

**THE INFLUENCE OF THE PHILOSOPHICAL STANCE OF THE
NARRATIVE PASTORAL THERAPIST IN GROUP THERAPY**

by

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SUMMARY

This study enquires into the influence of the philosophical stance of a narrative pastoral therapist in therapeutic groups for people living with depression within a church context. For the purpose of this study, a philosophical stance is defined as a metaphorical position which represents the therapist's epistemological stance and which shapes his or her interactions with the therapy group members. An explanation of the building blocks of the therapist's preferred philosophical stance is provided, the influence of modern and postmodern discourses in developing such a stance is discussed, and the effects of the therapist's philosophical stance on the group members are explored. The research is directed towards everyone who is involved in pastoral therapeutic groups for people with depression. The study found that concepts such as 'relational', 'collaborative', 'participatory approach', 'mutual care,' 'self-other growth' and 'co-creation' highlight some of the most helpful contributions provided by the therapist's preferred philosophical stance.

Key terms:

philosophical stance, narrative pastoral therapist, depression, epistemological stance, modern and postmodern discourses, relational, collaborative, participatory approach, mutual care, self-other growth, co-creation.

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INTRODUCTION

In doing this research, I realised that the therapy I am engaged in is meaningful and helpful to people. Before I embarked on this study, I doubted this, because I had been trained in a modern paradigm according to which efficiency should be measurable in terms of certain results, and problems should be fixed. Consequently, I thought I should have all the answers to people's dilemmas.

Since I have been introduced to a postmodern epistemology, I have adopted the stance that truth or knowledge is not absolute; that, indeed, it can be a different thing to different people. I now believe that knowledge is (co-)constructed as people interact and that each person interprets events differently. At first, this notion was somewhat confusing to me, as the certainties I had grown up with were a little shaken, including certainties about what is 'right' and 'wrong'. I became aware that many of my solid 'beliefs' were based on discourses which were socially constructed by those with the power to determine who can speak and with what authority. I made many assumptions, for example, about the meaning of concepts such as 'unconditional acceptance', which I now realise can have multiple meanings. My thinking shifted from being only 'black' and 'white' to lingering more often in the grey areas, where I discovered God's grace to be at work. It was often in these grey areas where I was surprised by the beauty and value of differentness.

I now view and approach therapy differently. Therapy is something I do *with* people. Together we co-construct new realities as the endless possibilities of the different shades of grey are creatively explored, subtly guided and influenced by the undertone of 'universal truths'. In doing this, multiple 'truths' can be held to be true, as grey areas allow for 'both/and'.

Dancing in the grey areas allows the soul back in; and both the client and the therapist are changed by the pastoral therapeutic endeavour as they join with one another and with God in 'a Godly dance' (Volf cited in Niemandt 2007:140).

A young girl from one of my therapeutic groups came to see me in private about her struggle with her own 'un-Christian' (her words) behaviour. Coming from an Afrikaans, fundamentalist, evangelical church background where I was taught to show people the 'right' way, it was very hard for me not to tell her what she should do according to my truths. I remember the tension in my body as I was listening to her, consciously putting aside my own ideas on the issue, while I asked her about her local knowledge. This girl has made life-changing decisions, as she could see things in a new perspective.

At the end of our research process, she said: 'I was formerly on a path of destruction; now I am on a path of healing. My life is filled with the things I enjoy.'

In the therapy group I was amazed to see how this girl reflected on the things that the other participants shared. She found her own voice. What excites me even more is her dream of using her new-found drama talent as a 'voice', creating a new discourse on depression in the church with others.

Instead of using my truths or so-called expert-knowledge, I now co-create new meanings and new realities with people, and my practice resonates with the following insight on the need for poetic language by Ricoeur (cited in Parry & Doan 1994:4):

Scientific language seeks to reduce a word to a single meaning (truth). But it is the task of the poetic (or narrative) to make words mean as much as they can and not as little as they can. Therefore the aim is not to elude or exclude this plurivocity, but to cultivate it, to make it meaningful, powerful, and therefore to bring back to language all its capacity of meaningfulness.

In my concluding remarks, I describe the shift I have been able to make...

CHAPTER 1

MAPPING THE HISTORY OF MY PHILOSOPHICAL STANCE

1.1 INTRODUCTION

This research project set out to explore my preferred philosophical stance – the stance that guides and supports my practices as a group pastoral therapist.

According to Anderson (1997:94), a philosophical stance refers to a way of being in relationship with our fellow human beings, including how we think about, talk with and respond to them: ‘It reflects an attitude and tone that serve as the backdrop for my relationships with clients and the therapy process, how I locate myself in a conversation.’ A ‘philosophical stance’ therefore represents a way of looking at and experiencing the world, and it is inevitably influenced by our values and biases: ‘It is a metaphorical position in which our social and personal attributes are convened’ (Anderson 1997:94). Until I began this study, I had facilitated many pastoral therapeutic groups, sometimes unknowingly, with a certain philosophical stance that shaped my interactions with the group members.

This central concern of this research project was developing a greater understanding of what the building blocks of my philosophical stance are and how that stance affects the group members’ experiences within the group context. In order to do this I formulated the following research curiosities and questions.

1.2 RESEARCH CURIOSITIES

I was curious about how my values and beliefs have influenced the stance that I take with other people in a therapeutic group context. I wondered what my preferred philosophical stance looks like in action as I journey with the group members. What effect(s) do my own experiences have on my therapeutic relationships and my listening to others? What does my therapeutic commitment entail and how does it affect the participant’s responsibilities? How does the way that I position myself

epistemologically influence the therapeutic group process? What narrative practices are helpful in a group setting where people journey with depression?

On the basis of these areas of curiosity, I asked the research question below.

1.3 RESEARCH QUESTION

What are the effects of the philosophical stance that I prefer to take in pastoral therapeutic groups?

1.4 RESEARCH AIMS

Two research aims were selected for this research project: the first research aim was to explore the effects of my philosophical stance on the research participants' experiences in the pastoral groups; and the second was to explore, with the research participants, other helpful elements of the philosophical stance of the pastoral therapist that could be included in the engagement with pastoral therapeutic groups.

In the next few sections I set out and discuss the development of my preferred philosophical stance. Furthermore, I explain the building blocks of my preferred philosophical stance – a positioning that guides my interaction, roles and responsibilities within pastoral group contexts.

1.5 MY OWN JOURNEY

I was the fourth child my mother had in four years; and she was not very excited about having me, especially because I was the third girl and my mother really wanted another boy to take her father's name.

I remember a happy, but somewhat lonely childhood. I felt loved by both my parents, but, as the youngest child, I felt 'voiceless'. Comments such as 'Oh, she is just in another phase/stage – the others also went through it' silenced me, preventing me from

sharing my own unique experiences. My mother called me her 'soet' (well-behaved, good) child.

When I reached high school, depression became a regular companion. I remember trying to talk to our pastor about the depression and about suicidal thoughts on a youth camp. His reaction was that it was a sin, and I walked away feeling condemned and, once again, silenced.

When I was at university, depression got the better of me. One night, in desperation, I called my parents, and finally they got me proper help. I received medication and talked to a psychologist. I do remember, though, that I did not want any of my friends to know about the depression, because of the stigma attached to it.

Even after I married Hendrik, who knew all about the depression I battled with, I was afraid that anyone else would discover my secret. Hendrik was a minister in the Dutch Reformed Church in Windhoek and I was concerned about his position and how it would be affected if anyone knew about my depression.

Later I trusted a few close friends with whom I could share my feelings and experiences of living with my 'secret'. It helped a lot to be able to voice my feelings.

We then moved to the eastern part of Pretoria, where Hendrik had applied for a post as Missions pastor in a large congregation. The transition was extremely hard and painful for me, as I felt excluded in more than one way.

We have a daughter, Charlotte, who was diagnosed with Rubenstein-Taybi syndrome and is mentally handicapped. While our friends in Windhoek accepted Charlotte as part of our family, I felt that she was socially unacceptable in our new environment. Consequently, I did not participate in social events unless I had someone to look after her. These negative experiences excluded me socially and marginalised me in the church.

In this new congregation I also experienced exclusion because I was a woman. Ten years ago, when we came here, the powerful positions in the congregation were all taken by men. Hendrik and I had formerly functioned as a team of equals, but then I was given a very clear message by the Church Board, which consisted only of men, that they had hired Hendrik to do the 'job' and that I should be very grateful that I was not obliged to do anything in the church. I presume that for some pastor's wives this would be a relief, but I felt rejected. At that time, I regarded Hendrik's calling as 'our calling' and I would have preferred to be talked to and to be asked what my opinion was on the issue – instead, I was silenced by those in power.

Then, of course, I still had my secret relationship with depression, which had worsened by this time, because of the painful transition to the new environment. I felt very keenly the loss of my friends, of my husband (who was so busy) and the loss of the dreams of 'our calling' in the ministry. I felt intensely isolated and lonely, frustrated and angry, helpless and misunderstood. These experiences of isolation made me increasingly aware of the effects of marginalisation on others who also face marginalisation.

1.5.1 My journey with those who are marginalised

*They drew a circle that shut me out
Heretic, rebel, a thing to flout
But love and I had the wit to win
We drew a circle that took them in.*

Edwin Markham (cited in Jamieson 2002:152)

Ward and Wild (cited in Jamieson 2002:158) argue that 'to define oneself as marginal is to define one's self in relation to someone else's centre; it is to accept another's definition of how things are'. Because of my experience of being 'pushed' from the centre to the margin, I identified with others who have been marginalised, especially by the church.

Through Charlotte, I came into contact with other differently abled ('handicapped') children. I became aware of these children's need to socialise and to be part of the

church. I began to talk to other parents of differently abled children and realised that most of them took turns coming to church as they could not bring their differently abled children with them, or else they could not attend church at all. Thus even the parents were excluded from the church because of their children's differentness. I asked them whether it would be helpful to have a group for these children during the church service. My aim was twofold: the children could experience 'church' in the group and the parents could be part of the formal church service (included).

My engagement with marginalised others soon expanded to include not only parents and children who are differently abled but also people who struggle with depression. About three years ago, I began to engage in therapeutic conversations with another group of marginalised people: women who were struggling with depression. After I had had individual therapeutic conversations with some of them for some time, I decided to start a group for people who live with depression. This decision was initially made because it became very time-consuming for me to consult with so many women on an individual basis. I also felt that the members of the group could benefit more from interacting with one another, because, according to Nicholas (1984:4) individual learning and change take place in an interpersonal context. Particular opportunities for interpersonal learning are afforded by a therapy group which cannot be duplicated in individual therapy.

Depression is a real concern in the church today. Benner (in Stone 1998:3) conducted a study in which he found that depression was the second most frequent concern brought to pastors by parishioners. This finding highlights the fact that church communities are faced with the challenge of caring effectively for people who are struggling with depression. In response to this challenge, I want to provide a caring context for people who are struggling with depression. Furthermore, my own journey with depression has convinced me that an abundant life (John 10:10) is possible for people who live with depression. It was therefore my intention to start a group for people struggling with depression, so that the group members could also experience an abundant life, despite the influence of depression in their lives. A group for people struggling with depression was my way of doing 'hope with those who have lost hope' (Weingarten 2000:402), as 'hopelessness is the perspective of most depressed individuals' (Stone 1998:74).

The group initially started with three women and myself, but soon grew to about seven women. Since then the membership has changed, with some people leaving and others joining the group. I also started a second group for working people, which included men, as they could not attend the morning group.

My groups started as pastoral care groups, as the participants asked to be helped, and we met regularly at a fixed time and place, as suggested by De Jongh van Arkel (2000:X). However, as I became more acquainted with narrative practices and other therapeutic methods, the groups became a source of a more specialised form of care, which, according to De Jongh van Arkel (2000:X) can be regarded as pastoral therapy. Heitink (1983:49) also states that group therapy requires specialised knowledge or expertise. I therefore now choose to refer to the groups as pastoral therapeutic groups. I do think, however, that the position of these groups in terms of this definition is not stable. Sometimes we move into other levels of pastoral work, for example, when we care for each other as group members, we are engaging in mutual care.

According to Clinebell (1966:210), group therapy (or group psychotherapy) describes a cluster of group approaches to therapy. They have the following characteristics in common:

- (i) The group has an avowed therapeutic purpose, which the members know in advance.
- (ii) Its activities are limited to those activities which are psychotherapeutic.
- (iii) The dominant concern of the group is its members' growth in self-awareness and self-acceptance and their ability to form creative relationships.
- (iv) Complete freedom of expression is encouraged and expected.
- (v) There is a continual and intensive focus on interaction within the group.
- (vi) Such groups are usually small (six to eight members). Many such groups continue to meet over several years.

Lindijer (1984:228) summarises 'group pastorate' as pasturing to each other, receiving pasturing from each other, true communion, engaging at a deeper level regarding faith and life issues.

Yalom (1995:17,21) stresses the importance of interpersonal relationships for people struggling with depression. As interpersonal relationships are the key to the therapeutic power of the therapy group, issues such as passive dependency, isolation and so on are addressed. The goal shifts from providing or finding relief from suffering to changing interpersonal functioning, a process unique to the group setting. Houtsma (1981:42) agrees that a group setting provides a specific 'growth-experience' that is not possible in the relationship between only two individuals. It seems that pastoral therapeutic groups are a very effective way of caring for people with depression.

After some time, it appeared that the groups 'worked', because the participants kept coming back and said things such as 'the group is my life-line'. I began to ask myself questions such as the following: Why did they continue to come? What happened in the group that was helpful to them in their struggle with depression? What role did I play in this? This life-line people talked about made me wonder about the possible relationship with isolation, marginalisation and depression, and about my theological and philosophical positioning as a Christian in caring with those who are marginalised.

During these group conversations, a question that seemed to emerge time and again was what the church generally thinks of depression. Does the church agree with the medical model of depression as described in the DSM IV (American Psychiatric Association 1994:317-391), or does the church perhaps assume that 'depression is entirely spiritual in nature' (Lockley 2002:16)? Is it possible that the church unwittingly contributes to experiences of marginalisation by people living with depression? A definition of depression, possible discourses on depression, and how the meaning of the word depression is socially constructed are issues explored in more detail in the next two chapters.

The questions mentioned above and some of the group participants' responses beckoned me on in my journey to continue finding ways for the groups to provide a safe space for

group members – a space where marginalisation is not experienced – in a ministry of involvement and participation, as advocated by Cochrane, De Gruchy and Peterson (1991:53).

1.5.2 Groups as a ministry of involvement and participation

To me, being church means participating with those who are marginalised. During the time when I was hurt by the church and felt excluded, I identified with people who, like Yancey (2001:5) wondered: ‘Where do I belong now?’ After having a conversation with a psychologist, I realised that being in these groups with the marginalised is my way of having a ‘church’ and of practising my faith. ‘Church’ in this context is a faith community with its own theological and liturgical life, apart from, but influenced by the mainstream church. Here I, with the other group members, can participate more freely in deciding how to express our faith, as suggested by Ackermann (1996:32), Barna (2005:58) and Ward and Wild (cited in Jamieson 2002:160). These groups provide a (faith) context in which I feel a sense of belonging and closeness – an experience that I have seldom had in the institutional church. In this regard, Ackermann (1998:94) differentiates between the institutional church and communities of faith. She says that faith communities include small groups of people who, although they are members of the church, follow the tug of their hearts to share and explore faith together in environments which favour closeness.

I was perhaps fortunate in this regard, in that I learnt a great deal from my mother, who believed that being church was also about having fellowship and communion with the poor, the elderly and the coloured people on my parents’ farm. She modelled church by caring and praying for them, inviting them to the friendly space of her house, listening to them, learning from them and enjoying their differentness. My philosophical stance is, in a sense, a reflection of these values I learned from my mother.

In the groups I have a voice and I am involved in creating a space for others to ‘be heard into speech’ as Morton proposes (paraphrased by Ackermann 1994:206). Ackermann (1994:206) argues that this is both a theological and a critical pastoral issue, because, in

addition to women's welfare, the values which shape our society and the church's role in shaping these values are at stake.

It therefore follows that in order to find speech and be heard, it is vital to create a safe space in which difficult things can be said, brought out into the open and explored. This is an important environment for many people's journeys of faith and their understanding of God at work in their lives (Jamieson 2002:146). Pattison (1993:48) proposes that a key factor in helping relationships is an attitude of acceptance which is non-authoritarian and which allows people to articulate their real feelings, a willingness to build up the empirical particularity of the situation under consideration, rather than judging it beforehand in a general way. Babin (cited in Niemandt 2007:82) suggests that the relationships that people find in small groups may well thrive in a postmodern world, as groups provide a safe place in which these relationships are cherished and can grow.

A participant in one of my groups once said that he felt excluded by the church because of its focus on victory and success. This appears to be a powerful belief within some faith communities. Jamieson (2002:147) suggests that stories of difficulties and struggles on a Christian journey need to be placed alongside those of victory or success. Jamieson (2002:158) adds that this acknowledgement of diverse experiences happens more often in the context of smaller faith communities.

These groups for people struggling with depression have become my 'faith community', but I often wondered whether the other group participants regarded the group in the same way. This research project attempted to understand what the group participants' experiences of these groups are. Do they also experience elements of being part of a 'church' within the group? Is this experience of being part of a church in any way helpful to them?

Apart from wondering whether these groups act as an alternative faith community for the members of these groups, I also asked myself about my role as facilitator in these groups. Embracing the calling towards a ministry of inclusion and participation, I, as group facilitator, enter into and bring into these groups a certain way of being or what

Anderson (1997) would call a philosophical stance. This study therefore also responds to a curiosity about the group members' opinions concerning what I, as the group facilitator, bring into the group that makes it beneficial for them to come back every week. I also wondered about being transparent to the group members about the philosophical stance that guides me as a pastoral group therapist, and about asking the group members to reflect and comment on the effects of this stance on their lived experiences within the group context.

1.6 A PHILOSOPHICAL STANCE

In this section I briefly mention the building blocks of my preferred philosophical stance. I believe that it is very important that this philosophical stance should become visible both to myself as a researcher and therapist, and to the research participants or group members, as these building blocks of the philosophical stance were the object of inquiry in this particular research project. My preferred philosophical stance has the following building blocks: first, values, beliefs and experiences; second, social constructionism; third, feminist theology; fourth, contextual practical theology; and fifth, therapeutic practices. This stance is only one of many different possible positions in pastoral group work. Some of the other positions are explored in more detail in the next chapter.

1.6.1 Values, beliefs and experiences

Every time when I enter a group, I bring along my own set of values that guide my interaction(s) with each person. I would like to define values as something that 'really makes us tick'. Malphurs (1996:14-37) describes values as being representative of what each of us stands for in life. They define who we are and what we are willing to do for ourselves and others. A value stirs our passion and excites us. Thus, values are the basis of my behaviour, as they rouse me to action.

Because of my exposure to narrative practices, I decided to attend a one week workshop in narrative therapy presented by Elize Morkel. After this workshop, Elize wrote a letter to each participant. She is my oldest sister, and she wrote the following letter to me:

'Your presence at the Intensive added a family dimension to my training that I have not experienced before. It stretched me into reflecting even more closely on family connections, the influence of my Christian beliefs, the role of the values that we were brought up with and life experiences that we share.' This letter made me realise that it is not only my experiences, but also my Christian beliefs and the values I have been brought up with that play an essential part in my identification with those who are marginalised.

In Yancey's (1997:279-280) discussion of Jesus' conversation with the Samaritan woman at the well, he marvels at Jesus' tenderness in dealing with people who are 'different'. Jesus treats them with mercy and without any judgement. The Jesus I know embodies the values that I would like to embrace, such as love, mercy, respect for all people (irrespective of their social status), acceptance, inclusiveness, trust and servanthood. I am aware, however, that this is not fully possible and depends very much on how each of these words is interpreted.

I want to be part of groups (a church) that 'measure(s) goodness by what we embrace and by who we include' (quoted from the French film *Chocolat*). Community is another Christian value I embrace, as I will explain in more detail later. As John Edwards (cited in Ambler 2005:3) said: 'One alone is nothing.'

I believe that the values and beliefs I hold influence the group members, as values are accepted by people if a leader (a facilitator) models those values with authenticity and passion over an extended period of time (Ambler 2005:4), just as I was deeply influenced by my own background.

In addition to identifying the preferred values that accompany me into every therapeutic encounter, another building block of my philosophical stance is my position concerning knowledge and truth.

1.6.2 A social construction discourse

As a young teenager I was confronted with a pastor's opinion that depression was a sin. In Biblical terms, a sin is a 'violation of that which God's glory demands of us and is, therefore, in its essence the contradiction of God' (Douglas 1980:1190). Being a young, vulnerable and religious person I was confronted with the powerful effects of such a statement, especially since it was made by an all-powerful and authoritative male pastor. Because I respected his authoritative position, which he had been accorded by a religious institution, I accepted his words, according them a lot of truth status. However, a few years down the line, I was exposed to the concepts of social constructionism and, all of a sudden, the truth status of that pastor's words was challenged and I began to experience a sense of relief, realising that perhaps depression is not a sin.

Consequently, I position myself within social constructionism as a postmodern discourse. Social constructionism suggests that what we regard as truth is historically and cross-culturally specific. 'Truth' is not a product of any objective observation of the world. Instead, our currently accepted ways of understanding the world are a product of social processes and interactions amongst people. This implies that our knowing is inherently contextual (Brueggemann 1993:8). The opinion that depression is a sin is therefore only one construct amongst many other opinions or constructs concerning depression. In a postmodern, social construction discourse, I found freedom in the following words by Brueggemann (1993:17): 'All claims of reality, including those by theologians, are fully under negotiation.' Regarding knowledge as socially constructed assists me when I am in a conversation with a person who is struggling with the stigma associated with depression.

Furthermore, social constructionism challenges the idea that there are essences inside things or people that make them what they are. Essentialism traps people in personalities that are limiting, while social constructionism opens up possibilities, as people are seen as 'the product of social processes and do not have a given, determined nature' (Burr [2003] 2004:4-6).

In a postmodern world we no longer assume that people's identities are primarily stable and singular (Drewery & Winslade 1997:38). A person's identity is continuously emergent, re-formed and re-directed as the person moves through ever-changing relationships (Gergen 1991:139). Unlike essentialism, postmodernism suggests that there are multiple selves and multiple identities. Labelling individuals in terms of a single identifying characteristic (such as 'being depressed') denies their multi-dimensionality and humanness (Sands 1996:168,174)

Who and what we are is not the result of our 'personal essence', but of how we are constructed in various social groups (Gergen 1991:170). Because the world is constructed when people talk to each other, language can be seen as a form of action and knowledge, as something people do together (Burr [2003] 2004:8-9). According to Freedman and Combs (1996:16), 'the realities that each of us take[s] for granted are the realities that our societies have surrounded us with, since birth. These realities provide the beliefs, practices, words and experiences from which we make up our lives or "constitute ourselves"'. The way people think is constituted by the language they use (Burr 1995:7). The way we speak is our tool for making sense (meaning) and the ways of making sense are susceptible to change (Drewery & Winslade 1997:34). A social constructionist framework therefore makes it easier to rename one's experience – to make sense of it – differently (Drewery & Winslade 1997:47).

