The role of the external practitioner

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The development psychologists

In the field of international cooperation, one of the fundamental dilemmas facing practitioners is how to define their role vis-à-vis the so-called ‘beneficiaries’ of development projects. What is the right role? Is the external practitioner a spy and a manipulator in other people’s cultural reality—or an ally of some aspects of it and an enemy of others? Is s/he a stimulus to a society, a catalyst of processes, a visionary able to anticipate the wishes of others—to propose and to negotiate, or simply to be a good listener? In reality, the development practitioner is a little of all these. It is a difficult job, and in the end it may be most useful to consider the development practitioner as therapist: a psychologist, with the community as the subject or ‘patient’. The relationship, then, between the practitioner and the community is not that of providing assistance ‘to satisfy needs’, but rather one of consultation and analysis: an engagement that encourages the autonomy of the subject. It is not a case of the development practitioner necessarily doing everything the beneficiaries want. Or at least it is not that simple.

Taking a cue from the wider context, one recalls that democracies are content to submit and act as directed by consensus and common will and by laws so derived and determined. Dictatorships and revolutions, on the other hand, are committed to changing people’s opinions, values, and perspectives through manipulation and influence. If we think about it, this is, in part, precisely what development projects aim to do. The problem, therefore, is not how to avoid influence and manipulation, but rather how to understand and use such interventions in the best interests of the ‘patient’.

It is often taken for granted that the therapist gives and the community receives. This is anti-developmental, creating a dependency that is contrary to the principles of helping people to help themselves. It is evidence of a flawed process, comparable in psychoanalytical terms to the process of ‘transference’, by which ‘clever’ patients displace and project on to the external practitioner or therapist their material wishes, and deploy the word need to obtain them. This creates a clientelistic attitude in the ‘patient-beneficiary’, based as it is on external dependence for the sake of a short-term survival strategy: the importance of getting something, and getting it quickly. As Migone has argued,

[0]ne should distinguish two types of support, one very different from the other. It is one thing to intervene in a way that provides a concrete outcome—a interpretation for example—and this is what one really aims for. It is quite another to seek out assistance for its own sake, and this should be resisted. Indeed Kernberg goes as far to say that the therapist’s desire to be supportive of the patient could already represent an example of ‘counter-transference’ that...
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is ripe for analysis: the abandonment of what Kernberg calls ‘the analyst’s technique of neutrality’ for a relational dynamic, and a potential trap, driven unconsciously by a patient as a possible projective counter-identification. (Migone 1999)

A change is provoked in the therapist, stimulated by counter-transference from the patient: in other words, the patient’s transference and the therapist’s counter-transference meet in a mutually enriching dialectical engagement in the course of analysis. There exists, then, in the external practitioner–beneficiary dynamic what in physics is called the ‘principle of interchange’, which postulates that, following an interaction between two bodies, traces of this interaction remain in the two elements concerned.

In light of this, there is little point in talking about self-development in the absence of an external stimulus to it. We have seen that it is impossible to produce systemic change and improvement without introducing a new element into a system. An intercultural variable is thus introduced into the patient–therapist analysis: we would underline the importance of an external agent to assist in the development dynamic, the more so if this agent is from a different culture. In psychotherapy, this is called ‘analysis of the demand’ or ‘diagnostic formulation’—the phase in which the unconscious element of a request for help (the fundamental but hidden motivation) is clarified with the patient. Often this unconscious wish is very different from what is explicitly wanted—it could even be quite the opposite. For example, the declared wish to change a situation could well conceal the real but unconscious desire to leave things as they are.

A cure requires a ‘therapeutic contract’, or else some preliminary agreement, which evidences confidence in and trust between patient and therapist. Similarly, development assistance is not just a matter of responding to the requests of beneficiaries, or of inventing solutions for them. However, the full consent of the ‘beneficiary’ is necessary before any intervention can be made in the patient’s system.

Critical analysis of our own reality

We would find ourselves with patients not requiring any treatment if beneficiaries were in a position to freely express their problems and their root causes and to come up with solutions. Development assistance is founded precisely on the principle that people should be empowered to analyse their specific situation and its causes critically, to identify opportunities for improvement, and to develop the ways and means to act on them and find solutions. Paolo Freire argued that it was necessary to support the oppressed on their road to liberation. In Pedagogy of the Oppressed, he stated that ‘education needs to be seen as a praxis of liberation . . . enabling people to become critically conscious of their own reality’ (Freire 2000).

At times, oppression creates a situation in which a population cannot act proactively, is conditioned by its oppression, and is fatalistic in accepting things as they are. In such cases, the role of the external practitioner is more complex: it is noticeable that the more a people are oppressed, the more difficult it is for them to participate in their own development and express their own needs.

