying to warn us against. What can one say to an author who has spent a hundred or so pages summarising the pitfalls inherent in cross-cultural research but who ends his book with the comment: "The various black cultures in South Africa generally seem to emphasise more intuitive and holistic ways of construing, organising and relating to the world and the process of knowing." (p. 184). This is then followed with an exhortation to members of these cultures to try on the analytic attitude adopted by the author himself. When the analytic product consists of little else than a rehash of standard works on the topic the exhortations, should it be required at all, will fall, rightly, on deaf ears.

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The APA or the Harvard system of referencing is preferred. The list of references, in alphabetical order and not numbered, should follow immediately after the end of the article. Footnotes should be kept to a minimum and where possible each should appear on the same page as its reference. Prospective contributors should send three copies of any piece, including a clear original. Authors are encouraged to submit their work on an IBM compatible disc (Preferably XyWrite or Wordstar). These will not be returned.

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