The importance of language and its constitutive effect can be illustrated by referring to our language about depression. If I say that 'you are depressed', I construct your identity as one of depression. However, by using language to separate a person from depression and referring to depression as a problem that is external to the individual, the picture may sound very different; for example, I could say instead that 'it seems that you are suffering with depression'. Thus a different identity can be constructed. When these words are used, depression is no longer constructed as the essence of who you are. Within a social construction discourse, therapeutic approaches such as narrative therapy seek to harness such ideas about the power of language and about how the self is formed and reformed through the use of language (Drewery & Winslade 1997:39).

Weingarten (quoted by Freedman & Combs 1996:17) explains that in a 'social constructionist view, the experience of self exists in the ongoing interchange with others.... The self continually creates itself through narratives that include people who are reciprocally woven into these narratives'. Thus it appears that a group setting provides ample therapeutic opportunities for new stories to develop, as ongoing interchanges with others take place and new realities are constructed. This process of construction and reconstruction cannot be accomplished by individuals on their own (Burr [2003] 2004:53).

I cannot assume that the other group members hold the same knowledge of depression as I do, or that my knowledge is more valid, true or privileged than theirs (Burr 1995:4). There may, however, be similar social, cultural and spiritual conditions that give the group certain (sometimes shared) understandings and assumptions. The contextual nature of truth and knowledge has also influenced my understanding and positioning in doing theology. I agree with Bosch (1991:422-423) that all theology is, by its very nature, contextual. As a deeply religious person, I am unable to separate myself from my own theological positioning and therefore this positioning is another building block within my epistemological stance.

1.6.3 Feminist theology

Because I am concerned with those who are marginalised, the pastoral therapeutic groups are an expression of my preferred ministry of inclusion and participation. Feminist theology supports and guides me in my attempts to side with those who are marginalised and to challenge the effects of marginalisation. Feminist theology thus influences the way in which I conduct the groups.

Christian feminist theology focuses on doing justice to all of humanity (Keane 1998:134). It wants to affirm all people's humanity in a just, loving, liberating and healing praxis (Ackermann 1994:199). Feminist theology, as a liberation theology, endorses a pastoral practice that seeks justice, peace, healing and wholeness for all (Cochrane et al 1991:96).

A definition of a feminist theology of praxis proposed by Ackermann (1996:34) suggests a 'critical, committed, constructive, collaborative and accountable reflection on the theories and praxis of struggle and hope for the mending of creation based on the stories and experiences of women/marginalized and oppressed people'. Feminist theology is therefore not only about the liberation of women, but about the liberation of all marginalised people. In a world that groans under much oppression, injustice and exploitation, it is helpful to remember that a biblical concern is the liberation of all God's children, so that they can become more fully human (Tutu 1983:37).

In the groups, I realised that many people (men and women) who live with depression experience themselves as being excluded, marginalised and isolated by and from the church and by and from society. This appears to be a common link between us. Possible reasons for the church's marginalisation of people with depression are that the church does not understand mental illness (as it is complex), that there is a false assumption that a Christian life should always be an easy path, and that the problem of suffering is hard to grasp (Greene-McCreight 2006:36; Oosthuizen 2007:11; Stone 1998:9). I therefore side with feminist theologians who have devoted themselves to finding a more inclusive view of humanity that affirms the value and integrity of all humans.

Relationality describes an inclusive view of humanity, as it challenges alienation, apathy and exclusion. It is a practice of love and justice between people, as Jesus commands us to love, according to Mark 12:30-31 (Ackermann 1994:203). Love cannot exist in isolation, it is by nature a relational activity. Active loving is living in relationship with yourself, with your neighbour, with God and with creation (Ackermann 1994:203).

Connected to the whole idea of relationality is the metaphor in 1 Corinthians 12:12-31 of the body of Christ. In this regard I agree with what Brand (cited in Yancey & Brand 2004:57) says of the body of Christ: 'If each (member) will acknowledge the worth in every other member, then perhaps the cells of Christ's Body will be acting as Christ intended'. Cloud (1990:82) interprets the image of the body of Christ as the value that God places on mutuality: 'You are part of a body and you cannot be emotionally

amputated from the blood-flow and expect to thrive.’ We are all healers who can offer health, and we are all patients in constant need of help (Nouwen 1998:66).

Psychology and pastoral care have tended to emphasise individuality at the expense of community. This is clear from the essentialist notion mentioned earlier that depression is an internal state of being residing within an individual. Individualist thinking could lead to the marginalisation and isolation of particular individuals. I therefore also value relationality and community, particularly the therapeutic value of being in community. As Tutu (1983:17) has said, a ‘person is a person through other persons’. I express this view in participating in groups, because I agree with Nicholas (1984:5), who is of the opinion that ‘the sense of community that binds the group over time is one of its primary healing agents’. Palmer (cited in Patton 1993:22) defines community as ‘a reaching for deep, inner insight about connectedness with one another, with the world, with God’s reality. Instead of conflict the church should offer comfort; instead of distance between persons, intimacy; instead of criticism, affirmation’.

According to Mother Theresa (cited in Ringma 2004:135), it is our responsibility to be a family to one another, a community, revealing to one another something of God’s love, concern and tenderness. Because we are part of one body, as Christians, we are responsible for that body as a whole (Cochrane et al 1991:84).

Tutu (1983:37) stresses the importance of community, saying that ‘we need one another in a pluralistic world for none can ever be self-sufficient. We are interdependent or we must perish’. Playing on Descartes’ famous words ‘Cogito ergo sum’ (I think therefore I am), Mbiti (cited in Niemandt 2007:67) said, ‘I belong, therefore I am’.

In a group setting like ours, ‘relationship’ is a key value. Marginalisation implies that people experience exclusion and are more likely become isolated. Because isolation ‘feeds’ depression, a group setting where people connect with other people in relationship can challenge isolation and exclusion. Cleve (cited in Stone 1998:76) argues that ‘loneliness is known to further complicate and aggravate depression...Contact with other people and an ongoing support system are extremely

effective defenses against depression'. Friendship is therefore very important for the mentally ill (Greene-McCreight 2006:33).

As a chaplain, Nouwen (cited in Yancey 2001:294) felt overwhelmed by people's sense of isolation as he heard their stories of guilt and shame. He wanted to draw them together to share their stories with each other, so that they could discover how much they had in common. Each person thought that only he or she struggled with a particular pain or doubt; however, in reality they were confessing a shared humanity.

Because I value mutuality, community and relationship, I agree with Heitink (1999:256) 'that the church has the responsibility to search for a credible way of "being church", for new forms of Christian community that call for a counter culture, against an extreme individualism and an anonymous bureaucratic collectivity'.

According to Heitink (1999:256), the time of 'grand narratives' (ideologies) has passed and the utopia of the coming of God's Kingdom should continue to be alive, through the 'small narratives' of movements, action groups and church communities. Pastoral therapeutic groups provide a context for a group of people to get together and to reflect the values of the commonwealth of God (justice, love, freedom and relationality) within their present context (Ackermann 1996:23).

1.6.4 A contextual participatory approach to practical theology

In this section, the role of group therapy as a pastoral therapeutic practice and where it is situated within practical theology are discussed.

In a contextual approach to practical theology, a lot of emphasis is placed on context. According to Bosch (1991:426), contextualisation suggests an ongoing dialogue between text and context, between a praxis of experience and reflection. Furthermore, Bosch (1991:424-425) suggests that in a contextual approach, the emphasis is on doing theology, since 'doing is more important than knowing'. As another of the building blocks in my preferred epistemological stance, contextual practical theology therefore guides my way of doing pastoral care. My pastoral involvement in these groups is

mainly informed by the group participants' local context – their own experiences of living with depression in a (sometimes) very unfriendly world.

Bosch (1991:423) maintains that contextual theology is theology from below. The privileged perspective is not the one which looks down from the heights of domination over others, but the one that gazes upward, from the pain, suffering, humiliation and indignity faced by human beings (Cochrane et al 1991:79; Pieterse 1998:79). Thus, the group members, as those who are marginalised in society due to their struggle with depression, experience themselves as being in the 'outer circles' of society, a term coined by Ackermann (1996:41) of society. In a contextual approach, their voices are used to guide and inform any pastoral response, and as such they should participate in deciding on and constructing a world for them to live in. According to postmodernism, knowledge is not a static object that has to be explained, but it is an immersion in the process of the transformation and construction of a new world (Bosch 1991:424; Rossouw 1993:901).

According to Kotzé and Kotzé (2001:7), 'a commitment to do pastoral care as participatory ethical care immediately challenges us not to care *for* but to care *with* people who are in need of care'. Heshusius (1994:208) suggests that participatory consciousness is not 'about' someone, but 'being with' someone. This is a participatory process in which pastoral therapists collaborate with people in challenging oppressive discourses and negotiating ways of living in an ethical and ecologically accountable way. Thus a contextual approach to pastoral therapy becomes co-research with people in search of alternatives (Kotzé & Kotzé 2001:8-9). This philosophical stance appeals to me, as I have experienced very prescriptive groups in the past.

A last building block of my philosophical stance is the preferred therapeutic practices that accompany me and guide me in my therapeutic interactions with people.

1.6.5 Therapeutic practices

Within the groups I participate in, I use various practices to enhance the value of the groups for the participants.

1.6.5.1 Narrative practices

Because my practices are guided by the narrative metaphor, stories are central in my practice. I do not regard myself as an expert on other people's lives as 'a client is the expert on his or her life experiences' (Anderson 1997:95). He or she brings expertise in the area of content to our encounter, and I as the therapist bring expertise in the area of process (Anderson 1997:95).

Morgan (2000:3) uses the metaphor of a journey to describe a narrative way of engaging with people. I commit myself to journeying with the people in the groups. When one man called Conrad joined the group, he told me that he had seen about seven psychologists and that none of them could help him. He could hardly cope with life and wanted to know whether I would be able to help him. I told him that I was not the expert on his life, but that I was willing to commit myself to come alongside him and journey with him. During the three years I have spent journeying together with Conrad in the group, I have probably learnt more from him than he has learned from me. I believe that when we join someone on such a journey, we both change.

The metaphor of a journey is not the only metaphor that is used in the groups. Other metaphors, symbols, ceremonies and even rituals are also used, as they communicate on more levels than 'straight' communication. They often set off powerful associations, and their creative use allows for newness in therapy (Combs & Freedman 1990:xiv-xvii). The Eucharist is an example of using a ceremony to communicate hope at a deeper level in a powerful way (Louw 1993:481-482).

As I am guided by a narrative approach to therapy, my pastoral conversations with the group members also include stories about God. As we go on the journey, the story of God (as this is a pastoral encounter), the stories of the counsellor (the therapist) and the counselees (the group members) interweave in a fusion of horizons (Gerkin 1986:59-64). From this fusion, alternative life-generating stories emerge. Because I believe in this approach, I was curious about the ways (if any) in which journeying with each other was helpful to the group participants.

Over the course of my journey with the group members, my therapeutic position can be described as mostly a decentred and influential position. Michael White (2003:s.p.) uses the diagram overleaf to illustrate the different ‘postures’ a therapist can take up in conversations with the people who consult the therapist.

	De-centred	Centred
Influential	De-centred and influential (potentially invigorating of therapist)	Centred and influential (potentially burdening of therapist)
Non-influential	De-centred and non-influential (potentially invalidating of therapist)	Centred and non-influential (potentially exhausting of therapist)

Figure 1.1: Therapeutic postures (White 2003:s.p.)

According to White (2003:s.p.), the notion of being ‘decentred’ refers to the therapist’s achievement in according priority to the personal stories and the knowledge and skills of the people who consult him or her. Thus, these people have a ‘primary authorship’ status which is linked to the participatory approach. The therapist is influential, not in the sense of imposing an agenda, but in the sense of building a scaffold through questions and reflections. In this way, people can describe the alternative stories of their lives more richly by exploring some of the neglected territories in their journey to become better acquainted with their own knowledge and skills that are relevant to addressing the problems at hand (White 2003:s.p.).

I try to maintain a posture of being decentred by focusing on the group participants’ personal stories and by validating their knowledge and skills. I do, however, ask questions to evoke the relevant knowledge and skills that may address their problems, and as such I am influential. I believe that the reason why the group meetings energise me is that I take such a stance. This belief resonates with the comments of Monk (1997:25-26) and Russell and Carey (2003:80).

As I described the narrative practices that I applied in the groups, I wanted to know whether the participants found these practices helpful in any way in their struggle against depression and if, and in what way(s) these practices helped them.

1.6.5.2 Informative practices

As I have already indicated, I am in favour of a contextual participatory approach to therapy which favours ‘local knowledge’ derived from immediate concrete experience, rather than ‘expert knowledge’, which can be seen as partially provisional and biased (Payne 2000:25-26). This approach fits in with a postmodern epistemology that assumes that truth is not rational or objective (Dockery 1995:15).

I do, however, make use of ‘expert knowledge’ in the pastoral therapeutic groups, in the form of psychiatrists speaking on physical and medical aspects of depression, DVDs, books, and other sources of information. It appears that as long as we are aware of the ‘provisional and transitory nature of these knowledge[s]’ and do not regard them as ‘absolutes’, they can be helpful tools for discussion, critical reflection and deconstruction, as any attempt to gain knowledge involves a continual reflexivity (Parker cited in Lowe 1991:43). I was interested to know how the group participants experienced the use of informative practices and how such practices informed their own knowledge.

To summarise the above, it is clear that my values, my experiences, my beliefs, my world views, my preferred theology, the knowledge I brought, and so on, influenced my being in the group. The term that best describes the above mentioned elements that I (as a therapist) take into the group, and that affect the position that I take in the group, is my ‘philosophical stance’, as Anderson (1997:94) calls it (as described in Section 1.1 above).

In the next section I explain the research methodology that guided and assisted me in doing this research project.

1.7 RESEARCH APPROACH

The research design involves a blueprint or plan of how a study is conducted (Mouton 2001:55). My plan is set out below.

1.7.1 Empirical research

This was an empirical research project, as the ‘object’ of this study was to explore human behaviour – in this case, the effects of the philosophical stance of the therapist on the group participants in a pastoral therapeutic context. The design was exploratory, as I explored, together with the group participants as co-researchers, how they perceived my philosophical stance and how my philosophical stance affected their experiences in the group. Primary (new) data was used which consisted of the group participants’ own words as they shared their experiences. The data was textual, because the group participants presented their stories in the group context where therapy usually took place. In terms of Mouton’s (2001:144) description of control, the degree of control was low, because I as the researcher shared the responsibility of conducting the study with the participants.

1.7.2 Qualitative research

I positioned myself within a social constructionist approach (as discussed in Section 1.6.2), which is the key philosophical assumption upon which qualitative research is based; that is, the view that reality is constructed by individuals interacting with their social worlds (Denzin & Lincoln 1994:2; Merriam 1998:6). This study was interested in the meanings that the group members constructed regarding their journey with depression, as their experiences were affected by my philosophical stance in the groups.

According to Merriam (1998:8, 20), the design of a qualitative study is emergent and flexible, responsive to changing conditions of the study in process, which requires adaptability from the researcher. Although I designed a ‘plan’ to conduct the research, I had to adjust that plan as I was going along. So, for example, I planned to audiotape

the discussions of the second focus groups, but because I had limited time and there was not all that much information, in the end, I used a notebook and pen and wrote down the participants' responses in the course of the discussion.

1.7.3 Action research

Grundy and Kemmis (cited in Zuber-Skerrit 1996:5) explain that action research is 'research [turned] into practice by practitioners for practitioners'. This research project was informed by my own concern with my practice as a pastoral group therapist and the effects of my practice on the group participants. It is relevant to my concern with my practice as a pastoral group therapist as informed by my philosophical stance that, as McNiff (2000:10) states, action research is a value-laden practice, as it involves reflecting on our values and asking ourselves whether we are living them in practice. Thus, my research became a site for my own learning as I struggled to turn my values into practice. The focus of my inquiry was myself, as advocated by McNiff (2000:209). However, because I was in a relation with others, I needed to negotiate my own processes with the group participants, in line with McNiff's (2000:203) suggestions.

According to McNiff (2000:203), the key elements of action research are: first, that I (as the researcher) am central to the process; second, that I am learning first about myself in order to possibly change a social situation; third, that I am not aiming for closure but am involved in ongoing development; and lastly, that the process is participative and educational. In this context, education implies a relational process between people that enhances their understanding of their practice with a view to improving it.

Zuber-Skerrit (1996) refers to action research as a kind of research that follows a cyclical process. In this process the following steps take place:

- (i) Strategic planning;
- (ii) Action (implementing the plan);
- (iii) Observation, evaluation and self-evaluation;

- (iv) Critical and self-critical reflection on the results of steps (i) to (iii) and making decisions for the next cycle of action research (revising the plan, followed by action, observation and reflection , and so on).

(Zuber-Skerrit 1996:3).

Using the cycle mentioned above as a guide, I followed a similar process. First, I had a discussion with both therapeutic groups to plan the research process. Following up on these therapeutic group discussions, we then had focus group meetings with the two groups separately, which stretched over two sessions. During the first session we constructed possible questions together, and in the next session we discussed the answers to these questions. The information that was collected was sorted, categorised and used to make meaning. The new ideas and suggestions were then taken back to and implemented in the therapeutic groups. A year later, we held another focus group in both therapeutic groups to see what influence a change in my philosophical stance had brought about. Thus a cyclical process was initiated which could be an ongoing process.

In doing action research, I endeavoured to show the process of growth in my own understanding and how this had a beneficial influence in the lives of the group members. Action research is a path to potential personal and social renewal (McNiff 2000:204 & 210).

According to Mouton (1996:109-111), validity is a criterion that should apply to every stage of the research process. First, the central concepts in this study, such as philosophical stance, were clearly defined, with an underlying theoretical framework that guided the research. During the process of operationalisation, appropriate questions (the measuring instrument) were constructed, through which the key concepts in the research were measured. Another aspect of the criterion of validity was that the sample had to be representative of the target population (the group participants as described in Section 1.8.1). The methodological criteria that were followed during the process of data collection included a suspension of personal biases, accurate recordings of observation, establishment of trust with the interviewees and creating optimal conditions in terms of location for collecting the data as described in Sections 1.8.2 and 1.8.3 (below).

1.8 RESEARCH PROCESS

In this section I explain the research process, including the selection of the research participants, and the methods used in the data gathering and data analysis.

1.8.1 Selection of research participants

The members of the two pastoral groups that I was facilitating participated in the research. The morning group had five members (including me). The evening group had six members (including me). My primary data source was the group participants, as they provided the information about the effects of my philosophical stance on them while we shared their journey with depression.

Barnard (cited in Reinharz 1992:29) describes how she realised that she ‘had to be trusted if she hoped to obtain information about people’s lives’. Merriam (1998:23) also stresses the importance of ‘an atmosphere of trust’ in qualitative research. The fact that the groups had existed for approximately three years by the time that the study was done was an advantage. There was already a relationship of trust amongst the participants, as well as between the participants and myself, as pastoral therapist and researcher.

1.8.2 Collecting or gathering data

Triangulation, a term applied to research by Denzin (Mouton 1996:156), describes the inclusion of multiple sources of data collection in a research project which is likely to increase the reliability of the observations. Therefore, I used different methods of data collection in order to compensate for the limitations of each method. The data gathering methods I used were focus groups and group therapy.

1.8.2.1 Focus groups

I used focus groups, which may be defined as an interview style designed for small groups (Berg 2004:123). It can involve either guided or unguided discussions addressing a particular topic of interest or relevance to the researcher (Edmunds cited in

Berg 2004:123). I had focus group discussions with each of the two groups separately, as the women in the one group indicated that they were afraid to be silenced by the presence of the men in the other group.

During each of these two focus group discussions I explained to the participants what my research questions and the research aims were. Together we constructed relevant questions for our discussion the next week, using the building blocks of my philosophical stance (which I wrote on a whiteboard) as a guide. We used a flip chart to write down possible questions based on the building blocks, which I explained as we went along. The two groups constructed their own separate sets of questions. Some of these questions were the following: What values did the therapist bring into the group? What effects did these values have on the participants in their struggle with depression? Are there other possible values that could also be helpful in the group? The next week we had a discussion guided by these questions, which were tape-recorded. As we had the discussion some questions had to be teased out a little more in order to open up discussion by the group participants. Once this was finished, I had therapy sessions with both groups, where the suggested changes were again discussed and implemented. A year later we had another focus group discussion with each of these groups separately, where we discussed the effects of the changes that were implemented. The participants reflected on the past year and whether and how the influence of my philosophical stance helped them to live their preferred narratives.

I wanted to use focus groups because of the ‘synergistic group effect’ (Stewart, Shamdasani & Sussman cited in Berg 2004:124). This effect implies that interactions among group members stimulate discussions in which one group member reacts to comments made by another. The focus groups were therefore very dynamic. Another reason was that focus group interviews were regarded by some feminist researchers as a way to reduce the imbalance of power traditionally created by the interviewer/interviewee relationship (Montel cited in Berg 2004:124).

Because the group members participated in constructing the questions that we discussed, they shared the power with me as the researcher. According to Gaventa and Cornwall (2001:71), empowerment means ‘expanding who participates in the

knowledge production process'. Being marginalised by society and the church, the group members already experienced themselves as being powerless, thus it was extremely important to me that they should feel that they have a voice in the research process.

The use of focus groups also fitted in with my proposed research project, first, in that this method was suitable for small numbers of participants, as in my groups; second, in that there was an informal atmosphere which I felt comfortable with; and, third, that it lent itself to data collection plans that were faster than traditional individual interviews – this suited me, as I had a limited amount of time available for the completion of my research. This approach is in line with the suggestions of Berg (2004:123-124). I was aware, however, that focus groups do not offer the same depth of information as a long semi-structured interview might. Meanings and answers that arise during focus group interviews are also socially constructed amongst the group members, rather than individually created (Berg 2004:127).

1.8.2.2 Pastoral group therapy

As I have already indicated, pastoral group therapy represented those sessions where we would 'do' group as usual. During these therapeutic group sessions, I attempted to implement the changes suggested in the first focus group discussions.

The cyclical process described by Zuber-Skerrit (1996:3), as discussed in Section 1.6.4, was thus followed: the first focus groups activity consisted mainly of strategic planning, the construction of questions and also reflection on our previous group sessions. In the subsequent therapy group sessions we implemented the 'plan'. After a year, in the second focus group discussions, we evaluated and reflected on the results, making decisions for the next cycle.

1.8.3 Data documentation

According to Merriam (1998:87), there are three basic ways to record interview data: The most common is to audiotape the interview; a second way is to take notes during

the interview; and, lastly, the researcher can write down everything he or she can remember after the interview.

