THE RELEVANCE OF PASTORAL COUNSELLING IN SOUTH AFRICA: WITH REFERENCE TO THE SOUTH AFRICAN ASSOCIATION FOR PASTORAL WORK

by

ILZE NEETHLING

Submitted in partial fulfilment of the requirements
for the degree

MASTER OF THEOLOGY

in the subject

PRACTICAL THEOLOGY - WITH SPECIALISATION IN PASTORAL THERAPY

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: DR J P ROUX
CO-SUPERVISOR: PROF. J A WOLFAARDT

NOVEMBER 2003

Declaration

"I declare that **THE RELEVANCE OF PASTORAL COUNSELLING IN SOUTH AFRICA: WITH REFERENCE TO THE SOUTH AFRICAN ASSOCIATION OF PASTORAL WORK** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references".

…… ……..

Signature Date

Abstract:

In South Africa, no occupational or professional councils for pastoral work exist as yet. In order to support pastoral counsellors in their negotiations to obtain professional status in this country, the presumed limitations and ineffectiveness of present mental health systems in South Africa is examined. Pastoral counselling as a possible national health resource is explored with reference to primary health care, freedom of choice, consumer rights, cost-effectiveness, spirituality, social change and reconciliation and multi-cultural application.

Arguments are imbedded in relevant theory and supported by vignettes of suffering, survival, and redemption in spirituality. A postmodern, qualitative approach is used. Participants' narratives indicate that they have experienced healing through utilising their religion and spirituality. However, this study does not claim to provide conclusive proof that pastoral work is relevant in this country – it should be seen as part of a process which aims to develop pastoral counselling as a profession.

Key terms:

Pastoral counselling; Profession; Religion; Spirituality; Postmodern epistemology; Narratives; Cost-effectiveness; National health resource and primary mental health care; Freedom of choice; Consumer rights; Social change and reconciliation; Multi-cultural approach.

CONTENTS

LIST OF TABLES

CHAPTER ONE

THE RESEARCH PLOT

1.1 STORIES ABOUT PASTORAL CARE, COUNSELLING AND THERAPY

Pastoral counselling is an approach to counselling in which the insights of theology and spirituality are integrated with the principles of modern behavioural science to help individuals, couples, families, groups and institutions achieve wholeness and health (De Jongh van Arkel 2000:107). Pastoral and spiritual work therefore can be seen as care, counselling and therapy by an appropriately qualified pastoral worker, utilising dimensions of faith, spirituality, religion and values towards an adequate definition of the life situation of the clients and in particular towards the holistic healing of individuals, groups and communities (Application Draft for the Establishment of a Professional Board 2002: 7).

Even though I mostly use the term "counselling" in this discussion, I use it inclusively in that I do not exclude pastoral therapy and even pastoral psychotherapy. According to De Jongh van Arkel (1999:89), the differences in the definition and use of these three terms are not great and therefore I believe we need not distinguish between these concepts for this particular dissertation. I approach this broader concept from my own postmodern perspective without implying, however, that my perspective is the only one possible.

Pastoral counselling is different from mainstream forms of counselling, as pastoral counselling is guided by the conviction that emotional distress or problems can best be addressed by taking into consideration both spiritual aspects and knowledge of human psychology (http://www.pastoral/explorefaith.org.Pastoral Counseling.htm). Problems often threaten both spiritual and emotional resources. A pastoral worker therefore explores the possibilities and implications of a religious or/and spiritual definition of the situation. A religious and spiritual definition of situation refers to beliefs, practices and groupings oriented towards a transcendental or supernatural reality (Application Draft for the Establishment of a Professional Board 2002:7). Pastoral counselling assists people in realising their potential, using their opportunities and making responsible decisions.

Pastoral and spiritual work is rooted in a history and tradition that date back to one of the oldest forms of care for individuals in need. The different faith communities have always endeavoured to

take care of members and people in need. A study of the religious documents of major faith traditions (Christian, Jewish, Muslim, Hindu and Buddhist) also reveals a particular sensitivity to and focus on the poor, suffering and marginalised, as well as situations of social injustice (http://www.pastoral therapy\Preamble.htm). According to Gerkin (1997:25), "care for the people…involves care that confronts issues of justice and moral integrity in the life of the people". Pastoral and spiritual workers feel that they have been called to practise this profession which addresses these issues and contexts (Application Draft for the Establishment of a Professional Board 2002:7).