I recall my first project planning session with indigenous Mexican women. In the course of the meeting I had to address the assembled group of young Indian women with my back turned, because to them speaking to a man directly face to face—let alone discussing a proposal for a project—was not acceptable. It took a whole afternoon to work through with them what kind of support they needed. The answer? A sewing machine! I remember asking myself that day what my role should have been in that context: that of a listener, plain and
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simple, or that of a proposer, negotiator, catalyst, stimulus, or analyst perhaps. . . and for every one of these the definition of what would have been required of me in each capacity would have been different.

It should be said that, all on their own, individuals are unlikely to be drawn into analysing how, and what, moves them—that is, to analyse the counter-transference. However, the focus provided by such an analysis, in examining the personal and immediate resources at hand, reveals how much depends upon the practitioner to improve a given situation.

Now, if it is difficult for a single individual to accept and get used to this practice of counter-transference, it is even more difficult for a collection of individuals, for a group, because to be non-formulistic, real, and truthful, counter-transference analysis includes exploring depression. (Pagliarini 1993)

Depression as a basis for regeneration

The first two steps required to bring about a process of change are an awareness of one’s own reality and the ability to challenge it. A development practitioner-cum-therapist has to set in motion a delicate process of local popular participation that gradually leads to a critical analysis of a specific situation, and to the actions that need to follow in order to achieve integrated development, be it at the personal or at the community level.

Let us now look at another dilemma: if we understand a psychic illness to be the breakdown between a person and his or her environment, a therapist should guide the patient towards a state of well-being. What exactly is that state of well-being? What is to be the benchmark? And who decides? Once again, we need to refer to our own vision of the world in order to find an answer and then to ‘negotiate with the patient’.

Responsible support on the part of a therapist or an external practitioner must therefore ensure that:

- individual project ‘beneficiaries’ are guided through a process of self-awareness to an understanding of the context in which they find themselves, and of their own potential and limitations;
- the group’s depression and regeneration are managed within a process in which a ‘project’ is only a temporary tool, a short-term intervention in the context of the beneficiary population’s history;
- this is done following a clear diagnostic formulation, within the framework of an agreement in which a therapeutic contract predicated on mutual trust and confidence binds the beneficiary and the practitioner to a long-term commitment.

Such a process sets the preconditions of real self-development: a given population, besides building its own road to self-improvement, addresses itself to the causes of and reasons for its current situation, and not simply to international cooperation as a surrogate of itself or some local state authority.

Finally, one needs to take into account that one of the major blocks to beneficiaries defining their own way to improve their welfare is rooted in cultural factors that are practically impossible to overturn within the timespan of a project: it is for this reason that in any serious therapy one knows when to begin but not when to end. In the same way, the relationship between practitioner and ‘patient’ or ‘beneficiary’ cannot be limited to the duration of a project.

References

Community development in Malawi: experiences at the grassroots

Paul Kishindo

There are many definitions of community development (CD), but the most relevant to Malawi is that of the UN, as ‘a process by which the efforts of the people are united with those of governmental authorities to improve the economic, social and cultural conditions of communities, to integrate these into the life of the nation and to enable them to contribute fully to national progress’ (United Nations 1963:4). For the UN, the essential elements in community development are:

- *participation* of the people in efforts to improve their living conditions with as much reliance as possible on their own initiatives; and
- *provision* of technical and other services by governmental agencies in ways that encourage initiative, self-help, and mutual help, and also make these more effective.

At independence in 1964, the government of Malawi adopted the UN conception of CD and sought to use it as a strategy to develop the rural areas, home to more than 80 per cent of the population. Communities were to formulate their most pressing needs and devise their own solutions to meet them, with assistance from the government and its institutions only to the extent that local human and financial resources were inadequate (Malawi Government 1988:125). National development was viewed as the ultimate goal of community development (Ministry of Health and Community Development 1969:6).

The UN definition was formulated before NGOs had become active players in grassroots socio-economic development. Today, however, NGOs are not only actively engaged in partnerships with communities but may even surpass government involvement in this field.

Theoretically, it should be possible to achieve community development without external assistance if all needed resources were available within local communities. The reality, however, is that the paucity of resources forces them to rely heavily on outside support for major projects, a situation which has sometimes led to donors or technical experts playing a dominant role in what is supposed to be an equal partnership (Kishindo 1994:206–207).

Three types of community projects can be identified in Malawi:

- community-initiated projects not requiring external assistance;
- community-initiated projects requiring external assistance; and
- centrally defined projects requiring local community contribution.

This paper reviews four community projects of the second two types from Balaka district in the southern region of Malawi and seeks to draw from them insights into CD in the Malawi context.