I chose the first method for the first focus group discussions, as it ensured that everything that was said was preserved for analysis. The participants were comfortable with being audiotaped, as a relationship of trust had already been established. Afterwards, everything that was said was transcribed and documented. During the second set of focus group discussions, I took notes during the discussions, as there was not as much information to be recorded as during the first focus group discussions, because we only discussed the changes that had been implemented.

1.8.4 Data analysis

According to Mouton (1996:161), data analysis usually involves two steps: first, reducing the data to manageable proportions; and second, identifying patterns and themes in the data. Then certain conclusions are drawn from these patterns and themes. The conclusions must flow logically from the empirical evidence if the results are to be regarded as 'valid' (according to epistemological criteria) (Mouton 1996:111).

While I was transcribing the first focus group interviews, I analysed the data by identifying patterns and themes, using the building blocks of my philosophical stance as a guide (Merriam 1998:161). I organised the data according to these themes and took the suggested changes drawn from the data back to the therapeutic groups to be implemented during the subsequent group therapy sessions.

1.9 ETHICAL CONSIDERATIONS IN DOING RESEARCH

Merriam (1998:214) reminds us that, as qualitative researchers, we are guests in the private spaces of the worlds of the research participants; and hence our manners should be good and our ethics strict. Ethical questions should therefore be asked, such as: who participates in and benefits from the research process; how is the information used? (Gaventa & Cornwall 2001:78; Kotzé 2002:10).

Kotzé argues for the use of participatory ethics, as opposed to prescriptive ethics. Prescriptive ethics ‘tell[] one what is right to do... no matter who[m] one might happen to be....’ (Walker cited in Kotzé 2002:16). Participatory ethics implies that the ‘researcher’ and the subject of research become participants in co-searching for new knowledge that will be to the benefit of all (Kotzé 2002:25-26). As I have already indicated, this is the reason why I chose to do action research, as informed by the values of participation, so that the participants could be the co-owners of the research and would not be left out at any stage (Kotzé 2002:28). After the research process, I was also careful not to make any generalisations on the basis of one or two groups’ experiences or to speak for all people who journey with depression. This choice resonates with the recommendations of Jakobsen (cited in Kotzé 2002:19).

Kotzé (2002:26) says that we need to reflect on ourselves as researchers and what we have learned about ourselves. This is very much what my study was all about: to learn more about myself, the role that the therapist played in the group and the effect that my philosophical stance had on the group members. A desired outcome would be that the participants also learned more about themselves and that the research process helped them to gain valuable self-knowledge, as advocated by Merriam (1998:214).

Winter (1996:16-17) proposes ethical principles as guidance for action research that I tried to adhere to: I informed some of the leaders of my church about my intended study, as the groups fall under their jurisdiction. I wanted to discuss whether the outcome of the study could be beneficial for the church in any way with the church leaders. Another principle was that all the participants should be allowed to influence the work, therefore I used focus groups and therapy as methods for data collection. As the development of the work was to remain transparent and open to suggestions, I tried to involve the group members in every stage of the process. I obtained permission from all the participants in the study before I used any material concerning their point of view. I also took responsibility for maintaining confidentiality.

CHAPTER 2

MAPPING MODERNISM'S PURSUIT OF TRUTH

2.1 INTRODUCTION

Since my preferred philosophical stance is a combination of many positions in pastoral group work, in this chapter I juxtapose my chosen stance to several alternative stances. My purpose is not to describe all the possible therapeutic approaches, but rather to discuss the philosophical basis of some of these approaches. I am also aware that I was influenced by different approaches and I value them as such. Hence, I do not intend to distance myself entirely from other approaches that may be different from my preferred approach.

To begin with, I reflect on the paradigm from which I initially came and on how I was influenced by it and the stance that such a paradigm subscribes to.

2.2 MODERNISM

When I started my work with the first group, several years prior to this study, my knowledge of depression was derived from my own experience as I journeyed with depression, and from some books I had read on the topic. My therapeutic knowledge was limited to the therapeutic models I had encountered while I was studying psychology up to an Honours level, about twenty years ago. Because I came from a paradigm where scientific knowledge was appraised, I was quite concerned that perhaps I did not have enough to offer the people in the group. It seems that modernism had already worked on me to make me feel measured and judged and regulate my thinking that I did not know quite enough.

Modernism was the cultural form of scientific thinking dominant in the western world for the past century and a half. It was the world view that had most influenced me, until recently. In science (particularly in the natural sciences), the modernist world view is

the paradigm that people apply in the belief that it is possible to find essential, objective facts that can be tied together into overarching, generally applicable theories by means of which we can understand the universe. In the humanities, a modernist philosophical world view would seek to develop grand, sweeping, meta-narratives about the human condition and how to perfect it. In the context of the research project, I would view the DSM IV classification of depression compiled by the American Psychiatric Association (1994) as an example of a meta-narrative concerning depression as a human condition. The DSM IV is widely used as a tool to diagnose people suffering from certain pathologies. One of the dangers, however, of such a classification of pathology is that people can become overidentified and excessively labelled by a diagnosis.

Such ideas and representations of general truths can trap us into thinking that there is some basic underlying reality that we all share around illness, thus leaving out other ways of knowing suffering. For much of the nineteenth and twentieth centuries, the western world has thought itself capable of arriving at absolute, foundational truths in all arenas through scientific inquiry. Knowledge is thus 'about' something external to the knower and can present itself objectively to the knower (Dockery 1995:13-15; Freedman & Combs 1996:20; Lowe 1991:46).

A defining characteristic of modernist thought is its anthropocentric concept of knowledge, which implies that the focal point of knowledge has been 'man', the rational, autonomous, western male subject who abstracts himself from his object of study in order to accumulate objective knowledge. This conception is associated with the development of fundamental dualities of modern thought, for example, subject versus object; rational versus irrational and so on. Another duality I want to add is that of the client versus the expert, as modern knowledge regards therapy as representing the progressive discovery and accumulation of objective knowledge about clients, and the value-free application of such knowledge in the form of disinterested, professional expertise (Lowe 1991:46). In my opinion, the duality of the client versus the expert is a stance promoted by modernism, insisted on and encouraged by the will to an absolute truth. Foucault (cited in Besley 2001:79) points out the problematic linking of the will to truth with the success of the professional disciplines in the production of the great meta-narratives of human nature and human development.

The way in which modernism views human nature also underpins the dualism of the client versus the expert stance, because from a modernist point of view, psychology's task is to study the individual and to develop the laws of his/her functioning. Heshusius (1994:16) cautions that in borrowing its methodology from the natural sciences, the humanities have borrowed the notion of distance, the notion that the knower (the therapist) is separate from the known (the client). For most of the twentieth century, knowing through constructing distance became the epistemological stance for the study of human behaviour as well. For a long time, psychology assumed that the object of its enquiry – the individual person – is a natural entity with attributes that psychology as a discipline can study empirically (Sampson 1989:1).

Hand in hand with modernism comes the structuralist notion of permanent deep structures such as human nature (Besley 2001:74). White (cited in Besley 2001:79) comments critically that 'it is the essentialism underlying both humanist and structuralist conceptions of the self and identity in therapeutic culture' that he considers to be limiting.

Humanist counselling theories (such as person-centred, psychodynamic and gestalt theories) tend to operate on the assumption that the discovery of the hidden knowledge of self (in other words, a person's true or essential nature) will set a person free. Traditional humanist assumptions about 'the subject' in psychology and counselling usually position a person as a stable, fixed, autonomous being, often characterised as fully transparent to him- or herself and responsible for his or her actions (Besley 2001:79).

Sampson (1989:1) criticises the western ideal version of psychology's subject as a self-contained individual. Geertz (cited in Sampson 1989:1) elaborates on the modernist view of personhood as follows:

The Western conception of the person as a bounded, unique, more or less integrated motivational and cognitive universe, a dynamic center of awareness, emotion, judgment and action, organized into a

distinctive whole and set contrastively against other such wholes and against a social and natural background

The concept describes a fictitious character with integrated wholeness, unique individuality and status as a subject with actual powers to shape events, as if society and the individual were two independent entities (Sampson 1989:3-4).

2.2.1 'Deficit theory'

The tendency to interpret social ills as psychologically derived creates a psychological subject who is given the full burden of responsibility for correcting his or her troubles (Sampson 1989:5). White (cited in Besley 2001:80) agrees that the operation of a 'deficit theory' strongly encourages, even coerces, people to think that they have to change, grow, develop or improve. This inadvertently reinforces the power of any 'experts' that aim to help them achieve this.

Against the background of a modernist world view, I next discuss what the role of the therapist and the role of the client would possibly look like in the context of groups.

2.3 THE ROLE OF THE GROUP THERAPIST IN A MODERN PARADIGM

Given my training in a modernist client-expert paradigm, I had a number of concerns and doubts regarding myself as a group counsellor or therapist. I knew I was a good listener, someone with a passion to journey with people. I used many of the modernist ideas around unconditional positive regard in relation to listening attentively to people in the group. I have always found Rogers's client-centred therapy helpful as a metaphor for (empathic) listening. However, deeply embedded in the assumptions I held about being the group leader, there lurked the anxiety-provoking assumption that I was there to fix every one of their problems and that I was somehow an expert on their problems. In spite of using a client-centred approach in which each client is encouraged to find the solution to his or her own problems, I still experienced a great sense of being responsible for other people's lives, and this overwhelmed me. I recall thinking that if I

wanted to be a ‘good’ therapist, I should gain more psychological knowledge to be able to help other people and listen with greater expertise, more ‘knowingly’.

Within any group healing process, there is likely to be a great amount of pain. One way modern techniques have helped therapists to deal with this pain is to separate themselves from it in the position of the expert looking at the client, with the expert as subject and the client as object. I also remember being concerned that I would be ‘sucked into the pain of all the problems’ (Shulman cited in Freedman & Combs 1996:xii), as another therapist once told me that it is hard not to be pulled down by the pain of other people’s problems. Since I myself had a history of journeying with depression, I was afraid that dealing with the depression of others could invite depression and its influence back into my own life. I was concerned that this could also compromise my own expertness in such a way that I might be disqualified from being the expert within the group.

Most modern theories of therapy assert that a therapist is to be an objective, neutral and technical expert who is knowledgeable about pathology and normalcy and who can read the inner world of a person like a text. Knowledge and expertise inform such a therapist’s diagnoses, strategies and goals. It is the therapist’s interest and responsibility to produce change, through influencing and knowing what this change should look like. Implicit in such theories is a relationship between an expert and non-expert, an assumption that one person can change another, or at least influence him or her to change. The notion of control directed towards achieving a particular goal invites the therapist into a position of control. Inherently, this assumption of expertise held by the therapist leads to inequality between the client and the therapist (Anderson 1997:93: Freedman & Combs 1996:4). As a leader of depression groups, I have often experienced the burden of this inequality.

When people join the groups, I often sense that they come into the process with the expectation that I (the therapist) will bring to the process the ‘knowledge’ to ‘fix’ their problems. They regard themselves as failures or problems, desperate to be helped, but because of previous ‘unsuccessful’ therapeutic intervention(s), they start to doubt

whether they are 'fixable'. They often come to me feeling disempowered, without a sense of personal agency and without much hope.

Although the intention of therapy is to help the client, treatment can sometimes disempower the client, by producing social hierarchies that erode notions of creating community and interdependence. In a modernist paradigm, in so far as differences between organisms and their environment have been understood to be non-reciprocal and hierarchical, a dominion of group over group, individual over individual, and so on, has evolved (Drewery & Monk cited in Besley 2001:80; Sampson 1989:1).

When a therapist is seen as the designer of clever interventions, he or she is assigned too much credit for any changes that occur. Although the client may achieve his or her goals, the therapy experience often does not enhance the client's sense of personal agency if the client experiences him- or herself as the passive recipient of eternal wisdom (Freedman & Combs 1996:4). The church as a provider of care is no exception to this, and many courses and groups within a church context are informed by modernist practices that are prescribed by an expert holding 'knowledge' to passive recipients of care.

Dualities such as rational versus irrational or expert versus non-expert encourage therapists and pastoral care workers to believe that they have privileged access to what is 'really' going on beyond the client's articulation of his or her predicament. The subject-object duality encourages the positioning of the client as the object of study, assessment and intervention, while enabling the therapist or pastoral care worker to abstract him- or herself from the social context and position him- or herself as an objective observer and agent of change (Lowe 1991:46).

All the arguments mentioned above suggest that, in a modernist paradigm, the therapist is in the more powerful position than the client because of his or her so-called 'knowledge'. Foucault had an interest in knowledge and power and how they worked together. He started with the truism 'knowledge is power', believing that 'power and knowledge are inseparable – so much [so] that he prefers to place the terms together as power/knowledge or knowledge/power' (White & Epston 1990:21-22). Thus for

Foucault the domain of power is a domain of knowledge and a domain of knowledge is a domain of power:

There can be no possible exercise of power without a certain economy of discourses of truth which operates through and on the basis of this association. We are subjected to the production of truth through power and we cannot exercise power except through the production of truth.

(Foucault cited in White & Epston 1990:22).

Foucault questioned the notion that we have any knowledge of absolute truth. He suggested that knowledge is socially constructed when a group of people get together and decide what is true. Thus mental force (power) is exerted by a powerful minority who are able to impose their idea of what is right (knowledge) on the majority. This involves power to create beliefs or discourses concerning what is normal or abnormal, or right or wrong. The people who decide what constitutes knowledge can easily claim to be the most knowledgeable, thus, to know more about others than they (the others) know about themselves (Fillingham 1993:8-11).

Power, according to Foucault's understanding, is not only repressive or negative, but also 'positive', in the sense of being constitutive in the shaping of peoples' lives and ideas:

According to Foucault, a primary effect of this power through "truth" and "truth" through power is the specification of a form of individuality that is, in turn, a "vehicle" of power. Rather than proposing that this form of power represses, Foucault argues that it subjugates. It forges persons as "docile bodies" and conscripts them into activities that support the proliferation of "global" and "unitary" knowledges and, as well, the techniques of power.

(White & Epston cited in Besley 2001:76).

For Foucault, 'truth' does not refer to objective facts about the nature of people, but suggests that, in constructing ideas that are ascribed the status of 'truths', such ideas become 'normalising' in the way that they shape and constitute people's lives. The new

methods of power are not ensured by right, but by technique; not by law, but by normalisation; not by punishment, but by control. The new form of power is much more subtle than the traditional notion, much easier to overlook and much harder to resist (Besley 2001:77).

White (1997:119) regards the culture of psychotherapy as a culture of professional discourses that are characterised by classes of knowledge that feature ‘truth’ claims about the human condition. These ‘truth’ claims are accorded an objective reality status and are considered to be universal, speaking of ‘facts’ about the nature of life that can be discovered in all persons, regardless of their culture, circumstances, place, era, and so on.

White (1997:119) gives a helpful explanation of what the different classes of knowledge comprise:

One of these classes of knowledge features truth claims about the “self” – that at the core of being human, there is a self that is the centre of identity, that is the foundation of personal knowledge and the source of human meaning. Another class of knowledge features truth claims about the nature of this self – about humanity, human development, identity formation, the workings of [the] psyche, and so on. A third class of knowledge features truth claims about problem formation. These are the knowledges of psychology, of the disorders, and of the dysfunctions. A fourth class of knowledge features truth claims about the resolution of these problems.

In all these techniques of producing knowledge, there appears both an expert (a therapist) and a recipient (a client). Knowledge then is handed down from the expert to the counsellee. In a one-way account of therapeutic process, the subject versus object dualism is reproduced. People’s lives are the object of the therapist’s knowledge(s) and practices. In this objectification, the ideal is for the person’s life to change as an outcome of the therapeutic conversation, while the life of the therapist remains as it was (White 1997:128).

By rendering invisible the way that this work touches our lives (as therapists), this one-way account of therapy excludes us from these acts of meaning in relation to the significant events of our work. That which could possibly change our lives in the therapeutic endeavour is lost (White 1997:130).

2.4 ETHICAL CONCERNS

It is a matter of ethical concern to me that there is a general tendency to foreground diagnosis and expertise at the expense of relationship and of an ethic of reflecting on the privileged power position that can so easily silence a client's own knowledge and agency. Furthermore, science as a particular kind and way of knowledge can never be innocent (Kotzé 2002:6) This is not to say that people working from a positivist framework do not consider their ethical position, or that they do not reflect on their work. However, my concern about the possibility of the client being silenced, introduces another dimension, that of power.

Foucault examined the interplay and interfaces between knowledge and power – ‘how people ended up becoming objects of bodies of knowledge and by means of internalising, allowed these knowledges to become a gaze subjugating their lives. Scientific knowledge has become an expression of the power/knowledge connection, since to know implies exercising the power of subjugation and domination’ (Kotzé 2002:7).

Foucault also argues that ‘power is always there’; one is never ‘outside it’. Because it is impossible to act apart from this domain, we are simultaneously undergoing the effects of power and exercising this power in relation to others. The ethical challenge, according to Kotzé (2002:8), is to establish conditions that encourage us to critique our own practices (White & Epston cited in Kotzé 2002:8).

A critique of our practices raises questions such as these: Who knows? What counts as knowledge and who determines what counts? To whose benefit are these knowledges? Who is silenced or marginalised by these knowledges? (Kotzé 2002:6-8). White (1997:123) maintains that in deconstructing notions of expert knowledge, therapists are

freed to embrace the ethical responsibility that they bear for the real effects of their work in the constitution of the lives of the persons who consult them. We are challenged by Foucault's power/knowledge ideas to reverse positions by moving ethical concerns to the foreground and scientific notions to the background (Kotzé 2002:8).

I support a 'participatory consciousness' (Heshusius 1994:16) which frees us from the categories imposed by the notions of objectivity and subjectivity and allows a re-ordering of the understanding between the self and the other to a deep kinship of 'self-other', between the knower and the known. This 'embodied' knowledge refers to knowledge with the other, distinct from knowing about the other. Within a participatory consciousness, knowledge is 'an ethical-political process, co-constructed in the course of relating with others in a specific context or situation, at a specific moment in time' (Kotzé 2002:6).

Many of the people in the groups have experienced the effects of knowledges or truths about them, without being invited to take part in constructing these truths. One of the participants in this study, Hermien, for example, experienced being objectified by the experts as the problem in her marriage. She has been silenced by a patriarchal system, while her husband was physically abusing her. Another participant, Conrad, was left powerless by a DSM IV classification of his depression, made by experts, without consulting him on his own knowledge of depression.

In both these people's lives it could have made a huge difference if those with a voice and power had honoured their ethical obligation to use the privilege of their knowledge to ensure participation with their clients (the silenced ones), had listened to them and had participated with them, instead of normalising a particular behaviour that differed from that of Hermien and Conrad. Such a shift towards a more ethical stance would have been in line with the suggestions made by Kotzé (2002:18-19).

As I perceived the effects of therapeutic intervention in the lives of some of the people joining the groups, I was left wondering what their roles may have looked like in a therapeutic endeavour informed by a modernist paradigm.

2.5 THE ROLE OF THE CLIENT (GROUP PARTICIPANT) IN A MODERN PARADIGM

In the definition of the role of the therapist in a modern paradigm earlier on, the role of the client was also implied. The modernist therapist was described as an objective, neutral and technical expert, one who was knowledgeable about pathology and normalcy, and in a position of control (Anderson 1997:93). The implied position or role of the matching client would then be one of an object to be studied or fixed. The client is invited into a relationship in which he or she is the passive, powerless recipient of the therapist's knowledge and expertise (Freedman & Combs 1996:21).

The expert knowledge and the scientific outlook of traditional Western psychology is based on a biomedical model of illness (as is implicit in the DSM IV classification of depression). This model can objectify, individualise and normalise the subject through diagnosis and has the effect of locating the problem within the person. For the client, the expert's diagnostic label of the client's 'self' tends to become part of society's (and sometimes their own) view of the client's essential nature and identity. Gergen (cited in Besley 2001:80) warns that diagnostic deficits can so totally affect the past, present and future of a person's life that the self becomes saturated by pathology and once again the client is disempowered.

By the time I met him, to Conrad, for example, depression had become an internalised state of being, reinforced as he was diagnosed by one medical professional after the other over the years, as he was seeking help. When Conrad talked about himself, I realised that he saw the experts' diagnostic label of his 'self' as part of his identity (White cited in Besley 2001:80). Conrad regarded himself as 'defective' and was looking for someone to 'fix' him. His past, present and future were so totally affected by the diagnostic deficits that his self became saturated by the pathology. Conrad became a passive, powerless recipient of the knowledge of experts (Gergen cited in Besley 2001:80; Freedman & Combs 1996:21).

The technologies which act as vehicles for the performance, the general privileging and ongoing production of these knowledges, include practices of observation, measurement and evaluation of behaviour, procedures for locating problems at particular sites of identity. The therapist will intervene and correct whatever is assumed to be amiss (White 1997:121).

These technologies coerce clients such as Hermien to engage in self-surveillance, and recruit them into policing their own lives in an attempt to reproduce the 'truths' of human nature, according to the norms of living that are championed by these 'truths' (White 1997:121).

When Hermien joined the group, she told us that she knew that she was the problem in her marriage and that she was aware that her 'behaviour' was not 'normal', but she explained that, since the birth of her child, she was struggling to get a grip on herself and her own life. She just could not manage to be a 'good' wife and mother. Previous therapists were trying to help her, but she had terminated the therapeutic endeavours because she could not manage to keep up with the changes she had to make. Each time, she increased her efforts at self-policing by giving herself marks out of ten for everything she attempted to do. Eventually all the failures culminated in a deep sense of self-defeat. She was labelled as being unwilling to change.

The following description by White (1997:129) could fit people (like Hermien) coming from therapeutic interventions in a modern paradigm:

They "understand" that they are bereft of the requisite knowledges or skills to address what it is that they find problematic in their lives. They "appreciate" the fact that they lack the personal wisdom to know what might be good for their lives. They have "realized" that they lack the personal qualities necessary to get themselves out of their predicaments. They have "figured" that they are personal failures and a burden to the lives of others.

In a one-way account of therapeutic process, the subject versus object dualism is produced, client's lives are the objects of the therapist's knowledges and practices – 'expert' knowledges and 'expert' practices.

For many of the clients, like Conrad and Hermien, who are constructed as recipients in such a one-way account of therapy, this status contributes significantly to the 'thin' identity conclusion that they bring with them to the therapeutic context (White 1997:129). Conrad described himself as '*chronically depressed*' and Hermien described herself as '*the problem*' or as being '*abnormal*'.

A 'thin description', as Geertz (cited in White 1997:15) calls it, of a person's actions excludes the interpretations of those who are engaged in these actions. Thin descriptions are typically those arrived at through the observations of those considered to be outsiders, who are studying the lives of other people. Conversely, a thick description of a person's actions is one that is inscribed with the meanings of the community of persons to which this action is directly relevant.

The knowledges that Hermien and Conrad formalised about themselves were global, universal and 'experience distant'. What about their own knowledges, which would be local, particular and experience near? Foucault (cited in White & Epston 1990:25-26) speaks of an insurrection of 'subjugated knowledges'. The term 'subjugated knowledges' refers to a whole set of knowledges that have been buried (historical knowledge) or disguised or disqualified as inadequate, for example, regional or local knowledge (such as that of the client). These knowledges could open up other possibilities that could lead to a thick or rich description of Conrad and Hermien's identities.

Because the groups I am involved with are therapy groups for people struggling with depression, I think it is necessary to look at the meaning(s) ascribed to the word depression.

2.6 A DEFINITION OF DEPRESSION

Since in this chapter I consider what the stance of the therapist would look like in a modernist paradigm and what the effects of such a stance would be, it is appropriate to look at the possible meaning(s) of the concept of depression through the lenses of a modern paradigm, and then to compare it to looking at the concept through the lenses of a postmodern paradigm.

Modernism insists that knowledge can be founded upon or grounded in absolute truth. It assumes that knowledge is about something external to the knower, and can present itself objectively to the knower (Lowe 1991:43). This implies that it is possible to give a definition of depression that is true for all people of all cultures at any given time. The expert definition I came across explains depression as ‘a spectrum of symptom configurations that have similarities but differ in duration, intensity and triggers’ (Cozad Neuger 2001:149). There is, however, much debate between experts about what the different categories and the possible treatments of depression might be.

Modernity encourages us to represent the world as if it were organised by meta-narratives of humanised science, progress and individual meaning. An example of such a meta-narrative is the Diagnostic and Statistical Manual, now in its fourth edition (American Psychiatric Association 1994:317-191), which represents the most detailed categorisation of the different types of depression, which are summarised below.

2.6.1 Major depression

A major depressive disorder is characterised by one or more major depressive episodes. The criteria for a major depressive episode are that five or more of the following symptoms should be present during the same two-week period: a depressed mood (the person feels sad or empty); a diminished interest or pleasure in most activities; a significant weight loss or gain; insomnia or hypersomnia, psychomotor agitation or retardation; loss of energy; feelings of worthlessness or guilt; a lack of concentration or indecisiveness; and/or recurrent thoughts of death or suicide. An untreated major depressive episode typically lasts six months or longer.

2.6.2 Dysthymia

The essential feature of a dysthymic disorder is a chronically depressed mood that occurs for most of the day on more days than not for at least two years (a more mild and chronic form of depression). Individuals describe their mood as sad or indicate that they are 'down in the dumps'. During periods of such a depressed mood, at least two of the following additional symptoms are present: poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions and feelings of self-criticism. According to Cozad Neuger (2001:152), this kind of depression becomes so present that it can begin to feel as if it is a personality trait.

2.6.3 Bipolar depression

The essential feature of a bipolar disorder is a clinical course that is characterised by the occurrence of one or more manic episodes, which is defined by a distinct period during which there is an abnormally and persistently elevated expansive or irritable mood. Bipolar depression involves swings in mood from major depression to mania and seems to have a strong biological basis. A milder and more chronic form of bipolar depression is cyclothymia.

2.6.4 Mood disorder/minor depression

This mood disturbance may involve a depressed mood, markedly diminished interest or pleasure, and/or an elevated expansive or irritable mood.

2.6.5 Seasonal affective disorder

The essential feature is the onset and remission of major depressive episodes at characteristic times of the year. In most cases, the episodes begin in autumn or winter and remit in spring.

2.6.6 Hormonal depressions

Here there are two categories, namely premenstrual dysphoric disorder and post-partum depression. For a diagnosis of this kind, the symptoms must be severe enough to interfere with daily living. The symptoms are both physical and emotional, in other words, tiredness, a lack of concentration and psychomotor agitation, as well as anger, hopelessness and anxiety.

When a classification such as that in the DSM IV is used, there is a possibility that people can be labelled accordingly. This could result in situations where people are objectified and dehumanised (like a machine with a defect that needs to be fixed), or their problem is simplified (medication is seen as ‘the simple solution’ to the problem). Cozad Neuger (2001:153) and Foucault (cited in Fillingham 1993:61) caution that this happens when professionals who use criteria such as those in the DSM IV behave as if they possess a set of descriptions for real, homogeneous, mental disorders that holds true for all people across all contexts.

As I have already explained, Conrad was labelled as being ‘chronically depressed’ according to the DSM IV criteria. He saw this diagnostic label of his ‘self’ as part of his identity, as described by White (cited in Besley 2001:80), because for a period of seventeen years this diagnosis was reinforced as he moved from one professional to another, seeking help. Conrad became a passive, powerless recipient of the ‘knowledge of experts’ (Gergen cited in Besley 2001:80). I remember how, when I first met him, he described himself as being ‘*needy*’ and ‘*helpless*’.

According to Cozad Neuger (2001:153), labels can be hurtful or helpful to the people for whom we care. We can use them to objectify, simplify and dismiss the people who come to us for help, or we can use labels to help us understand them better, and to counsel with them. Diagnostic criteria for depression can be useful, insofar as ‘they lead us to a better ability to connect with those suffering with them and help us to build a better set of skills for helping them resist depression in the present and the future’ (Cozad Neuger 2001: 153).

When we try to define depression, it is also important to look at the role that language plays in knowledge-formation and in meaning-making. Modernist thinkers tend to be concerned with facts and rules, while postmodernists are concerned with meaning. In a modernist paradigm, language is regarded as a conveyor of facts and rules, while, in a postmodern paradigm, language is regarded as a constructor of meaning. Traditional psychology has regarded language as the passive vehicle for our thoughts and emotions, and modernism believes that language reflects or represents reality. Thus the professional disciplines that induce ways of speaking and writing that are considered to be rational, neutral and respectable tend to emphasise notions of authoritative accounts and an impersonal expert view. The use of a privileged 'scientific' language contributes to the exclusion and marginalisation of clients – people such as Conrad (Burr 1995:7; Freedman & Combs 1996:22; Lowe 1991:3; White 1991:36).

2.7 CONCLUSION

Because a modern paradigm is not my preferred paradigm, I attempt to discuss my preferred philosophical stance, which is based on a postmodern paradigm, in the next chapter. There I also continue my discussion of depression, of how it is socially constructed through language and of what depression means today in the context of the groups I am involved with.

I do, however, consider some of the practices based on a philosophical stance emerging from a modern paradigm, such as the DSM IV classification, to be helpful in informing my therapeutic practice. I am very aware, though, of the pitfalls of such expert knowledges and am cautious in the way I use them.

I prefer to focus on the notion of 'both/and' (Derrida cited in Sampson 1989:8) rather than binary opposites such as 'either/or' when I attempt to position myself within a certain paradigm, as I am aware that 'postmodernism may itself fall prey to the same problems which beset modern thought. It is in danger of becoming a new totalizing meta-narrative, of the very kind it sought to repudiate' (Lowe 1991:48-49).

CHAPTER 3

EXPLORING NEW MAPS CENTRING A RELATIONAL ETHIC

3.1 INTRODUCTION

As I have already mentioned, my preferred philosophical stance is grounded primarily in a postmodern epistemology. The purpose of this chapter is to reflect on postmodernism, on the roles of the pastoral group therapist and the client in a postmodern paradigm, and on how postmodernism influences my knowledge of depression.

First, I reflect on how I was introduced to postmodernism, how postmodernism influenced my thinking and on social constructionism as a postmodern discourse.

3.2 POSTMODERNISM

I encountered postmodernism at a time in my life when I had begun to question the certainty with which people in authoritative positions (such as pastors) claimed to hold the truth. Postmodernism, along with theories of poststructuralism, resonated with some of my own questions about truth and authority, questions such as these: Who knows the truth? Is there such a thing as absolute truth? Who has the right to claim their knowledge as truth? Is truth a universal phenomenon, or is it local?

The work of feminist writers such as Ackermann, Bons-Storm and Cozad Neuger also attracted me and I was drawn to the ideas of contextualising, of giving people a ‘voice’ (especially those who are marginalised), of the communal basis of knowledge and of the significance of power relations. For feminists who position themselves within a postmodern paradigm, an empiricist orientation to knowledge is not generally a congenial perspective, because such an orientation covertly advocates the manipulation, suppression and alienation of those one wishes to understand. Furthermore, from a feminist perspective, empiricist science seems to have been most often employed by

males to construct views of women that contributed to the subjugation of women (Gergen 1985:272; Russel & Carey 2003:71).

These ideas mentioned above made even more sense to me when I became more familiar with the work of Foucault (the dominant poststructuralist thinker that influenced narrative therapy) and with how he challenged knowledge and its assumptions. His work deconstructs much of what we take for granted and shows how objects of knowledge are constructed by discourse, which determines what is seeable and sayable and by whom. To me, Foucault's understanding of the relationship between power and knowledge and how power produces reality opened up new ways of thinking (White cited in Besley 2001:74; Townley 1994:17).

When I started with my first group for people with depression, I used a number of narrative ideas and techniques that I had become acquainted with. Because narrative therapy is positioned within postmodern, poststructuralist discourses, I was also exposed to a poststructuralist, postmodern, narrative, social constructionist world view. This exposure made me realise that it was particularly helpful to approach people and their problems with attitudes supported by the ideas offered by such a world view. In this sense, narrative therapy has transcended the scope of being a mere therapeutic technique, and has become a lifestyle and a political project (Besley 2001:78; Freedman & Combs 1996:22).

3.2.1 A postmodern view of knowledge

The ideas represented by a postmodern world view comprise a radical questioning of the foundationalism and absolutism of modern concepts of knowledge. Postmodernism is a rejection of both the idea that there can be an ultimate truth and of structuralism (the claim that the world is the result of hidden structures). Postmodernism provokes an attitude of uncertainty and unpredictability, of studied doubt; and any attempt to gain knowledge involves a continual reflexivity which underlines the provisional and transitory nature of that knowledge. This doubt and reflexivity also inform and subvert self-knowledge. Change is a given and is embraced (Anderson 1997:36; Burr 1995:13; Parker cited in Lowe 1991:43).

Postmodernism also rejects the modernist claim that the world can be understood in terms of grand theories or meta-narratives; and emphasises instead the co-existence of a multiplicity and variety of situation-dependent ways of life. Postmodernists choose to look at specific, contextualised details more often than at grand generalisations, at difference rather than at similarity. Postmodern thought moves toward knowledge as a discursive practice, towards a plurality of narratives that are local, contextual and fluid (Anderson 1997:36; Burr 1995:14; Freedman & Combs 1996:21-22).

When we use the narrative metaphor (as influenced by postmodern discourses) to orient our work as therapists, we are intensely curious about the ‘local knowledges’ of each new person we meet. What people are feeling, what they are undergoing, how they perceive this, how they are responding – these are the experiences that constitute the primary data of the context (Cochrane et al 1991:17). Such an approach opens up multiple interpretations of reality and experience, rather than to reduce interpretations to the clarity of a diagnosis (Freedman & Combs 1996:31).

Postmodernism aims its attack mainly at the production and maintenance of knowledge, the question of authority, and the shortcomings of a representational view of language. In this way, rather than focusing on any given pathology (in this case depression), it pays attention to the ways in which certain realities have been dynamically constituted through discourse. Discourses are about what can be said and thought and about who can speak and with what authority (Ball cited in Lowe 1991:44). Discourse thus constitutes knowledge and confers power.

3.2.2 A social construction discourse

It is a central tenet of social constructionism and a postmodern discourse in a postmodern world view that beliefs, laws, social customs, habits of dress and diet arise through social interaction over time. People construct their realities together as they live them. Knowledge is thus socially arrived at and it changes and renews itself in each moment of interaction. Knowledge is continually evolving and continually broadening (Anderson 1997:36; Freedman & Combs 1996:23). I therefore try my best to allow the

group participants to create their own meanings of depression according to how it operates in their lives, as suggested by Penwarden (2006:65).

Social constructionist inquiry is principally concerned with explicating the process by which people come to describe, explain or otherwise account for the world (including themselves) in which they live. Social constructionism proposes that we adopt a critical stance towards our formerly taken-for-granted ways of understanding the world, including ourselves. Social constructionism sees the ways in which we understand the world as culturally and historically specific. The categories and concepts that people use are products of that culture and history. Dualisms or oppositions are also seen as socially constructed rather than real.

Today, the church is also beginning to realise that dualisms are social products of modernism and is starting to move away from dualisms such as 'holy' versus secular, theology versus ethics, the individual versus the community, and is shifting towards more holistic thinking (Niemandt 2007:73).

Social constructionism sees knowledge as sustained by social processes, as people construct knowledge between them, through language. Language is regarded as mediating or constructing reality, rather than reflecting or representing reality. According to social constructionism, knowledge and social action go together. Knowledge is therefore not seen as something a person has, but as something that people do together. Social constructionism emphasises the relational nature of knowledge and the generative nature of language (Anderson 1997:36; Gergen cited in Burr 1995:2-8; Gergen 1985:266-267; Lowe 1991:43-44).

Depression is a word that came into use in the twentieth century to signify that a person is experiencing a sense of low energy, is in a 'down' mood or restless, or, at the other end of the spectrum, it can mean that a person is experiencing symptoms of an overwhelming lethargy that saps his or her interest in living (Cozad Neuger 2001:149-150). It can refer to any number of symptoms or experiences between these two ends of the spectrum. Unlike the DSM IV suggests, the word 'depression' does not have a 'fixed' meaning

Later in this chapter I discuss how my knowledge of depression has been influenced by postmodernism, social constructivism and poststructuralism.

3.2.3 A poststructuralist discourse

According to Derrida (cited in Freedman & Combs 1996:29), meaning is not carried in a word by itself, but by the word in relation to its context, and no two contexts are exactly the same. Therefore the precise meaning of any word is always somewhat indeterminate and potentially different, and it should be negotiated between two or more speakers.

This inevitable mutability of language can be useful, as it makes our conversation with the people we work with opportunities for developing new language, thereby negotiating new meanings for problematic beliefs, feelings and behaviours – new meanings that can give legitimacy to alternative views of reality (Freedman & Combs 1996:29). In this regard externalised language (as used in narrative therapy) is very helpful to separate the person from the problem, thus creating space for new meanings to develop (Morgan 2000:17,18; White 2007:26).

Western psychologists tend to have privileged the construction of the self as an individualised, skin-bound ‘true self’ or ‘essential self’, which is primarily seen as stable and singular. A postmodern concept of different experiences of a self brings home the notion that ideas of the self, like other constructions, are formed through social interaction within particular cultural contexts; and the self is subject to change. ‘Selves’ are thus socially constructed through language and maintained in narratives (Besley 2001:79; Freedman & Combs 1996:34; Sampson 1989:2). The notion that externalising conversations establish a context in which a person is separated from the problem, so that the problem becomes the problem, and the problem no longer speaks to them of their identity and alternative descriptions of self can be explored (Besley 2001:76; Morgan 2000:24; White 2007:9).

Derrida’s view of deconstruction describes the undoing of the centre (for example, the ‘essential self’) and the certainty that marks so many Western ‘master-designed’

enterprises. Thus individuals are not in the centre, fully aware and self-present masters, but have been decentred. This introduces a picture of a subject who is open-ended, indeterminate and multi-dimensional, rather than the integrated hierarchically arranged Western conception held for so long (Sampson 1989:15).

As different selves emerge in different contexts, no one self is truer than any other and, as people are continually constituting each other's selves, there are many possible stories about self.

Instead of looking for a centred essential self, therapy can attempt to bring out into the light various experiences of self and to distinguish which of these selves clients prefer in which contexts. Therapists then work toward assisting them in living out narratives that support the growth and development of these 'preferred selves' (White cited in Besley 2001:78; Freedman & Combs 1996:35).

3.3 THE ROLE OF A GROUP THERAPIST IN A POSTMODERN PARADIGM

In the light of the above discussion on the role of a therapist using theories of poststructuralism within a postmodern paradigm as my philosophical underpinning and my positioning of myself as a therapist, it is clear that I have adopted a profoundly different position from the position that I might have assumed within a modernist paradigm. These roles are now discussed in more detail against the backdrop of postmodernism and a social constructionist discourse.

When I was introduced to postmodern ideas, I already had a therapeutic group for people with depression. I remember the sense of relief I felt when I realised that I did not have to bear the burden of being the expert responsible for a cure. Coming from a 'not-knowing' position made me feel much more comfortable and ethical as I began to learn from the group participants as their stories unfolded. I realised that every person in a group has expert knowledge about his or her life story; and it was exciting to learn from everyone else in the group. It was also enriching to open up my own life to share

and to be influenced by the group members and their stories. We saw ourselves as a team, collaborating with each other to find new stories.

At first it was quite scary not being able to 'prepare' for a group session, as there was no recipe or programme to follow (as there would have been in a modernist approach). I discovered, however, that I could just be myself and trust the conversational process to open up space for new possibilities. In the process, I too was 'reconnected to ways of being that are congruent with who I believe I am and who I choose to be' (Alec Ross cited in Freedman & Combs 1996:xiv).

A postmodern therapist's position rests heavily on the view that human action takes place in an understanding of reality that is created through social construction and dialogue. The therapeutic conversation is a mutual search and exploration through dialogue, a two-way exchange in which new meanings continually evolve toward the 'dis-solving' of problems. The focus of a collaborative approach is thus a relational system and process in which client and therapist become conversational partners (Anderson 1997:95; Anderson & Goolishian 1992:26-27).

In a collaborative approach, the expertise of the client and the therapist combine and merge. A client brings in expertise in the area of content, because a client is the expert on his or her life experiences. A therapist brings in expertise in the area of process. The role of the therapist is that of a conversational artist – an artist of the dialogical process – whose expertise is in the arena of creating a space for and facilitating a dialogical conversation (Anderson 1997:95; Anderson & Goolishian 1992:27). My philosophical stance is therefore a de-centred and yet influential position as a therapist, putting the person's knowledges and skills of his or her life at the centre of the conversation, as suggested by White (cited in Russel & Carey 2003:80).

With the notion of therapy as an art of conversation, where the therapist invites and allows the client to collaborate, responsibility becomes shared, and dualities such as subject-object (as described in Section 2.2) and a hierarchy between client and therapist collapse. Therapy entails an 'in there together' process. The therapist is a co-participant 'in' a conversation, rather than an expert who 'uses' conversation. People talk 'with'

one another and not 'to' one another. The therapist and client participate in the co-development of new meanings, new realities and new narratives (Anderson 1997:105; Anderson & Goolishian 1992:28; Lowe 1991:46).

A postmodern therapist exercises this therapeutic art through the use of therapeutic questions which serve as a primary instrument to facilitate the development of a conversational space and the dialogical process. To accomplish this, the therapist exercises an expertise in asking questions from a position of 'not-knowing', with an attitude of genuine curiosity, rather than asking questions that are informed by a specific method which demands specific answers. A postmodern therapist takes more of an 'I am here to learn about you from you' stance. Central to this therapeutic stance is the therapist's honest and sincere capacity to be receptive to, invite, respect, hear and be engaged in a client's story. A 'not-knowing' stance requires that the therapist's understandings, explanations and interpretations in therapy should not be limited by prior experiences, preconceived opinions or expectations, or theoretically formed truths, and knowledge (such as that contained in the DSM IV). The therapist's role is to facilitate an emerging dialogical process in which 'newness' can occur. The therapist positions himself or herself in such a way as to be informed by the client. It is a stance that 'maintains that understanding is always interpretive and that there is no privileged standpoint for understanding' (Wachterhauser cited in Anderson & Goolishian 1992:28-29; Besley 2001:81). My philosophical position is thus one of joining with the client in a mutual exploration of the client's understanding and experience; the process of interpretation becomes collaborative.

A non-hierarchical, non-interventionist position does not equal passivity. It does not mean that anything goes or that the therapist is not influential. As I have already explained in the first chapter when I used White's graph (see Figure 1.1 in Section 1.6.5.1) to illustrate the different 'postures' that a therapist could take up in therapy, my preferred therapeutic position can be described as a de-centred and influential position. When a therapist adopts a de-centred position that grants primary importance to the client's world views, personal stories, meanings and understandings. The therapist is influential in the sense of building a scaffold through questions and reflections. A therapist is always influencing the client through the questions that are asked, likewise,

a client is always influencing the therapist (Anderson 1997:95; Besley 2001:76; White 2003).

The uncertainty that results when a therapist's talk, action and thought are informed on a moment-by-moment basis can be unsettling, because if we are accustomed to a modernist way of doing things, we are used to the certainty of recipe-like 'informed' behaviours. However, therapy based on a postmodern view allows for the development of a therapist's own personal style in his or her work, as well as for encouraging clients to connect with their own most imaginative and creative selves (Anderson 1997:98-99).

To illustrate how very creative and imaginative this work can be and how strongly it is a reciprocal process where the client and therapist influence each other, I want to share how Conrad used his talent to create an alternative story of his relationship with God, which gave him hope. Conrad joined the Monday group from the start, and I committed myself to journeying with him. He had many faith issues and questions about God's not being involved in his life. It was difficult for me to resist providing my own certainties about God to him, and rather to co-create the meaning of an experience with a personal God with Conrad, as recommended by Griffith (1995:137). I knew such a stance was very important to Conrad, as he had previous experiences of people applying their knowledges of God to his life. Conrad experienced his world and his life as very dark, with a huge insurmountable wall between himself and God. Because he has a talent for painting (he started art lessons after joining the group as a means to reduce the influence of depression in his life), he was encouraged by a friend to express these feelings of darkness and isolation from God through his painting.

Conrad took a canvas and completed twenty-one paintings on one canvas. After he had completed the first painting that portrayed the darkness and a huge, high wall, he photographed it (see Appendix 1). He then added new things to the painting, for example, a bridge, trees, plants which started to grow over the wall to the other side. Next he created a hole in the wall to reach the other side (see Appendix 2). Every time that the painting was completed, he took a photograph. In the end, Conrad printed all twenty-one photographs on separate canvases and mounted them on a huge door, ending with the photograph of his last painting, representing his preferred picture, or outcome

(see Appendix 3) . This last picture was of a garden with a bench next to an overgrown wall full of blooming flowers and with a bright light streaming in through a hole in the wall. He said that this last painting represented his preferred way and place of being. Although he was not always there, in that preferred place, he was visiting it more often. This visual expression reminds him of his journey and fills him with hope. Conrad is also aware that this is not the end of his journey, but that the process of meaning-making and ‘newness’ will always continue. My stance of not-knowing probably facilitated a dialogical process that created space for Conrad to develop new meanings and realities that could be painted and integrated into his preferred picture or narrative.

I also want to acknowledge Conrad and thank him for the influence he had on my life through our journey together. Conrad taught me that it is worthwhile to connect with people and to journey together, as both lives (that of the client and that of the therapist) are transformed and influenced. Conrad helped me to believe in the work I was doing and that I did not have to have all the answers. He also challenged me regarding my faith and helped me to gain clarity regarding what I believe and why. Through all our struggles and joys together in the group, Conrad and I experienced how our personal stories merged with one another’s and with our stories of God, and how both of us ended up with new stories. This is the ‘fusion of horizons’ that Gadamer (cited in Anderson 1997:39) refers to in order to describe what happens when an understanding emerges that is unique to a specific encounter and that cannot be attributed to either participant on his or her own. Gerkin (1991:20-21) explains the metaphor of a fusion of horizons by saying that the individual self, in the course of his or her development, creates a narratively constructed horizon of meaning concerning his or her self and the world. In the encounter between the person seeking help (in this case, Conrad) and the pastoral therapist (in this case, me), a dialogical process develops that can be understood as a fusion of horizons, as the persons engaged in the encounter interact in ways that bring about alterations in the meaning horizons of both persons. Conrad’s story also had an impact on the rest of the group, as it gave them hope too. In this sense, their horizons were also broadened.

I was even more excited by the fact that the effect of Conrad’s story is not limited to me or our group, because I am convinced that the best preachers of our time are the artists

and storytellers, as Seay (cited in Niemandt 2007:114) suggests. Conrad's 'door of hope and transformation' was selected for an art exhibition that was held at our church. Conrad attached the following note to it:

The artwork is a depiction of a personal spiritual vision, with a message. It is a metaphor for truth, hope and transformation. It is not a depiction of absolute truth, which can never be obtained in full, but stands in relation to truth, which is a person, the Son of God, the Christ. It has a universal as well as a personal message of hope, transformation, growth and liberty. Furthermore it is totally open to interpretation and is intended to induce thought and reflection, regarding each individual person's own journey of transformation and hope out of bondage into liberty, also inducing reflection on what could bring forth this change and growth in the context of the Christian faith, which I believe is a unique personal "way" for each person. The artwork is multivalent; it has many layers of meaning, which are interwoven to form the whole. Like our mortal Christian journey, the artwork is never finished, our search for truth and to find God's ways, is never finished. The act of producing the artwork was in itself a healing and therapeutic process, creating hope and transformation was in the process itself, not only in the message. This underlines the idea that faith, or words without action is dead, that faith and hope is often created by action. May we all partner with God to become co-creators of a better world as God intended it to be...

Journeying with Conrad while he was constructing his 'door of hope and transformation' certainly enriched my life and filled me with hope. I do know, however, that Conrad would like his message of hope to touch other people so that through his artwork, he can become a co-creator, with God, of a better world. In this way the personal becomes the political (according to a well-known feminist phrase). In this way Conrad's experience is not solely his own, but is linked to other people's experiences, 'it is linked to a broader politics' (Russell & Carey 2003:71).

3.4 ETHICAL CONCERNS

As discussed above (in Section 2.4), my philosophical position is deeply connected to an ethics of care in which my position as a pastoral therapist is an attempt to avoid merely scientific notions of diagnosis and a preference for opening up space for multiple interpretations of reality. This position is based on Foucault's theories on the way that power works with knowledge and the very real political and ethical effects that this has on constituting reality in people's lives (Kotzé 2002:8-9). It is the effects that these knowledges, truths and beliefs have on people that concerns me. Who benefits from these knowledges, truths and discourses? Who suffers? To me these questions are crucial ethical-political questions, as explained by Kotzé (2002:11). Lowe (1991:48) says about the power of discourse that the 'most significant questions, therefore, are less concerned with what a discourse is, than with what it does', as it has powerful constituting effects on individuals' sense of self.

A dominant religious discourse such as that of prosperity theology is an example of how discourses can have powerful constituting (yet marginalising) effects on individuals' sense of self. In the church that Conrad attended, it was a prevailing discourse that a Christian should be healthy, prosperous and leading a joyous life. Conrad, by contrast, experienced poor health, suffering and depression. When members of the congregation prayed for him, '*claiming*' healing from God and nothing changed, he was marginalised, because he did not fit the belief (discourse) held by these members of the congregation. This '*isolation*' by and from the church added to Conrad's despair. Hermien was punished by her husband for not being a 'good wife'. The discourse of patriarchy silenced her and held her captive in a society (and church) where a husband is still seen as the authoritative figure in the home.

In Western society, pastoral care and therapy was always concerned with caring for individuals. However, both the above examples illustrate the danger of thinking that each individual is separable from society and that personal growth is possible without taking into account the communal, social dimension (Jenkins cited in Pattison 1993:85, 88). Although pastoral care should never lose its concern for individuals, many of the things which affect the well-being of individuals originate in the wider social and

political order (Pattison 1993:82). Therefore, pastoral care should also take cognisance of the social and political discourses that play a constituting role in clients' lives. Pastoral therapy should be 'discourse sensitive'.

'Effective pastoral care, if it is truly to alleviate sin and sorrow and to nurture human growth, must widen its concern and vision beyond the suffering individual' (Pattison 1993:82). I was left wondering what our ethical obligations as pastoral therapists are towards clients (group participants) regarding discourses that marginalise them and that contribute to their depression.

In his 'holistic liberation-growth model' of pastoral care, Clinebell (cited in Pattison 1993:89) argues that pastoral care and counselling must be 'holistic, seeking to enable healing and growth in all dimensions of human wholeness'. For Clinebell, wholeness is relational and involves the community and society, not just individuals regarded as separate entities. In this, Clinebell is moving beyond what he has previously argued for within an individual paradigm, so he too is moving— not static and not purely modernistic.

A pastoral therapist therefore does have an ethical obligation to take into account the social and political causes of whatever it is the client may be experiencing. Selby (cited in Pattison 1993:90) believes that to presume to care for other human beings, without considering the socio-political influences they are subject to, is to confirm them in their distress while pretending to offer healing. Selby accuses pastoral care of having for too long simply tried to adjust individuals to the social circumstances which prevail, rather than helping them to become involved in a long-term and painful struggle for justice and peace.

In a postmodern culture, we are often overwhelmed by the profusion of new technology, creating distance between people. Therefore Babin (cited in Niemandt 2007:82) predicts that relationships such as those we can find in small groups will flourish in such a time and from these groups society will be influenced.

Some people believe that the stigma attached to depression no longer exists, but my

experience in the group suggests that the stigma and marginalisation of people struggling or living with depression is still very much alive, both in society in general and in the church. Earlier this year, the South African depression-and-anxiety support group participated in an international survey to determine to what extent people with depression are still stigmatised. According to that study, South Africans still have huge amounts of prejudice about and still reject people with depression and bipolar illness (Van Eeden 2007:19). Oosthuizen (2007:10-11) confirms that depression is still a secret illness which people are ashamed to talk about, as they are confronted daily with the stigma attached to the illness. People who are mentally ill (people with major depression, bipolar depression and schizophrenia) are one of the groups of people against whom it still seems to be socially acceptable to hold prejudice (Greene-McCreight 2006:36). Lockley (2002:14) suggests that 'being a depressed Christian in a church full of people who do not understand depression is like a little taste of hell'. Other Christians hints that they wonder about unconfessed sin, about whether the person with depression is truly a Christian or whether they can put their trust in that person because of his or her mental state.

I recently attended a church meeting where a professional spoke on the topic of depression. A pastor stood up and said that people only have to come into the right relationship with Jesus, then their problems will be solved, suggesting that there is something wrong with your relationship with God if you struggle with depression. The discourse that 'real' Christians do not struggle with depression still prevails.

Another discourse in the church on depression – one we often come across in the groups – is that Christians who trust in God do not use or rely on medication for depression. (Why this 'rule' only counts for depression, I do not know). Oosthuizen (2007:54) describes depression as an illness of the brain which has to do with the chemical activities of the brain. In the same way that people do not expect someone with diabetes or epilepsy to just 'snap out of it', it is impossible for someone with depression to 'snap out of it'. One of our group participants was invited to a support group for Christians with depression that measures its 'success' by the number of people in the group who get rid of their medication. Another group participant was told by her Bible study group that 'victory' over depression would imply that she would stop taking her medicine and

rely only on faith. (She did this for a while, with disastrous effects!) Another person in the group attended a church which believed that illness was not from God and that taking medicine was a sign of unbelief. Consequently he stopped taking his medication and came to me devastated, because he physically needed the medicine and he wanted to stay in his church, but he did not want to live a lie. He could not speak of his relationship or battle with depression out of fear that he would not be able to complete an advanced church programme that he was following. Oosthuizen (2007:12) warns against the irresponsibility of people advising others to stop using their anti-depressants (and other medicine for mental illnesses).

Lash (cited in Lowe 1991:48) suggests that some forms of postmodern reflexivity tend to pay more attention to the producer of a discourse than to the product(s) and process of discourse. Thus a postmodern orientation urges social scientists to examine critically not only the validity and effects of discourses, but also the social and power position of the producers of discourses.

It seems to me that the church is in a very powerful position as a producer of discourse(s), especially regarding faith issues. Lambourne (cited in Pattison 1993:92-92) argues that pastoral care (and thus pastoral therapists) should be concerned with 'the radical progressive formation of the behaviour and conscience of the church fellowship as it exercises its corporate responsibility in being a holy servant to people'.

This implies that I would thus use every opportunity to inform people (in society and in the church) about depression to refute misconceptions on depression and to be involved in creating new, liberating discourses on depression. Ethically, it is impossible for me not to be involved in the socio-political context that influences the group participants (Lowe 1991:48). The groups can also influence society and the church as producers of new discourse(s) on depression (Niemandt 2007:82).

As Conrad's '*door of hope and transformation*' illustrates, the group participants also gained self-respect and learned to take responsibility for themselves and for their worlds. Social and political awareness and involvement then followed. Conrad does not want to keep his message of hope and transformation for himself: he wants to 'partner

with God to become (a) co-creator(s) of a better world', as suggested by Pattison (1993:92). His works of art can be used as a very powerful medium to convey the Christian message, as proposed by Dreyer (2007:14).

3.5 THE ROLE OF THE CLIENT (GROUP PARTICIPANT) IN A POSTMODERN PARADIGM

In defining the role of the therapist in a postmodern paradigm, the role of the client is automatically implied (as in Chapter 2, with modernism). Postmodern therapists are described as conversational partners who bring expertise in the area of process to the situation. The implied position of the client is that of a collaborator or co-seeker of knowledge who brings expertise in the area of content to the situation. The therapist and the client thus participate in the co-development of new meanings, new realities, and new narratives. Therapy entails an 'in there together' process (Anderson 1997:95; Anderson & Goolishian 1992:29).

In a postmodern paradigm, the client is no longer seen as a passive, powerless recipient of the therapist's knowledge and expertise, but as an active participant in a dialogical process of first-person story-telling. The dialogue creates opportunities for self-agency, freedom and possibilities that are unique to a client and his or her situation. The sense of 'agency' is derived from the experience of escaping 'passengerhood' in life and from a sense of being able to play an active role in shaping one's own life. A sense of agency implies possessing the capacity to influence developments in one's life according to one's purpose(s), to the extent of bringing about preferred outcomes (Anderson 1997:94; Freedom & Combs 1996:21; White 1991:38).

On my journey with Conrad, I experienced how he was able to move from 'passengerhood' to active participation in the therapeutic relationship. Conrad moved from a position of being the object to be 'fixed' (which nobody managed to do), to a position of being the narrator of his own preferred story. He actively participated in shaping his own life to such an extent that he could make a career change and eventually move into his own home.

In narrative therapy, 'speaking' and a 'voice' are used as metaphors for the agency of the client. When clients are the narrators of their own stories, they are able to experience and recognise their own voices, power and authority. It is as if the roles of the therapist and client are reversed: the client becomes the teacher. The therapist is led by the client into the client's own world. The client's world views, meanings and understandings are granted primary importance. The therapist is always in the process of coming to understanding and always changing. The therapist does not dominate the client with expert psychological knowledge, but is led by and learns from the expertise of the client (Anderson 1997:95; Anderson & Goolishian 1992:33; Drewery & Winslade 1997:43).

In the groups, I experienced the women in particular gaining a sense of agency when they were given opportunities to voice their own stories and were listened to authentically and respectfully – without enfeebling them in the process. Hermien, who had experienced domination and humiliation from her husband, began to find a space within the group to create her own preferred story. Another woman gained a voice and could then tell her husband about her living with bipolar disorder and how he could support her. A young woman could tell her mother how her truths were different from those of her mother. In all these women's lives, these enabling stories allowed them to speak in their own voices and to work on the problem, instead of being passive recipients of the position they had been given in the story (Drewery & Winslade 1997:42; Monk 1997:32-33).

Expertise (as in a modern paradigm) may easily silence the knowledges and abilities that might otherwise come to the fore in and be used by the client. One man in the group was quite knowledgeable on therapy and diagnosis, as he was a former social worker. He also journeyed with depression. My experience in the group was that his 'expert knowledge' silenced the rest of the group. Because I was sensitive to the effects of expert knowledge, I created a context for the group members to reflect on the effects of expert knowledge within the group process. We discussed the effect that expert knowledge had on the other group participants in the presence of this man, and what the possible role of expert knowledge could be. We came to the conclusion that an inquiring, curious stance gave the group participants the opportunity to discover the strengths that were present in themselves (Monk 1997:25-26). Unfortunately this man

did not shift his stance as will be discussed later.

Through the co-creation of therapeutic productions (dialogue and documents or accounts of therapy), clients become knowledge-makers; and knowledge-makers become knowledgeable. Both their knowledge-making capabilities and their knowledgeableness are authenticated by documenting it and using it (for example, in a research report such as this). In the process, these knowledges become known. This encourages people to deploy their knowledges more knowingly; it increases their own authority in matters of concern, and decreases their dependency on expert knowledge. It was wonderful for me to see how excited the group participants are to be part of this project and how eager they are to share their knowledges. Epston and White (1990:24) believe that such knowledges can be more viable, enduring, and efficient than the expert knowledges which are often disabling.

A discussion follows below of the ‘meaning’ (knowledge) of depression in a postmodern paradigm.

3.6 A POSTMODERN DEFINITION OF DEPRESSION

A few months ago, Conrad attended a workshop by experts for lay counsellors regarding depression. Three psychologists and a psychiatrist addressed the lay counsellors, teaching them how to counsel people who struggle with depression. After a while, when questions could be asked, Conrad stood up and asked: *‘Where are the people who journey with depression? Shouldn’t they be part of the panel of experts? What about their knowledges?’*

Looking through a postmodern lens, Conrad questions the claim that depression can be understood mainly or only in terms of meta-narratives. His questions suggest the co-existence of a multiplicity of situation-dependent ways of looking at depression, and this resonates with suggestions by Burr (1995:13-14).

According to Kuhn (cited in Anderson 1997:13), modern science has the basic aim of actualising the promise of the existing paradigm, and thus forcing nature into the

performed and relatively inflexible box that the tradition-bound paradigm supplies, instead of attempting to create new knowledge.

From a social construction view, new understandings evolve from and within ‘socially negotiated forms of meaning’ (Anderson 1997:14). The generative nature of language in creating knowledge is emphasised. People’s social, economic, cultural and political locations significantly affect their interpretation of phenomena. In such a view, knowledge is a discursive practice – there are a plurality of narratives that are local, contextual and fluid. Different forms of knowledge that have been subjugated are given the opportunity to be released, find expression and be explored.

We cannot have direct knowledge of the world (or of depression); we can only know it through experience. We continually interpret our experiences and interpret our interpretations. As a result, knowledge is always evolving and continually broadening. Knowledge is therefore a process, rather than an outcome. Our knowledges create a multiverse rather than a universe of perspectives (Anderson 1997:15; Hart 1995:10; Lartey 2003:38).

It is thus impossible to write a single postmodern definition of depression, as there are multiple ‘truths’ regarding the word and its meaning. I would prefer to allow the group participants to make their own meaning of depression and how it operates in their lives, rather than simply seeing depression as a set of diagnosable symptoms. Therefore I choose to take up a curious position with regard to what people call ‘depression’ and to create a space for them to define and frame their own experiences of depression from a position of being the experts in their own lives. Even then, the process will not be completed, as new meanings of the word will continue to evolve (Penwarden 2006:65-66).

3.7 CONCLUSION

Even though I choose to position myself in a postmodern paradigm in terms of my philosophical stance in therapy, I am aware of the criticism and many of the challenges faced by such an epistemological stance.

A constructionist orientation appears to be excessively relativistic, as it offers no foundational rules or warrant. Postmodernism can thus be criticised for ‘throwing out the baby – the large historical narrative – with the bathwater’. However, embracing uncertainty, unpredictability and the unknown does not necessarily mean that ‘everything goes’. Practitioners are invited to view ‘rules’ as historically and culturally situated and therefore as subject to criticism and transformation. From a postmodern perspective, everything is open to challenge, including postmodernism itself (Freedman & Combs 1996:31; Gergen 1985:273). According to Doan (1998:381), a therapy which embraces postmodern, constructionist notions (as I have explained in this chapter) would not be inclined to offer itself as a singular account to which all other therapies should pay homage. Even within its own ranks, it would be very tolerant and inclusive of various ways and means of conducting narrative therapy. A question that then arises is whether narrative therapy is violating its own assumptions. It should be acknowledged that narrative therapy is a socially constructed reality, just like any other set of ideas (or therapies). It is no more and no less privileged than other paradigms (Doan 1998:382;385).

CHAPTER 4

WALKING THE MAP: PARTICIPATING IN THE RESEARCH PROCESS

4.1 INTRODUCTION

Against the backdrop of the theoretical grounding of my philosophical stance (as given in Chapters 2 and 3), in this Chapter I attempt to convey and make meaning of the group participants' contributions in the focus groups. I do this in order to answer my research question, which is the following: What are the effects of the philosophical stance that I prefer to take in pastoral therapeutic groups?

The purpose of this chapter is thus to discuss and reflect on the information that I gathered in this study. As I described in the comments on the methodology followed, I held two focus group discussions, with the 'Monday' and the 'Wednesday' groups. Bearing in mind the building blocks of my philosophical stance (see Section 1.6) in mind, together, the group participants and I constructed questions that guided our discussion, as suggested by Edmunds (cited in Berg 2004:123). When I analysed the data, I again used the same building blocks of my philosophical stance for the first focus group and arranged the discussion around these themes (see Section 1.6). These sessions were recorded on audiotape, in line with Merriam's (1998:87) suggestions. The sessions are discussed in this chapter according to the building blocks. The two focus group meetings held with each group were a year apart, allowing space for us to explore the changes recommended in the first focus group sessions. Other helpful elements of the philosophical stance that could be included were also explored. This is in line with my research aims.

4.2 FIRST FOCUS GROUPS

At the time when the first focus groups met, the Monday group consisted only of men and myself, while the Wednesday group consisted only of women. This was not intentional.

4.2.1 Values, beliefs and experiences

4.2.1.1 Values

In the first chapter I used Malphurs's (1996:14) definition of values as being 'representative of what one stands for in life' and defining 'who one is and what one is willing to do for [one]self and others'. This was the first building block of my philosophical position (see Section 1.6), although the conversations were not ordered or structured. For the purposes of this study I have selected the comments by the participants that appeared most relevant to this building block.

Two weeks before we had the men's first focus group discussion, the group participants suggested that we write down 'what the group stands for' in order for newcomers to know what to expect when attending the group. In accordance with Malphurs's (1996:14) definition, we actually wrote down the values of the group. One member suggested that we call what we had noted '*the ten steps*' followed in our group. This was in line with some of the philosophy of groups such as Alcoholics Anonymous, which have had a great impact in society. Under the influence of my own philosophical stance, the group eventually decided not to take such an approach, as the philosophical underpinning of this group was one in which prescriptive steps, or prescriptive ethics, was laid aside in favour of relational principles which are more fluid than a ten-step programme. We wanted to write about the things that we stood for, recognising that they were liable to change as we moved on. This is in line with a social construction understanding of ourselves not as fixed identities, but as a group that allows for greater fluidity of who we are and who we become. Formulating our values helped us to prepare for the focus group, as it stimulated our thinking about how the group was influenced by my (the therapist's) values, which are part of my philosophical stance.

The group participants from both groups said that they experienced the value of acceptance in the groups, which helped them to '*take off their masks*' and '*be themselves*'. In line with a focus group approach, I selected this word '*acceptance*', along with '*taking off masks*' as words or phrases that were very commonly used by the participants, as I noted in transcribing the text from the audiotaped conversation. Being

mindful that the self is not a fixed identity, there are many possible meanings to the concepts of *'taking off masks'* and *'be[ing] themselves'*. Both groups elaborated on their meanings to describe to me that they did not feel judged, despite feelings of confusion or inadequateness. In other words, a lack of judgement of the other seemed to accompany (or make possible) the taking off of masks. An ethical stance of privileging a value of building trust between the self and the other, instead of, for example, a focus on a *'ten-step programme'* might be significant here. One man mentioned that he felt that the *'core of the therapist's interaction with the group was unconditional acceptance and care'*. He also thought that this acceptance influenced the group participants to be accepting of one another. Another participant said: *'The acceptance that I experienced since the first time I attended the group, made me come back, because I found a safe place where I could just be.'* One of the women said: *'I could open up and share my heart, whether I felt sad or good.'* This value of acceptance, which was accompanied by taking off masks and being oneself, therefore seemed to speak of an ability to expose humanity without its being judged, or a *'quantitative value'* being placed upon it.

This philosophical stance is perhaps far more difficult to measure than a more structured programme that adheres to certain developmental rules and steps and measured values. This form of unconditional acceptance is very present in most pastoral care models of practice (Pattison 1993:48, also see Section 1.5.2), although unconditional acceptance in a postmodern understanding of the word has no fixed meaning and is only found in the interactional patterns of relationship. The term *'unconditional'* itself becomes problematic: it needs to be defined in more detail in that no relationship is unconditional – within a reciprocity of relationship there are many unspoken conditions and rules that may not, at first, be exposed for others to see. This view would be more in line with a Foucauldian understanding of a power relationship.

The group felt that this value of acceptance was practised and employed in certain actions such as comprehensive listening, a sensitivity for everyone's uniqueness and not judging others. Hearing the participants voice the notion of *'comprehensive listening'* made me as group leader feel that perhaps I was in a difficult position, because I feel that in many ways I cannot ever be fully present or comprehensive, in that according to

a social constructionist understanding of identity I can at best select information that fits the meanings that are constructed within the group. 'Uniqueness' is another concept that is open to negotiation, in that within a social constructionist understanding of the self there is no autonomous unique self, but only one that is constructed through the discourses that live. These examples indicate just how powerful a philosophical stance such as the one that I take is in forming ways of relating to one another.

Apart from acceptance, trust played an important role, as did confidentiality. These values made the group meeting a '*sanctuary*' where the group participants felt safe and cared for. Pastoral therapy models generally espouse these values, which challenged me in doing this research to understand something about the differences between this and other models and distinctions within the philosophical stance that I took. Perhaps what is significant here is that a more unstructured, fluid way of embracing values places great emphasis on creating a space for people's lived humanity to 'be' without having prescriptions laid down in a rule book. Relationship is foregrounded in such a stance, because within a participatory consciousness new knowledges can be co-constructed (Kotzé 2002:6, 2.4).

Another value that the women mentioned was commitment to the group and the other group members. So, for example, one woman said: '*If participants are not committed to the group and do not attend regularly, it is difficult to build relationships of trust.*' The other participants generally agreed with her. Many programmes define what is expected from a group and are specific about what it means to be committed. This was not an approach I could endorse on the basis of my own philosophical stance, and instead the notion of commitment was negotiated over time in a less stable form of group accountability. The women appeared to connect commitment to some engagement beyond the formal group and defined it as a need for contact with one another outside the group, as friends. It seems that in building relationships inside and outside the group, the boundaries between the values of the group and the value of friendship tended to blur. It could be described more as an internalised way of practising their values in the community.

My own philosophical stance relating to values was perhaps then connected to an ability to work in a more fluid way. Because I let go of the process, the group's agency was enhanced and through the interconnectedness that was created within and outside the group, isolation was reduced, as also described by Yalom (1995:17,21). Such a development potentially frees me as a pastoral therapist, in that it generates communities of care where unconditional acceptance is deconstructed and shared within a group with a sense of (shared) responsibility.

4.2.1.2 Beliefs

Christian beliefs have shaped my way of living in the world, both through my cultural upbringing and the church context in South Africa. These beliefs have exercised a powerful influence on my family, as well as on the broader Afrikaans culture I come from in its way of holding onto meaning and value(s) within its group identity. My own strong Christian beliefs have emerged from this larger discourse. My own beliefs have shifted and changed, but a more fundamental and patriarchal belief system has deeply influenced my faith and my philosophical stance. A patriarchal rigid evangelical belief system is deeply influenced by a prescriptive top-down approach to God and the Bible. Because such rigid systems are incongruent with my current philosophical stance, I wanted to know from the group participants what they thought the effects of my Christian beliefs were in the group.

The group participants did not experience my Christian beliefs as '*top-down doctrine*', but as a practical demonstration of God's love and support. One man described it as '*a pleasant fragrance that lingered in the group*'. Somewhere in the multiple meanings formed within the dominant fundamentalist discourse in my upbringing, great attention was paid to caring for others; and this I learnt from my mother. This reveals how, in some ways, discourses become self-contradicting and shows that they cannot be adequately understood in simple terms. Although I perhaps do things differently now, in that I attempt to care 'with' rather than 'for' people, it is very much a fragrance that lingers with me too – something I took from my mother's voice, and that in turn was largely driven by her own Christian convictions. This care was formed within a patriarchal practice in which women, in particular, were expected to nurture; and in

many ways this discourse restricted her from doing otherwise. Within any discourse, ways of practising beliefs both permit care and freedom in one way, and restrict them in another. Within my own framework and discourse of participation then, participants can also be restricted in respect of what is 'allowed' or what they feel permitted to talk about through the way the group's beliefs are constructed. Thinking about this, I wonder how much cannot be said, even in such a warm inviting climate – in other words, what becomes unacceptable in this group.

One participant was very honest about her own struggle with faith issues, which reminded me of shifting belief systems, from a prescriptive top-down patriarchal way of understanding God to a sense of a less controlling God. This is very much in line with my own shifting realities. One aspect of my philosophical position was my desire to pay attention to these shifts in consciousness and to allow doubt to play a role. However, this participant said she never felt uncomfortable in the group because of 'Christian talk' and could share her struggles openly.

Another group member felt a bit threatened in the beginning by 'Christian talk', because she felt her own behaviour was very 'un-Christian'. This young girl came to me in private to share those things she was too ashamed to mention in front of the others, and she asked me to pray with her. Her caution could be a result of her sense of what she was allowed and what she was not allowed to say within the discourse constructed and adopted by the group. But perhaps there was a quality of my own acceptance and non-judgement that permitted this girl to find a way of languaging these things in private.

Although we regularly prayed for one another in the group meetings, some members felt a need for more prayer '*as it will strengthen our faith*'. One woman shared with us that she always prayed before group meetings for the guidance of the Holy Spirit in the meeting. This comment allows for multiple ways of doing faith and, at the same time, holding onto a core value and belief in prayer.

The rest of the group felt that the weaving of Christian beliefs and practices into the discussions in the group was '*spontaneous, unstructured and non-prescriptive*'. One man would frequently refer to Jesus as his model of love, of being non-judgemental, and

so on. It was felt that the ‘unique *relationship that each one had with God was accepted and enhanced*’.

4.2.1.3 Experiences

In response to my curiosity about the effect of my own life experiences on the group participants, they indicated that they felt that I could really understand their struggle, because I also journeyed with depression. My story gave them hope. Our journey with depression became a ‘*shared experience*’ through which all of us could renew our ideas on depression (see Section 2.2). This is a particularly significant point in view of my choice of a philosophical stance that supports working with others, not as someone who holds the answers, but as a fellow traveller on a long road to freedom

4.2.2 A social construction discourse

The effect of my preferred social construction and participatory discourse stance, which in this instance privileged local and group knowledge over a more prescriptive programme, as I brought it into the group as part of my philosophical stance, was described by one of the group participants as follows: ‘*The focus in the group is not on fixing the person with depression through expert knowledge. The fixing comes as a by-product of acceptance and by sharing and talking with each other.*’ Many pastoral care theories (sometimes inadvertently) assert that a therapist is an expert on pathology and normalcy. The philosophical stance in this study focused on enquiring not as an expert, but rather as one who wished to learn from the group participants about their local knowledges. This is in line with a narrative pastoral care approach. Such a stance is designed to create space for many possibilities and a richness of new meanings to occur (Freedman & Combs 1996:31), as also explained in Section 3.2.1 of this study

As knowledges are created through social interaction, and language is our tool for making meaning (Drewery & Winslade 1997:34; Freedman & Combs 1996:23), it was important in this study to explore the ways in which the group found this stance to be practised. One man shared how the language we used in the group helped him to separate the depression from his value as a person, creating space for new meanings to

occur: *'I used to use blaming, destructive language towards myself. Now I am able to say "Yes, I do have depression, and I can still enjoy many things in life".'* The depression which dominated his life before was no longer totalising his life. Narrative practices that separate a person from a problem helped him to move away from essentialism towards becoming a human being in a more accepting way that he preferred (Besley 2001:7; Morgan 2000:24). This idea is also discussed in Section 3.2.3 of this study).

Another group participant added: *'I think through the interaction between group members, the sharing of ideas about who we are, who God is, etc., new ideas are created, new possibilities open up as well as new ways of looking at things.'* In this context, narrative therapy is understood as an art of conversation where the therapist is a co-participant 'in' conversation. This philosophical position invites participants to collaborate, find new meanings, new realities and new narratives within their multi-storied lives (Anderson 1997:105; Anderson & Goolishian 1992:28; Lowe 1991:46).

Group participants said that my own philosophical position was not one that held preconceived ideas of *'how things were supposed to be'* or *'how a Christian is supposed to believe and live'*. One group member said: *'I don't like models, because what happens if you don't fit?'* They said that they had the freedom to hold their own truths according to their own experiences: *'My Christianity was not questioned because of my depression. I could be both a Christian and have depression.'* Derrida's notion of both/and allowed for a subject whose experience and agency is open-ended and multidimensional (Sampson 1989:15).

Someone in the group explained the sharing of ideas and experiences by using the metaphor of a pot into which different ingredients were thrown. After the mixture had been stirred and had simmered for a while, the concoction was ready. The contents could be of value for some, but perhaps not for others, because what works for one group participant might not necessarily work for another.

4.2.3 Feminist theology

I align myself with feminist theologians in my desire to find a more inclusive view of humanity which affirms all humans' value and integrity, so I was interested in some of the ways in which such a therapeutic stance affected the group participants.

One of the group participants described his experience of alienation as being '*a circle-person who operates in a square world*'. He felt as if he did not fit in, while no-one seemed to notice or care. He said: '*I didn't dare to tell my Christian friends about my depression.*'

The group members held a generalised assumption that people with depression are marginalised by the church and it made me wonder whether, from a feminist perspective, men who live with depression are not sometimes even more marginalised than women who live with depression because of the assumptions that patriarchy places upon the meanings of 'maleness'. Both men and women described their sense that the church does not really know how to deal with people who have depression and other psychiatric illnesses, as these problems are quite complex and people with such illnesses have been separated from what has been accepted as 'normal' within the dominant church discourse. They think people in the church judge them out of ignorance. One man said: '*The church doesn't know how to relate to us, like I don't know how to relate to handicapped people. Shouldn't we hear from them how they experience living with their problem?*' This suggestion resonates with Ackermann's (1994:199) invitation to society and the church to be more just, liberating and healing in their praxis. By creating space in the groups for members to be 'heard into speech' (a term used by Morton, cited in Ackermann 1994:206), this way of doing theology within the depression groups has sought to affirm the validity of their experiences.

One group member said that the group provided a '*forum*' where people could bring out their voices without being ashamed of living with depression. The importance of having a 'voice' was stressed throughout the discussion by group participants. This led them to question the larger church and their own experiences of being silenced. '*Why is it so difficult for the church to give certain people a voice?*' one person asked. This led the

group members to want to take part (to be included) in producing new discourses regarding depression and faith.

An inclusive view of humanity, such as feminist theology advocates, can be described by words such as relationality, community, mutuality and connectedness (as indicated in Section 1.6.3 above). Group members indicated that they often felt that the therapy group was the only place where they could connect with people on a deeper level: *'Here it is not about performance and success; it is all about relationship.'* They said that the group helped them out of their former isolation and loneliness, as also indicated by Yalom (1995:17,21) and mentioned in Section 1.5.1 above. The women's group reported that they seemed to find it easier to move in and out of the group and form relational space, but the men did not report the same experience. This could indicate that men face another difficulty, namely connecting outside the group, and thus our experiences together helped them to find another skill to challenge depression.

The women shared this experience of isolation and loneliness before they joined the group. In the group they experienced community and made true friends. We talked about how the women would linger by their cars or in the sitting room, sometimes for more than an hour after the group meeting was over. They enjoyed the togetherness and community.

The Biblical metaphor of a body was also used to describe mutuality and connectedness in the group. One woman said, for example: *'We are the Lord's hands and feet to each other.'* Group members agreed that it was not only meaningful to be supported, but to feel valuable because they contributed to someone else's life. One of the men said that he felt as if he had a function and that he belonged: *'You don't feel like a transplanted heart that the body will reject.'* Another one said: *'The group is one of the few places where I experience being part of the body of Christ.'*

4.2.4 A contextual participatory approach to practical theology

Contextual practical theology (explained in Section 1.6.4 above) guided my way of doing pastoral therapy in the groups, so the group participants' local contexts – their

experiences of living with depression – informed my pastoral involvement, as advocated by Bosch (1991:424-425). Furthermore, my philosophical stance subscribes to a participatory process in which the pastoral therapist collaborates with the group participants in negotiating new ways of living, as described by Kotzé and Kotzé (2001:8-9). In my research, I was curious to know in which ways the group participants experienced my approach as being contextual, and what influence such a participatory approach had on them.

The group participants described my role as that of a facilitator who was also part of the group. This role is aligned with a philosophical stance that privileges a greater merging of the ‘self’ and the ‘other’. Group members could participate in the construction of the meetings and in the decision-making processes. They appreciated the fact that I did not approach the group with a fixed structure or model and they were positive about the pliability of the group. I do realise that even though my philosophical stance privileges relationship, there is inevitably some structure in the groups in terms of time, place and so on, as Clinebell (1966:210) points out (see also Section 1.5 above). The structure is probably more fluid than that of many other groups, and it might be interesting to see what the benefits of a more fixed structure could be.

Group members enjoyed having a place to share their own different experiences of God. In the church they sometimes felt that God was placed in a box and to them *‘God is much more than what the church says about Him’*.

The groups both expressed a need to find a greater voice within the larger church context in order for the church to understand people with depression better. They said that *‘sometimes Christians with depression feel guilty, because they don’t know what is wrong with them. Why don’t they have joy? Is depression a sin?’* One group member suggested that we should invite the pastor(s) to our group, so that he (they) can hear what we say and see our experience from our perspective.

Contextual theology is a theology from below, from the perspective of those who suffer (Bosch 1991:423; Cochrane et al 1991:79; see also Section 1.6.4 above). Other members suggested that there should be an organisation for Christians with depression,

to give them a voice, especially in the church. Contextualisation suggests that an ongoing dialogue should take place between a praxis of experience (the text) and reflection (Ballard 1992:116 – 117; Bosch 1991:426).

One man shared how the group helped him to integrate the spiritual aspects of his experience with the rest of his life (his context). He said: *'I realised that when I paint, it is just as spiritual for me as when I pray in church. God speaks to me in different ways; ways that you don't always find in church.'* Now he can say: *'I am a Christian and I experience God like this....'* In this way he moved away from a position where the church and faith are separate from daily living. He is now embracing a quality of inclusivity of experience, shifting from a perspective where God was someone 'out there' to be sought and found, to a more postmodern position where God is constructed within the context of lived experiences.

4.2.5 Therapeutic practices

4.2.5.1 Narrative practices

Different narrative practices assisted me in conducting the groups and became an integrated part of my philosophical stance. We therefore discussed the effects of these practices on group participants in the focus groups.

We talked about the value of sharing the stories of the members of the group, because stories are central in narrative therapy. By telling and listening to each other's stories, group participants gained a new perspective on their own, as well as on each other's lives. One woman said: *'You have more understanding when you know where the person is coming from.'*

One of the men said that the narrative practice of separating the depression from him as a person helped him to *'make decisions and bring about changes'* in his life. Through 'externalisation', his language changed and an alternative story developed as the depression was not totalising in his life anymore. This externalised way of talking about depression was accepted by the rest of the group participants, and they also developed

new stories, as suggested by Drewery and Winslade (1997:39, see also Section 1.6.2 above), Morgan (2000:17-18) and White (2007:9; see also Section 3.2.3 above).

The use of the metaphor of a journey, which is a narrative way of engaging with people, was another helpful 'tool', as it conveyed the idea of a long-term process and long-term relationships in which people live their stories with the intention of holding onto a narrative of time. The group participants experienced depression as a long-term illness or problem, therefore 'quick fixes' did not work for them; and they needed to find the skills they needed to live with depression on their life journeys, rather than try to eliminate it from their bigger stories. Their experiences in the past were that many people tried to help them and prayed for them, but rejected them when they did not 'get better'. On their journey with the people in the group, they experienced love and acceptance, irrespective of the fact that depression was still part of their lives after a year or two. One member said: *'To journey with people is to demonstrate God's love to them.'* Another helpful aspect of the metaphor of a journey is that *'you are filled with hope when you look back on your journey and realise that you made progress'*. Using this metaphor therefore allows people to draw a distinction between where they were and where they are now. One man described his journey as *'taking small baby-steps'*. By sharing those small steps of progress in the group, people were given hope, a much-needed attribute when people journey with depression (Stone 1998:74; see also Section 1.5.1).

In the groups we marked our progress by celebrating significant milestones. When one of the women's divorce was settled and she managed to buy a new house on her own, we had a celebration to affirm her courage. At the end of each year, we have a ritual where we affirm each other by writing a card or giving a special gift. One year, we each drew a name and gave a metaphoric gift to affirm a certain quality or strength in that particular person. In the focus group discussion, the women said that they would like to celebrate more, because it highlighted their achievements, instead of focusing on the problems. They said: *'Such meetings lift our spirits!'* The powerful associations of metaphors creates hope as suggested by Combs and Freedman (1990:xiv-xvii) in Section 1.6.5.1.

Lastly the focus groups helped me to gain insight regarding my therapeutic position as a pastoral group therapist, as the group participants described how they observed my 'posture' (see White's draft; in Section 1.6.5.1) and the effect of my posture on them. The group participants experienced my 'posture' as that of facilitator of the group, as the one who guides by asking questions and by leading the reflection on what is said. In this way I was influential, as the process was conducted by me. The men's group felt that I did not often share with them on a deep personal level, which they appreciated, as they said they would probably be uncomfortable with it if I did. The woman's group, however, wanted me to share on a deeper level. Neither of the groups experienced me as being in the centre (I chose not to be in the centre, as was explained in Section 3.3). It could be interesting to explore the gender differences in the two groups, but that is beyond the scope of this study.

4.2.5.2 Informative practices

All the group participants felt positive about the sharing of information in the form of books we read individually, the DVDs we watched together, the talks by the experts we invited, such as psychiatrists, and so on. They said: '*These practices opened up new prospects.*' They felt that these knowledges were never held before them as 'the truth'. They found it helpful to discuss the information and they felt they could take from it whatever was useful to them in their context.

One man in the group found these informative practices especially helpful, because he was busy constructing '*a model for Christian counselling*' which he planned to use for the training of lay counsellors. He was not very positive about my use of narrative practices. I sensed that his beliefs were mainly grounded in a modernist epistemology (as discussed in Chapter 2). This became frustrating for me, as it sometimes felt as if we spoke different languages.

4.3 THE INTERIM

One of the things I realised in the focus groups was that my concern about perhaps hurting group members' feelings sometimes constrained openness in my feedback

towards the group members. It seemed that this lack of openness had an impact on the rest of the group, as they were also hesitant to be open about 'negative' things they experienced in the group, as can be seen from the feedback in the first focus groups. It was as if they were there to 'cheer me on' and provide all the evidence that this way of working is 'better' than another. This has been a limitation of this research and I often wondered how I might have asked questions differently in order to create a richer text. I noticed that my own philosophical stance, which includes not being confrontational, meant that the group members also seemed to prefer to withdraw than to confront.

These are the 'not-said' things I referred to in Section 2.1.1. One woman who attended the group since we started, for example, told me that she had stopped coming to the group because she felt neglected by us. She did not feel comfortable about voicing these feelings of neglect in the group, as she thought it could make the group members (including me) feel bad. I realised that I had become so focused on my studies that I did not invest as much time and interest in the group members as I had earlier on, and that they missed it. However, I also realised that it could perhaps be helpful to create boundaries, or else the relationships could consume me and dependency on me could take over. This links back to the notion of 'unconditional acceptance', which becomes problematic in that many assumptions can be made about the therapist's meeting 'all' the needs of the clients.

This 'incident' made me ask myself some questions regarding my own openness in the groups. I asked myself whether I was open enough about what I was experiencing in the group. Was it in any way helpful for the participants to try to spare their feelings by not being open? How would they benefit if I was more open? In a way 'not-being-so-open' might have helped me to stand back a bit and not to become overly responsible or too vulnerable to their judgement.

Asking these questions motivated me to have an 'open' talk with the man I mentioned previously, who was not very positive about my use of narrative ideas. In this way we were able to begin to find a language for our differences.

The man attended the group meetings for approximately one year. He joined the group because he had a history of living with depression. He is a qualified social worker, and he did not always agree with my approach in the group; and he challenged many of the beliefs I held, especially on postmodernism. In a way, having these ideas challenged helped me to define more clearly what I believed and why I believed it. I was also aware that different people could hold different beliefs or truths and acknowledged that this man might feel threatened by my position. I did, however, have a problem with an attitude that it would be acceptable when people imposed their truths on others as if their truths were the ultimate truth.

On quite a few occasions, I felt that this man was imposing his opinion on others, especially the newcomers. I tried to guide the conversation by asking whether it would not be more helpful to listen first, instead of trying to find a quick solution. We talked about different truths for different people and about the client as the expert of his or her own life. Although he did not agree with me on many issues, the man kept coming to the group. It really became a problem to me when he started to act as if he were a co-facilitator of the group. I did not want to be involved in a power struggle, but could not avoid it, as his way of doing was not compatible with my epistemology, theology or therapeutic practices. I was not willing to compromise what the group and I stood for (and had agreed on). I thus decided to have a very open talk with him.

Asking questions was a very helpful way to guide the conversation and to find out what his perception was. He acknowledged that he was acting as co-facilitator in the group, while we had never agreed to it. I told him that I did not want a co-facilitator, especially not one who worked against me. He accepted what I said and together we negotiated other options. I told him that I did not have a problem with his attending the group, as long as he would stop acting as co-facilitator. He said that this would be too hard for him and that he would rather attend group meetings without participating in conversations. I disagreed, as the intention of the group was participation. I suggested that he should start his own group, where his philosophical stance (his epistemology, theology, values, therapeutic practices, and so on) could be negotiated with the group participants. In this way, his group would develop its own flavour, attracting those who favour such a stance. In this way I attempted to remain close to my own philosophical

stance of holding multiple realities and options for running groups, although this was a difficult thing to do. This indicates that taking this particular fluid philosophical stance does not mean that 'anything goes'. It can be somewhat confrontational, although it seeks ways of respectfully engaging with people while at the same time being firm about values, beliefs, and so on.

In this instance, it was easier for me to find a voice and allow him to move on without judging myself, because I had such strong convictions about my stance of not being the expert that I could not allow this man to take up such a powerful position and consequently silence the rest of the group.

At first he was reluctant to leave the group, as he felt safe and cared for. I did tell him, however, that he was still welcome to visit the group at times and that he could call me whenever he wanted to. Together we informed the other group participants about our conversation and his consequent leaving of the group. He started individual counselling and the training of lay counsellors in his church. He often called me to update me on what he was doing and with prayer requests. He came to see me, visited the group a few times, and attended the second focus group.

I think that by finding ways of being open and not judging one position to be better than another, we were able to accommodate each other and be supportive within our relationship rather than working in opposition to one another. This in turn was in line with my own philosophical stance. I am also aware that neither of us is 'right' or 'wrong', but that we hold different truths. In the group, we still refer to things he used to say, as he influenced our thinking. This experience made me even more aware that my philosophical stance has very definite effects.

In the next section, I refer to some of the themes that emerged in the second set of focus group discussions which took place a year after the first set. This allowed the group participants to talk about any changes they had noticed in the group because of my philosophical stance.

4.4 SECOND FOCUS GROUPS

The second focus group discussions were less guided by questions, but were a more spontaneous reflection on the past year in relation to the first group. This time I did not use the building blocks of my philosophical stance as a guide in asking questions, but chose to focus on changes in the groups (regarding my philosophical stance) since the first focus group sessions instead. I thus reminded the group participants of their suggestions for change and asked them to reflect on these, as well as on any other significant experiences during the past year. Because the suggested changes were different in the two groups, I decided to reflect separately on the responses of the two groups.

4.4.1 The women's group

With regard to their suggestion that more openness was needed, the women's group reflected on an incident in a group meeting about four months previously to the second focus group session.

In this meeting, one of the women had an emotional outburst, during which she said that she did not feel welcome or accepted by the group and that she expected the group to be more like a Bible study group. She accused me of being '*false*'. She also said that she would not attend the meetings anymore. The rest of the group were very upset at her accusations. They reacted by giving her examples of things we had done to demonstrate our acceptance of her. It was as if we were pushed into polarised positions of support and defence which was not in line with my philosophical position. This became a challenging time and it is interesting that the women opened the discussion with this incident, perhaps because it had such an impact in their memories.

Five days after the group meeting, she called me to apologise for her behaviour and told me that her new medication made her very aggressive and irritable. When she asked whether she could come back to the group, I replied that it was important to talk about the things she said in the next group meeting.

In the meantime, one of the other women called me and said that she felt that this woman was *'bashing us with the Bible during group meetings'* and thus silenced the group. She would be relieved if this woman would stop attending the group. Again this pushed the group into a polarisation of belief.

At the next group session, the woman who had had the outburst could not attend, so the rest of the group discussed the matter. The other women felt that it was futile to take this woman back into the group, as it seemed that she had a different need (for Bible study) from what the group provided. We had already tried a few times to explain to her why we preferred to function as we did, but to no avail. The rest of the group felt that she was impeding the effective functioning of the group, as she spiritualised everything they said, and used Bible verses *'as a plaster on every wound'*. This made it hard to find a fully inclusive way of working without excluding some from the process that had to be informed by certain rules and adherence to these.

I felt that we should not give up on this woman, because she had been rejected so many times in her life. I suggested that we tried again to negotiate with her what our group stood for and the terms (that the group had decided on) that participants had to adhere to. The other women approved, and said that they wanted to be present in the negotiations, as they all needed to voice their feelings.

In the next meeting, the woman was present again and we pinned our values up on a whiteboard and discussed them. In this case, the board acted as a form of externalisation, reducing the tension within the group and allowing an engagement with the board rather than the possibility of accusations within the group. As we went through the values, the group participants voiced their concerns regarding her not being in line with them. She in turn explained how she felt. At the end of the meeting, everyone was positive about having been able to say things that were hard to say.

When we reflected on this episode in the focus group, the group participants were of the opinion that *'even though it is difficult to say it when you feel hurt, or disagree with someone, being open brought us closer to each other'*. They also agreed that the group should be a *'safe place'* to practise *'appropriate'* behaviour, as we learn from each

other. This resonates with suggestions by Jamieson (2002:146), and the notions set out in Section 1.5.2 above).

The group participants also reflected on the importance of new members coming into the group being prepared for what to expect there, in line with Clinebell's (1966:210) notions, and the ideas discussed in Section 1.5.1 above. With some newcomers, I had had a preparatory meeting to hear about their needs and expectations and to brief them on how the group functioned. With the woman who had had the outburst, I did not have such a meeting, which could, I realise in retrospect, have helped the initiation process into the group.

Another suggestion for change that was made in the first focus group was a request for more interaction and support between group sessions. With regard to this suggestion, all the women gave examples of how they had given and received support during the past year. It seemed that my being busier and their being more open to ask for support made them realise that they had a mutual responsibility to care (De Jongh van Arkel 2000, 1.5.1). This moved me from a position where I had previously experienced guilt for becoming more absorbed in my studies to a position where I was able to let go more of the responsibility.

4.4.2 The men's group

At the end of their first focus group session, the men said that there were no changes that they would recommend, because '*the group works well as it is*'. During their second focus group session each one of them reflected on the past year, while the others added their ideas.

Since we had had the first focus group session, one woman had joined the men's group (the Monday group), after she and I had had a preparatory meeting. Unfortunately, she could not attend the focus group session, but she told me that the most meaningful experience in the group was the evening when we had taken the Eucharist together. We had a special ceremony by candlelight and devotional music, during which we were individually served the bread and the wine by my husband (a Dutch Reformed minister)

and afterwards we prayed for everyone in the group. This woman said that during this very simple ceremony, she was touched by God. Some of the men were also emotionally touched by the experience.

A young man who left the group and moved on shortly after our first focus group session came back to attend the second focus group session. It was interesting to hear from him how he saw his experiences in the group in retrospect. He said that although he had since joined a cell group at his church, he could see the importance of being in a therapeutic group first. By receiving empathy, he learnt to have empathy with other people and to be sensitive towards them in their struggle with problems. He realised the value of community in groups, and that there was healing in community. His realisation resonates with those of Tutu (1983:37) and Heitink (1983:258), and some ideas already discussed in Section 1.6.3 above. He said: *'Groups are not only for sick people as we all learn from each other.'*

Another man reflected on the progress he had made during the past year and on how the group helped him on his journey with depression. He learned a lot about the 'strategies' of depression to dominate his life. Now he felt he could manage his life better, in order to minimise the influence of depression. He had also found a spiritual home in a small, independent, alternative faith community where he felt much more at home than in a big congregation. He said that he would never have been able to join this faith community if he had not attended the therapeutic group first. Here he received healing and support to make life-changing decisions.

Another man who attended the focus group session was the one whom I mentioned earlier on, who had left the group after our discussion of the differences between our epistemologies. He said that the highlight of his attendance in the group was the way in which we honoured him when he left the group. He reminded me of the certificate of acknowledgement that I made for him, in which I used the metaphor of a lion to describe him. I gave him a toy lion as a token and wrote Revelations 5:5, which refers to Jesus, the Lion of Judah, on the certificate. I also added Proverbs 30:30, where the lion is described as the 'mightiest among beasts (that) turns not back before any'. In a voice touched by emotion, he said that at the time when I gave him the certificate, he did not

think of himself as a lion. However, this metaphor with its powerful associations of braveness and the strength of Jesus in him encouraged him to step out in a new direction on his journey, and despite obstacles he could keep going strong! (Combs & Freedman 1990:xiv – xvii, see Section 1.6.5.1).

4.5 CONCLUSION

Whilst writing down the responses of the group participants, I realised again how much I have learnt from the groups as I have journeyed with them. With them I enjoy the adventure of being a life-long learner, learning to handle life together; in this my life is enriched, as Erickson (cited in Freedman & Combs 1996:10) suggest. Many valuable contributions were made in the focus groups, but for the purposes of this study, only the ones that were most frequently mentioned and that were in line with the building blocks of my philosophical stance (as set out in Section 1.6) were chosen. In the next chapter, I engage with the literature to optimise my learning from the group participants, especially with regard to the effects of my philosophical stance as a therapist in pastoral groups.

CHAPTER 5

REFLECTING ON MY LEARNING FROM THE MAPS CREATED

5.1 INTRODUCTION

In this chapter, I engage in a conversation between the data that was presented in Chapter 4 and the literature. Such a conversation can be beneficial for both the therapist and the group participants, as the literature adds to the meaning we make from the results of our research. My philosophical stance can thus be adjusted or changed accordingly, to the benefit of the group participants.

The reflection on the data is presented in the same order as in Chapter 4, while the literature is used to discuss it further and to find appropriate applications.

5.2 REFLECTION ON FIRST FOCUS GROUPS

As my philosophical stance is mainly grounded in a postmodern epistemology (as discussed in Chapter 3), the values, beliefs, and so on that I bring into the group are not an attempt to be prescriptive and they are not fixed, thus I am not trying to create a theory for all pastoral groups for people with depression. My ethic of practice, my deeply held morals, and cherished values do surface, are exposed to challenge and will probably also continue to change, as Anderson (1997:36, 100) and Freedman and Combs (1996:23) suggest.

5.2.1 Values, beliefs and experiences

5.2.1.1 Values

From the responses of the group participants in the first focus groups, it became clear that they were influenced by my (the therapist's) values. Even if I wanted to foster a value-neutral reality, I could not. Instead, I rather attempted to create space for my own values, explaining enough about my situation and my life experience for the group members to understand me as a person, rather than as an 'expert' of professional

knowledge. This is in line with what Freedman and Combs (1996:36) propose. This indicates how powerfully reality is created within a group process and how influential a leader can be by choosing ways of being de-centred in the deconstructive questions that are used within a narrative and participatory way of working.

The values that affected the group participants most and that contributed most to the therapeutic value of the group were what the group described as unconditional acceptance and care, comprehensive listening, being non-judgemental, the embrace of uniqueness and differentness, trust, confidentiality and commitment. I list these values here as they were the ones most commonly noted in the focus groups.

Pattison (1993:48) describes acceptance as ‘the key factor needed if helping relationships are to be successful’ (see also Section 1.5.2 above). Trust and acceptance go hand in hand. It is important to create an environment in the therapeutic groups where people experience acceptance, and through this medium, relationships find ways of thriving (Niemandt 2007:88). The French philosopher Babin (cited in Niemandt 2007:82) predicts that the relationships that people find in small groups (such as ours) will thrive in a postmodern world, as groups provide a safe place in which these relationships are cherished and grow. It is in such an environment that people learn to serve each other and the world. As the grand narratives of modernism give way to alternate ways of living, this perhaps becomes a significant way of holding onto group identity in more fluid and flexible ways.

In the first women’s focus group, when we talked about the value of ‘openness’ and they suggested more openness in the group, I became aware of a tension in myself regarding being both accepting towards the group participants and honest with regard to my values and beliefs. To me it was important to sort out in what way my values and beliefs could be part of the therapeutic relationship in such a way that it minimised the negative features of judgementalism or moralism, and could be compatible with acceptance and compassion, as explained by Pattison (1993:49). I do realise, however, that in some ways it is impossible not to judge.

As I described in Section 4.4.1, the women's group had a very open discussion after one group member made several accusations about the rest of the group. The other group members felt that her behaviour was not compatible with the values of the group, which is in itself a judgement. As ethical confrontation is not a one-way process, we had a mutual discussion, with everyone involved taking part. In a collaborative approach where mutuality is valued, dualities and hierarchies between the client and the therapist collapse and the dangers of judgementalism and authoritarianism are reduced (Anderson 1997:95; Anderson & Goolishian 1992:27; Pattison 1993:52).

The way in which people are approached when there is a need for confrontation is enormously important, because the introduction of confrontation or differences can cause people to raise their defences or flee from a relationship where they feel inadequate and condemned, thus creating yet another prescriptive group in which there are insiders and outsiders. Confrontation also leads to a potential polarity between right and wrong, good and bad, which in this research and philosophical stance it was important to avoid. One man actually fled from the group one Monday evening as he felt judged. It is interesting in the light of this particular study on the researcher's own position that he said he returned due to '*an openness about who and what we were and that we could still talk*'. Perhaps the significant point here for this study is the context of acceptance and empathy that was generated in the group. This in turn links with what Pattison (1993:50) describes as a warm trusting and understanding relationship that should be established in which the person has the experience of being listened to and understood, before confrontation takes place.

Another incident in this study that demonstrated a philosophical stance of non-confrontation and acceptance arose with the person with whom I had a bit of a power struggle over leadership (as described in Section 4.3 above). It appears that my own philosophical position, which values relationship over being right or wrong, was partially created in my own value of asking tentative questions within a caring relationship rather than confronting him with the rules of the group. My aim was to negotiate a good option for both of us in the situation. Thus ethical confrontation in pastoral therapy becomes an invitation to consideration, exploration and discovery rather than an attempt to enforce to conformity (Anderson 1997:93,105; Anderson &

Goolishian 1992:28-29; Besley 2001:81; Heshusius 1994:16; Kotzé 2002:6-8,18-19; Lowe 1991:46; Pattison 1993:51).

Within any given discourse, people need to conform to certain ways of doing, being and working. However, in my position as a facilitator of the group I wanted to allow for difference, without overly privileging rules over relationship and difference. This philosophical position resulted from my own experience of feeling different and my desire to tolerate difference in others within a religious discourse that was intolerant of difference (as discussed in Section 1.6.3 above). The group participants appreciated this sensitivity for everyone's uniqueness. Freedman and Combs (1996:33) sum up my feelings with these words: 'We [I] work with people in ways that invite them to celebrate their differences and to develop and perform narratives that they prefer...' (Erickson cited in Freedman & Combs 1996:10). Listening to people's local knowledges and valuing their unique experiences instead of subjecting them to a normalising modernist discourse about their behaviour or experiences brought forth very creative, unique new narratives that they prefer, in line with what Anderson (1997:98-99) argue (see Sections 3.3).

Together with the value of acceptance, some group participants mentioned empathic listening as the reason why they came to the pastoral groups. To really listen empathically to people means that we have to listen to them as they are, influenced by the context in which they live and operate; 'temporarily living in the other's life, moving about in it delicately without making judgements' (Rogers cited in De Jongh van Arkel 2000:226). As I mentioned in Section 2.3, empathy moves beyond a postmodern paradigm. This is a quality, along with all the qualities I mention, that pastoral counsellors usually seek to display. Within my postmodern position, however, it is a value held less by the individual and more within the group process. Outside the group, the members often felt that people did not listen or understand and tried to give 'quick fixes' to their problems. If the therapist is not able to listen, to hear, to respond exactly, to help the person share what is felt, the person is basically left alone. To really understand requires us to listen with focused attention, patience and curiosity while building a relationship of mutual respect and trust (De Jongh van Arkel 2000:225; Freedman & Combs 1996:44; Patton 1993:33).

To be in community with others requires commitment, a value that was particularly mentioned by the women's group. An outflow of commitment is trust, which can only flourish when people make time for one another and listen to each other's stories. It appears significant here that trust may have less to do with the internalised belief of an individual than with the context of mutual care. Pastoral care models that work with more modernist assumptions appear to focus more on the individual and his or her growth than on connectivity. Within such more structured models, mutuality can sometimes be pathologised as over dependency. However, in a postmodern paradigm, through listening and by showing empathy, understanding, encouragement and comfort towards one another (as demonstrated by the therapist as part of her philosophical stance), the group participants help each other reciprocally and mutual care takes place (De Jongh van Arkel 2000:15; Niemandt 2007:88).

5.2.1.2 Christian beliefs

Holding onto the values of Jesus as described in Section 1.6.1 is a difficult value to describe, in that words and actions are context-dependent: what might be understood as 'loving' or 'caring' in one situation may be understood very differently in another age or place. In a postmodern world, where the focus is on relationships (rather than on dogma), the most important question is 'Who is Jesus for me?' Therefore I accept that everyone in the group has a different relationship with God, as Isherwood (1999:1) and Niemandt 2007:29) explain.

5.2.1.3 Experiences

Like those I am in conversation with, I take my knowledges, prior experiences and biases into the therapy arena. I do try to carry them without prejudice, without a pre-conceived plan about how the group participants should approach solutions to the problems they face in order that, through dialogue, new meanings, narratives, behaviours, feelings and emotions can emerge, as suggested by Anderson (1997:97-98). My experience with depression does help me to be accepted by the group as a 'fellow traveller' (a term used by Spencer Burke cited in Niemandt 2007:125). This position is

difficult to document and difficult to reproduce or train people into, which is one of the limitations of this philosophical stance.

5.2.2 A social construction discourse

Against the backdrop of what has already been said about social constructionism in Sections 1.6.2 and 3.2.2, I set out a reflection on the effect of my positioning in such a discourse on the group participants below.

A significant outcome of the reflection in the two groups was the importance of people being allowed to be the experts of their own knowledge, including the two people who were in conflict with the group. In this, a philosophical stance which allowed for the social construction of knowledge became a significant contribution to this position. It became clear from their feedback (see Section 4.2.2) that the participants did not want to be ‘fixed’, as the word implies that the person seeking help becomes an object to be fixed by an expert who provides solutions, interventions, treatments or answers. The social construction position that I upheld of a collaborator who interacts with people to construct new realities with them became an important part of the group dynamic. This is in line with the thinking of Anderson (1997:93) and Freedman and Combs (1996:18).

One man in particular said how helpful it was for him to use different language in the group, as the ‘new’ language brought forth new, more workable realities in his life. Mutability of language in the group seemed to open up conversational opportunities for developing new language, and thus negotiating new meaning for problematic beliefs, feelings and behaviours – new meanings that can create alternative realities. In this, being informed in my philosophical stance by theories of social construction and narrative therapeutic techniques (as set out in Section 1.6.5.1), appeared important. Where once this man said: *‘I am chronically depressed’*, he could now say: *‘I do have depression, and I enjoy many things in life’* (see Section 4.2.2). The Derridean logic of both/and helped him to see himself as multi-dimensional (Anderson 1997:98; Burr 1995:7; Drewery & Winslade 1997:34; Freedman & Combs 1996:12, 28-29; Lowe 1991:3; Shotter & Gergen 1989:15). Instead of locating identity in a physiological

essence, it permitted his identity to be understood as fluid and multiple, which reflects the trajectories of social exposure that a person has followed (Lartey 2003:39).

The conscious decision to focus on relationship rather than a 'model' or theory in the group, seemed to give the group participants the freedom to live out their own experiences. This too links with the limitations of being restricted to a model or theory. It also presents new dilemmas, as it becomes difficult to teach people as leaders to facilitate a group, because of the fluidity and slippage that evades universally applicable interpretations or applications. Thus using local knowledge and experience is both life-giving and problematic. However, it does celebrate diversity, with endless possibilities for new ways of being (Freedman & Combs 1996:33; Lartey 2003:39; Lowe 1991:46).

5.2.3 Feminist theology

Dominant discourses have a tendency to silence and render unacceptable that which does not fit (see Section 3.4). This was experienced in the group in that they felt that they did not fit into society and they were marginalised by discourses in which depression was not acceptable. Both groups described ways in which they could not tell other Christians about their depression and that their sense of being marginalised by the church and society. Thus much of their suffering went unnoticed and uncared for. This corroborates what Greene-McCreight (2006:36; see also Section 3.4) says, namely that part of the tragedy of mental illness for Christians is that they cannot tell many people what is wrong, because it still seems socially acceptable to hold prejudices against this group of people. Possible reasons why the church marginalises people with depression is that the church does not understand mental illness (as it is complex); because there is a false assumption that the Christian life should always be an easy path; and because the problem of suffering is hard to grasp (Greene-McCreight 2007:36; Oosthuizen 2007:11; Stone 1998:9). It is also because the church in this context is not understood as an institution that stands separately from the larger political discourses in society in which mental illness has been shut away.

The people in the groups said that they want to be able to contribute to the ways in which depression is defined in the church; they want to be in a position to name and

shape their own realities. Out of these formerly untold stories from the outer circles of discourse, the material for a feminist theology of praxis emerges. Thus it is very important for the church to hear these stories and acknowledge their suffering so that no people will be excluded (Ackermann 1998:84, 85). 'Postmodern people seek new ways of fitting together, not fitting in' (Sweet & McLaren cited in Niemandt 2007:88).

Group members told stories of severe isolation and loneliness before they became part of the groups. This is in line with the idea that depression is aggravated by a tendency to social isolation and by marginalisation (Stone 1998:76). As is described in Section 1.6.3, the therapeutic groups became an indispensable part of resisting and defeating the threat of depression, as they provided a countercommunity which gave the members a sense of belonging, as suggested by Cozad Neuger (2001:175) and Nouwen (1998:119). Tutu (1999:31) describes this sense of belonging by using the Nguni word 'ubuntu', which means 'My humanity is caught up in yours. We belong in a bundle of life'. It also says: 'I am human because I belong. I participate, I share.' Part of my philosophical stance in the groups is to show 'ubuntu' by being hospitable, friendly, open and available, affirming, caring and compassionate.

The focus on relationship as a process of healing (see Section 1.6.3) appeared to play a significant role within the groups. As is described in Section 4.2.3, group members said '*we have made true friends*'. A relational ethic seems particularly important in a church that has to function in a fragmented society of individuals and the resulting isolation. This too challenges the church within the context of the times to focus on the need for creating more relational contexts of acceptance. Relationality affirms all people's value and integrity, as God bestows an unconditional dignity and value on all human beings, irrespective of and prior to any personal achievement (Ackermann 1994:199; Patton 1993:24; Rossouw 1993:903).

The group participants also described their experiences in the group as being part of the body of Christ, having gifts that can contribute to the building of the church, acknowledging the suffering Christ. In this sense they (and I) can become both healers reaching reach out and offering healing, and patients in need of help. Thus healers become students who want to learn, and patients become teachers who want to teach

(Ackermann 1994:204; Nouwen 1998:66-69; Yancey 1990:238; see Sections 1.6.3 and 1.5.1).

This study has perhaps exposed and confirmed that the idea of praxis is central to practical theology, reclaiming and reformulating from a feminist perspective which includes the voices of marginalised people, as feminist theologies are committed to concrete changes in the situations of marginalised people.

5.2.4 A contextual participatory approach to practical theology

The contribution of postmodernism (see Sections 1.6.4 and 3.2.1) in this research has allowed for space that knowing is inherently contextual and that what one knows and sees depends on where one stands or sits (Brueggemann 1993:8; Cochrane et al 1991:17). What has formerly passed for objective, universal knowledge (see Section 2.3) has been only a claim by dominant voices that were able to impose their view on others and silence all alternative or dissenting opinions (Brueggemann 1993:8). It is therefore significant in this study that my own philosophical stance of co-researcher and co-traveller permitted the participants to find a language for their own knowledges without my being seen as the expert in a top-down approach.

In this context, then, authentic participation means allowing multiple perspectives so that different forms of knowledge of God can be expressed and explored (Lartey 2003:33, 38). Griffith (1995:137) says: 'The Holy's other name is Surprise. If one is too certain of her specifications of God, she will miss God.' I never pretended to know all the answers in the group. To say: 'I don't know', means to drop the heavy tools of rationality in order to gain access to lightness in the form of intuitions, feelings, stories, experience, active listening, shared humanity, awareness in the moment, capability for fascination, awe, novel words and empathy (Weick cited in Peters 2003:321). My pastoral responses were located in the lived experiences of the group participants (Cochrane et al 1991:16). Sometimes, though, it is important for a leader to know, for example, how to listen emphatically; or what the diagnostic features of bipolar depression are; or how to use the narrative practice of externalisation, and so on.

Contextual theology generally foregrounds the local knowledge of those who experience something from below rather than from above, in that it concerns itself with power and its potential for abuse. In this way the hermeneutical circle begins with praxis and proceeds to reflection, thus seeking to challenge the dominance of power. This research has sought to reflect on what contextual theologians describe as the 'doing' of theology, or the 'praxis' of faith in action (Ballard 1992:117; Bosch 1991:423-425). This was evidenced in the focus groups in attempting to find a voice for privileging knowledge on depression held by the participants. This position is not only found in postmodern and contextual theology, but is generally accepted in pastoral work as a dialogical relationship between the issues and problems involved in the particular human situation at hand and the meanings of the Christian story. Both 'stories' become open to re-assessment, re-evaluation and re-interpretation. Using Gadamer's metaphor (cited in Gerkin 1991:19), a fusion of horizons take the place of these two separate interpretations. To put it another way, it becomes a way of discipleship (De Gruchy & Villa Vicencio 1994:12). The role of theological reflection is thus to interrogate the claims I make, to question my assumptions and presuppositions, to test the significance of my behaviour, to investigate the foundational perspective which orients my way of being in the world, to allow others to see whether what I say and do is coherent and intelligible, to raise the questions of meaning and truth (Cochrane et al 1991:74).

Dominant power discourses in the church include some ideas and exclude others, thus placing God in a 'box'. This cannot be avoided, in that all discourse does this. The challenge in this study has been to explore some of the restrictive effects on people suffering with depression and my own philosophical stance in siding with the silenced, thus going outside the box and challenging the church to grow its own boundaries, as suggested by Kimball (cited in Niemandt 2007:116). The ways in which group members seemed to challenge the boundaries of the boxes were different. One man realised that for him, painting was a spiritual encounter with God; to be creative was worship. Another woman said that seeing a bird symbolised God's presence to her. We live in a time where people not only want to think with their minds, but need to be touched in their hearts (Bosch cited in Niemandt 2007:113). They do not only need truth (theory) and justice (praxis); they also need beauty, the rich resources of symbol, piety, worship,

love, awe and mystery (Bosch 1991:431). We realised that to laugh and play, to watch a beautiful movie, to be in nature – ‘every moment is the possibility of a God-moment’ (Steward cited in Niemandt 2007:73). The kingdom of God is about everyday life; there should not be a dividing line between the two (Niemandt 2007:74, 76). Group participants felt that in the groups it was easier for them to integrate the spiritual into their lives than in the church.

As I said in Section 1.5.2 in the first chapter, Ackermann (1998:94) refers to such groups as ours as small groups of people who, although they are members of the church, share and explore their faith in a more intimate environment, where there is a commitment to hear ‘the other’ and to respect the validity of his or her story in a common search for healing. I also see similarities between the therapeutic groups and the base Christian communities referred to by Cochrane and others (1991:90-92), which is relatively homogeneous in nature, where personal relationships between people develop and which is responsible for the richness and extension of worship and the faith which sustains them. Here people are no longer anonymous, but participate in deciding and constructing a world to live in.

The problem with such groups is that they can remain isolated within the broader context of the congregation (Cochrane et al 1991:92). That is why the group participants suggested that we invite a pastor(s) to allow the church to see from the perspective of those who hitherto felt alienated and excluded by it. This resonates with a suggestion by Pieterse (1998:79). The group participants and I experienced in the workshops on depression in the church that totalising and complete explanations for depression have been handed down by the experts (the powerful) to us (the powerless – see Sections 3.4 and 3.6). We would prefer to participate authentically in discussions of depression, on our own terms, as Lartey (2003:33) puts it. The aim is that expertise should be enriched and informed by the experience of those on the receiving side of expert opinion (Rossouw 1993:901). The groups also suggested the founding of an organisation for Christians with depression to give them a voice, especially in the church. The aim of such an organisation would be transformation (in the church and society), redeeming humanity through a knowledge born of subject-empowering, and life-giving love, which heals the biases victimising people (Bosch 1991:424).

5.2.5 Therapeutic practices

5.2.5.1 Narrative practices

In a way it was difficult for me to explore the effects of the narrative practices that I used as part of my philosophical stance in the groups, as I did not think these practices as such were always very visible to the group participants. Deconstruction, for example, could be interpreted as ‘asking questions’. One woman once said that I did not give them answers; I asked them ‘*all these questions*’. Most of the time when I asked them whether asking these questions were helpful, they would say ‘yes’. At other times I would recognise that group participants started to use ‘different’ language. Even the man who said that he did not agree with the narrative practices I used became aware of how his language supported the discourse of patriarchy, and he started to change his language about and towards women. I do not think, however, that he or the other participants were always aware what effects the narrative practices I used had on them.

I want to use Freedman and Combs’ (1996:15-16) words to describe how I understand my use of narrative practices. They say:

We no longer try to solve problems. Instead, we became interested in working with people to bring forth and thicken stories that do not support or sustain problems. As people inhabit and live out the alternative stories, the results are beyond solving problems. Within new stories, people live out new self images, new possibilities for relationship and new futures.

The group participants said that the use of externalised language was a very helpful way of separating the problem from the person (them)(see Section 1.6.2). As the problem no longer defined their identity, it opened up space for them to take action against the problem by identifying abilities, interests, competencies and so on (Cozad Neuger 2001:168; Morgan 2000:17,24,;see Sections 2.5 and 3.2.3). Thus alternative stories developed in the lives of group participants, for example, the divorced woman who demonstrated the courage to buy a new house and started a job after being a housewife for many years (see Section 2.5.1).

Depression can be externalised in many ways; through words, pictures and through metaphors. One woman described depression as a cocoon that she struggled to get out of. Conrad created paintings of his journey with depression, where the depression was symbolised by a huge wall (see Section 3.3). Constructing a 'picture' of the problem by using metaphoric drawings or language helped group participants to develop the externalisation of the problem, to look at it from a distance, and to gain power over it, in line with the suggestions of Penwarden (2006:66).

The metaphor of all of us together on a journey (Morgan 2000:3, see Section 1.6.5.1) added richness of meaning to our togetherness in the groups, by describing qualities such as a long-term process, commitment, relationship, love, acceptance, exploring new territories, hope, and so on.

The group members said that when they looked back at significant steps they took on the journey away from the problem story to the new preferred version, it created hope in them. This happened especially when these steps were marked by rituals or celebrations in the group, as also described by Morgan (2000:111) and Penwarden (2006:70). When people experience depression, hope is often far from them. If hope is partly held communally then it seems significant to grow such communities of faith (Greene-McCreight 2006:36; Stone 1998:74; Weingarten 2000:402; also see Section 1.5.1).

The group participants valued the use of symbols and ceremonies in the group and suggested that we use these practices more often. We used symbols to affirm certain qualities in each other that assisted them in living their preferred stories, because symbols set off powerful associations and have a richness of meaning crystallised within them (Combs & Freedman 1990:xiv-xvii, see Section 1.6.5.1). When one woman resisted her family's domination over her and voiced her desires, we gave her a butterfly as a symbol for coming out of the cocoon. She kept the butterfly as a reminder of how she preferred to live. We always have a special ceremony if someone leaves the group or when a significant change takes place. These ceremonies both create a context in which change can occur and metaphorically marks change (Combs & Freedman 1990:xiv-xv). The group participants experienced these ceremonies as encouraging and uplifting.

In the first chapter, in Section 1.6.5.1, I explained my desired therapeutic position on my journey with the group participants as de-centred and influential (White 2003). I do think, however, that I sometimes moved into different positions, for example, when I confronted the man who took up the role of co-facilitator in the group, I took up a much more centred and directive position. The trouble with empathic listening which remains non-directive and non-confrontational is that eventually it can leave a person trapped in the boundaries of his or her own horizons. Therefore, confrontation or a directive therapeutic position is sometimes essential in pastoral care, as it allows the enlargement of people's self-understanding and it allows the therapist to be him- or herself (Pattison 1993:50, 3.3). However, it seemed though the group members experienced my position mostly as that of facilitator and participant who exercised the 'therapeutic art' of conversation through the use of conversational or therapeutic questions, from a not-knowing position (Anderson & Goolishian 1992:27, see Section 4.2.5.1). It is interesting, however, to note that in the second set of focus group sessions, the incidents that were most talked about were the ones that evoked confrontation and in this way it seems significant to find ways of negotiating conflict in non-abusive ways.

5.2.5.2 Informative practices

Group participants felt that the information that we shared was helpful in the sense that it opened up new ideas and that it stimulated discussion. They appreciated the fact that these knowledges were never imposed on them as '*the truth*', as there are many truths, and that what one person holds to be sensible and true may not be so for another. Truth is made, not given (Drewery & Winslade 1997:49; see also Sections 1.6.5.2 and 3.2.2).

5.3 THE INTERIM

As the value of openness has already been discussed earlier in this chapter (see Section 5.2.1.1), a reflection is given below on the influence of expert knowledge and power relations in the group by referring to my discussion with the man who acted as co-facilitator in the group without my agreement (see Section 4.3).

Using expert knowledge (of therapeutic models etc.) placed this man in a more powerful position than the rest of the group participants, which had the effect of silencing them, especially the newcomers, as is also described by White and Epston (1990:21-22). As I have already said in Section 2.4, I support a 'participatory consciousness' (Heshusius 1994:16), a process by which knowledge is co-constructed in the course of relating with others in a specific context, at a specific moment in time (Kotzé 2002:6). Because of my more powerful position in the group (as therapist), I choose to try to take up a 'not-knowing' stance, using listening, therapeutic conversations and questions to open up new possibilities. My stance is thus person-centred and influential and empowering for the person with the problem (Besley 2001:8, see Section 3.3). My stance (of not-knowing) next to this man's stance (of being the expert) created a problem in the group, as he and his knowledges became the centre of discussion, instead of the person with the problem. His knowledges also disempowered the person with the problem whose local knowledges were subjugated (White & Epston cited in Besley 2001:76).

I reflect on the effect of our discussion further on in this chapter (in Section 5.4.2).

5.4 SECOND FOCUS GROUPS

As the women's group implemented the suggested changes regarding my philosophical stance since the previous focus group, the effects of these changes are reflected on.

5.4.1 The women's second focus group

The women said that openness brought them closer to each other; everyone benefited, as they all learnt from each other; they could reveal deeper emotions; they could relate better to one another, and they could '*practice appropriate behaviour*' in a safe environment. The therapeutic groups provided the members with an opportunity to experience and learn about relationships and effective interaction within a social context (Nicholas 1984:xii; see also Section 5.1.5.1.).

The group participants highlighted the importance of a pre-group interview with every future member to sufficiently prepare him or her for group therapy. Several goals can be

accomplished in a preparatory discussion, for example, clarifying misconceptions, and addressing unrealistic fears and expectations; anticipating and diminishing group therapy problems (Yalom 1985:286).

Since the group participants mentioned their desire in the previous focus group for more interaction and support between group sessions, they made a special effort to make contact with one another by sending an sms frequently, making telephone calls and helping one another in times of crisis. These examples of reaching out strengthened the bonds between the members and enhanced the potency of the group. This is a finding similar to that by Yalom (1995:132). In Section 1.5.1, I mentioned the importance of ‘a continual and intensive focus on interaction’ between group participants, as described by Clinebell (1966:210), which was in this instance a possible result of a change in my therapeutic stance from being overtly responsible, to letting go more of the process of mutual care.

5.4.2 The men’s second focus group

In the men’s second focus group, the emphasis was on the value of the groups to help participants live out their preferred stories, as well as the significance of ceremonies to bring and to mark significant change.

The celebration of the Eucharist was described by the woman who joined this group later as the most meaningful experience to her, as her desire to experience God’s presence was fulfilled. She longed for an experience carried by rich and deep symbolism (see Section 1.6.5.1), where she could sense God’s presence, as also described by Niemandt (2007:31) and Nicol (1989:29-30). Morgerthaler (cited in Niemandt 2007:13) says:

Get out of the way. We need to give God the holy, silent space in which to do the holy, silent work that only God can do.

Two of the men looked back on their journey with the therapeutic group and realised the significant role it played in helping them to step out in a new direction. They were able to implement life-changing decisions and live their preferred stories. They both joined

another group and faith community while they were still part of the therapeutic group. They eventually stopped attending our group. Both of the men stressed the value of being in a therapeutic group first, because their problem with depression was specifically addressed in an environment where healing empowerment and growth could take place. This also echoes comments by Clinebell (cited in Lartey 2003:22; see Section 1.5.1). They both believe in the value of community; that is why they are still part of fellowship groups where they are joined in a loving relationship with other Christians and with God in a 'Godly dance' (Volf cited in Niemandt 2007:140). The modelling of the group acted as an interim training and a launch pad into other church groups.

As I mentioned earlier in this chapter, we always have a ceremony when someone leaves the group, to mark the transition. The man who left the group because of our difference in epistemologies, highlighted the ceremony at his leaving as his most significant experience in the group. To him this concluding stage of his journey with the group marked a new beginning. His experience resonates with comments by Epston and White (1990:25).

5.5 CONCLUSION

The men's group had already closed down by the time when I wrote this chapter, because every one of them felt that it was time to step out in a new direction on their journey.

The women's group is still going strong, and I am excited as I see how we all benefited from the things we have learnt through this research experience.

CHAPTER 6

POST-REFLECTION – RE-IMAGINING MAPS FOR THE FUTURE

This chapter seeks to reflect on this research journey, looking back to where I began to ask the question concerning my philosophical stance, re-evaluating where I am now and looking ahead to how this approach may be helpful to other pastoral care workers.

Pastoral care can be understood in many ways. Clinebell, for example, who has in many ways led the discussions in pastoral care, in his earlier work focused on the individual and wholeness (see Section 1.5.1) which can be understood under the umbrella of modernism. De Jongh van Arkel, Heitink, Lindijer and others describe pastoral therapy as a specialised form of care that requires specialised knowledge or expertise, and suggest a pastoral position in which the therapist is called to stand back and not get too involved. This is in line with many earlier pastoral care models.

Pastoral care from the position this research took sought to focus on pastoral care as something that is inherently relational in nature. This is not to say other models do not work with relationship, but that this more postmodern position seeks to locate the therapist within the process rather than in a more prescriptive position that privileges expert knowledge. From this more relational perspective participants' local knowledges work to inform the process. This way of looking at pastoral care did not begin as an academic position or pursuit of one model versus another but came from my own lived experience of experiencing marginalisation within the church (see Section 1.5).

This philosophical positioning meant that I was deeply immersed within the research process, often blinding me and reducing my ability to stand back and observe the research from a more neutral and empirical position – Mouton (2001:144) cautions against this. This was inevitable considering the position I took with my philosophical stance. My compassion with the marginalised could sometimes lead, in this sense, to an over-involvement with group participants which sucked me in and left me exhausted. This will always raise questions in pastoral care, particularly from a participatory care stance: when is enough enough? This was evident in this work, for example, with the woman who did not feel cared for enough (see Section 4.3). This left me with questions

such as ‘When is it enough? How far am I willing to go in taking care of people? At what cost am I doing it?’ The philosophical stance I took worked with the idea of ‘caring with’ rather than caring for (Kotzé 2002:6; White 1997:121). Moreover, within this particular study, I found it difficult to work within this position where I was both a participant and a leader. These questions encouraged me to look at the value of distance between the therapist and the client that is created in other therapeutic models (see Section 2.2). In another way, however, it made this research very participatory in nature.

I deliberately took a position within a postmodern paradigm where the boundaries between client and therapist are blurred (Kotzé 2002:25-26; Mouton 2001:144) and where the client is given the agency to be the expert on his or her own problems (Anderson and Goolishian 1992:29; White 1991:38). I did not want to create client-expert duality, where the client becomes an object to be studied (Sampson 1989:1 see Section 2.2) or fixed (White cited in Besley 2001:80 see Section 2.2.1), as this could lead to a one-way account of therapy, where knowledge is handed down from the expert to the counselee (White 1997:128 see Section 2.3). My choice of this more collaborative approach to therapy that focused on a relational system in which the client and therapist are conversational partners (Anderson 1997:95; Anderson & Goolishian 1992:26-27 see Section 3.3) became a complex web of relationships and power. I am aware that it is difficult to create boundaries within such a collaborative philosophical stance.

In this regard it was helpful for me to hold on to De Jongh van Arkel’s model of pastoral care (see Section 1.5.1), which suggests that we can move into different levels of pastoral work, where group participants take the responsibility to care for each other (mutual care), instead of relying on the group therapist to take the sole responsibility to care for them all. Yalom (1995:17,21 see Section 1.5.1) and Houtsma (1981:42) agree that interpersonal relationships in a group setting address issues such as a passive dependency of group participants (as in the case of the woman who felt neglected). Lindijer (1984:228) affirms that in group pastorate the focus is on self-other relationships rather than self-acceptance. Although my philosophical stance has not worked with pathological categories such as ‘passive dependence’, it has helped me to work metaphorically to identify some of the relational patterns that sapped my energy.

When reflecting on Clinebell's (1966:210) summary of the characteristics of group therapy (see Section 1.5.1), I see how some aspects of Clinebell's approach have become incorporated into my philosophical positioning in pastoral care. Firstly, the pastoral therapeutic groups that I led were small and continued over several years. They also have an 'avowed therapeutic purpose' which is embedded in the building blocks of my therapeutic stance, and is regularly negotiated with the group participants. During the course of this research I realised the importance of having a preparatory interview with newcomers to discuss the purpose of the groups. Even though I thought that the group sessions were not structured, in many ways they were structured. The structure focused on certain values and 'rules' that participants needed to know in advance in order to decide whether they wanted to be part of such a group. There has to be structure in order for a group to come together, but the structure within this philosophical stance is negotiated in a more fluid way in than a more modernist approach to pastoral care. This emerged very strongly from this research. Such an interview at the beginning, as well as a regular re-negotiation of the structure, can avoid misunderstandings such as we had with the woman who expected a group doing Bible study (see Section 4.4.1).

Our activities are not limited to psychotherapeutic activities (as Clinebell suggests), but also include different levels of pastoral care, such as mutual care (De Jongh van Arkel 2000:X; see Section 1.5.1) and in this way subscribe to some of the signs of our times where many of the assumed boundaries and structures that have been in place are changing. Whereas 'growth-models' tend to look at individual growth, the focus of my philosophical stance in this research was more on exploring self-other growth, which again is something that is being written about within a more postmodern positioning. The self-other position places greater emphasis on the support structures within the community, thus blurring the boundaries even further.

Lastly, as Clinebell (1966:210) suggests, complete freedom of expression is encouraged. This research focused on freedom and expression that is formed within certain discourses. This allows some things to be said, leaving other things not being said. This raises suspicion of the idea that there can be real 'freedom of expression'. This research paid great attention to what was not said and what people were not free to express. As my philosophical stance was embedded in a feminist theology of praxis and

discourse, it attempted to create a safe space for participants who have experienced marginalisation to find a voice in this respect (Ackermann 1994:206 Jamieson 2002:146). I realised that in creating space for the group participants to have a voice, I needed to be careful not to lose my own voice, as with the woman who wanted more care (see Section 4.3). However, when I felt that one man was taking over as co-facilitator, I did manage to find a voice to confront him (see Section 4.3). In this I was both enabled and disabled by my own philosophical stance.

In a collaborative participatory approach where both the voices of the participant and therapist work together, attempting not to privilege one voice over another, it is sometimes difficult to know what position to take as pastoral therapist and leader of the group. In line with a philosophical stance that privileges a greater merging of the 'self' and the 'other', my role as facilitator and as part of the group was therefore not always clearly distinguishable.

Using White's (2003) graph in which he refers to the therapist and client position (see Section 1.6.4.1), I attempted to position myself as de-centred and influential. The participants of both groups generally found this to be both helpful and true, particularly in the questions I asked (see Section 4.2.5.1). Both groups thought that I was influential in leading reflections, without centring myself. The nature of deconstructive questions, however, makes them appear 'natural' and 'easy', often hiding the complexity of their structure. This was not always evident to the participants, because they have not been trained in these forms of questions. Working within a church setting that is generally not familiar with a postmodern participatory stance, the participants may have experienced my philosophical stance, but may not have found adequate language to formulate it within their dominant discourse.

The posture I took required a shift in my thinking, as I myself came from a modernist paradigm (see Section 2.2), which assumes that the object of inquiry is a natural entity (the individual person), with attributes that can be empirically studied (Sampson 1989:1 see Section 2.2). The assumption was also that the therapist came to the process with knowledge and answers.

It was an ethical concern to me when diagnosis and expertise was foregrounded at the expense of relationship (see Section 2.4), as I noted with the social worker in the group who took up the power position of co-facilitator and foregrounded his knowledge, thus silencing the other group participants (see Section 4.3). My philosophical position is connected to an ethic of care because I prefer to open up space to produce multiple interpretations of reality (see Section 3.4) and multiple experiences of self (see Section 3.2.3). However, this does not mean that there is no place for diagnosis using meta-narratives of human nature, such as the DSM IV. The challenge was to engage both these meta-narratives and the local knowledges of group participants in such a way that the one could inform the other. Maintaining this philosophical position was quite difficult and required a shift in consciousness to deliberately decline the thoughts that tend to diagnose and want to inform, and instead to privilege the voice and local knowledges of the client, as I experienced with the young girl that I mentioned in my introduction.

As I support a participatory consciousness, (Heshusius 1994:16; see Section 2.4), knowledge in this way is an 'ethical-political process, co-constructed in the course of relating with others' (Kotzé 2002:6) An illustration of this reciprocal process, where a merging of 'self-other' takes place, was Conrad's paintings (see Section 3.3), where my philosophical stance had both real effects on his life and allowed for his life to influence mine.

This study has attempted to lay aside certainties about God in order to co-create with the group participants the meaning of an experience with a personal God, as suggested by Griffith (1995:137; see also Section 3.3), for example, by celebrating the Eucharist in the group, thus allowing for people's own experiences with God.

In the light of this shift from an ethics of control to a participatory ethic, it has been important in the research project that the participants be the co-owners of the research (Kotzé 2002:28; see Section 1.9). If I could do it again I would involve the group participants in analysing the data and arranging it into themes, after it was transcribed. Taking part in this process could help them to take full ownership of implementing the changes, instead of my bringing the suggested changes to them to be implemented in the

therapeutic group sessions. This would, however, need to be weighed up against the time it would have taken out of the therapeutic sessions. Of greater importance, however, is that the participants who formerly experienced exclusion should be included and have a voice regarding issues concerning them, thus weaving it back into the therapeutic process.

Another aspect of this research that emerged and took me by surprise was the significance of symbols, celebrations, rituals and rites of passage. The most rewarding moments mentioned in the focus group sessions were tied to the group participants' making meaning and treasuring of these markers on their journeys. For example, the Eucharist signified to one woman the touch of a living God. A man stood up and walked with the boldness of a lion and pursued the things he believed in, inspired by a powerful metaphor which added to his identity-description. A butterfly became Hermien's symbol of hope, and Conrad's 'door of hope' in his living room tells the story of a journey not yet complete. If I could have predicted this, which of course I could not have, I would have spent more time exploring the use and practice of these rites within a more theoretical frame.

Since completing this dissertation to the last few pages Conrad invited me to come and see his 'funky' new garden. It was unlike any garden I have ever seen. Unusual plants (that people do not usually value) were used in unusual combinations and I was astounded by its beauty. I never would have thought that these combinations would work so well together.

With God Conrad became a co-creator of extraordinary paintings, gardens and new stories – of his own life and touching the lives of others, like mine.

This is not the end of the journey. My philosophical stance will probably change some more as I will be influenced by fellow-travellers on my journey. I am encouraged by this research process to keep on partnering with others and with God co-creating exciting new, life-giving stories.

When the group participants were given a voice and agency, they learnt to take responsibility for themselves and their worlds. Together we will influence society and the church as producers of new discourses on depression (Lowe 1991:48; Niemandt 2007:82). This links up with Heitink's (1999:256, 1.6.3) idea that the time has come for the 'small narratives' of movements, action groups and church communities to keep the coming of God's Kingdom alive. In this way, this research could be to the benefit of all who experience marginalisation because of their journey with depression.

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APPENDIX 1



APPENDIX 2



APPENDIX 3