This is especially relevant in the new South Africa. Apartheid and its consequences do not simply die. "It has created many offspring who will struggle for life as they face extinction" (Cochrane, De Gruchy & Petersen 1991:5).The contextual, political and economic dimensions which could contribute to transformation therefore also need to be addressed with regard to optimal health. Within South African society especially, power relations and social injustices have to be addressed continuously (Application Draft for the Establishment of a Professional Board 2002:6). Pastoral work aims to address such concrete situations, which differ from one person to another or from one culture to another. Context is considered vital, as "Amos is not identical to Paul" (König 1998:22). A situation characterised by consuming diseases and poverty raises other considerations than when rich atheists/Christians/Spirituals are addressed (König 1998:23). Pastoral care in a black township is inevitably different from that in a white community. Indeed, issues in the black community more often than not are those of struggle, conflict and suffering (Cochrane et al 1991:85). Often supposedly personal pastoral problems are then related to their social context, even if they are not directly caused by that context. Discrimination, unemployment, poverty and abuse or violence are intricately and intimately linked, even though one does not necessarily or directly cause the other(s). A spiritual and value-based assessment of issues relating to power, inequality and empowerment can then be provided by a pastoral counsellor. It is the responsibility of pastoral work to address patriarchal, ethnocentric and non-egalitarian religious perspectives and practices (Application Draft for the Establishment of a Professional Board 2002:7).

The above implies that the pastoral counselling profession has developed a unique identity which centers on the pastoral and spiritual transformation of the broader society, toward justice and equity. This suggests a shift away from situating pastoral and spiritual work only within the context of faith-based communities. It also indicates that pastoral and spiritual work no longer has to find

legitimacy through or identification with psychology or psychological and other counselling approaches (Application Draft for the Establishment of a Professional Board 2002:19).

Even though traditional spiritual counselling continues to help many people in need, long ago it was already realised that in many cases specialised, professional pastoral care was necessary for effective treatment. In the 1920's, The Reverend Anton Boisen, Father of the Clinical Pastoral Education movement in the United States, revived the important role of the clergy in the treatment of mental illness by placing theological students in supervised contact with patients in mental hospitals. This innovative educational programme brought disciplined training to the historical link between faith and mental health. The systematic integration of religion and psychology for psychotherapeutic purposes began in the 1930's, with the collaboration of Norman Vincent Peale, a renowned minister, and Smiley Blanton, a psychiatrist, and the formation of the American Foundation of Religion and Psychiatry, now called the Institute of Religion and Health (http://www.metanoia.org).

Today, the pastoral profession is practiced internationally and is recognised by professional bodies and associations responsible for the organisation and regulation of the profession (Application Draft for the Establishment of a Professional Board 2002:22). Pastoral counselling has, for instance, now become a major provider of mental health services in the United States, accounting for over three million hours of treatment annually in both institutional and private settings, offering individual, group, marital and family therapy (http://www.metanoia.org). In South Africa, the South African government has also identified several key issues towards the resolution of which pastoral and spiritual work can make a significant contribution. These include moral regeneration and the national partnership against HIV/AIDS (www.gov.co.za/keyissues).

1.2 RESEARCH CURIOSITY: A THOUSAND AND ONE NIGHTS

When I was a child, I was always fascinated by a tale of a beautiful princess who told a different story to her husband each night in order to prevent him from killing her, as he had done to all his other wives. She continuously kept him in suspense and curious enough always to postpone her execution yet another day in order to hear the outcome of her stories. This oriental tale has enriched my life to the extent that I could liken my research curiosity to this prince's curiosity: always on the brink of a conclusion, but constantly searching for more; enticed by the magic of different stories, and enthralled by the constant possibility of creating alternative ones. And this is

very like my fascination with the issues that surround the present mental health services as well as pastoral counselling situation in South Africa.

The demand for spiritually-based counselling is on the rise. According to Gerald DeSobe, past president of the American Association of Pastoral Counselors (AAPC) (http://www.aapc.org), not only "is this a time of increased emphasis on therapy [counselling], but also a time of increased interest in spirituality. Combining these two areas in a person's life in helpful and healing ways is what pastoral counsellors do".

Despite increased interest in psychotherapy and increasing numbers of counsellors, the advent of managed mental health care has brought about a reduction to many people of the counselling services available to them. As a result, many people still turn to the clergy for help with personal, marital and family issues as well as faith issues. Many working poor have no insurance benefits at all and need to seek free or low-cost counselling outside formal Western-style health services (http//:www.aapc.org).

In South Africa, according to the ANC Health Plan (African National Congress 1994:181), one of the legacies of apartheid policies is large disparities between races in terms of socio-economic status, education and especially health. A fragmented health system has resulted in inequitable access to health care, a situation that is particularly noticeable when one compares urban and rural areas. The private sector provides services to about only 20% of the total population, and health care is heavily concentrated in the wealthier urban areas (Gilbert, Selikow & Walker 1996a:165). Health services are mainly accessible to those who can afford them. Part of the attraction of the private sector is that it offers better remuneration than community work can. Unfortunately, it seems that health services have become a commodity that can be bought and sold to the highest bidder, leaving rural and poorer communities especially – white as well as black – out in the cold.

The above comments demonstrate the limited availability and some of the controversies surrounding standard health services in South Africa, and introduce the first focus of my research curiosity. It is actually quite difficult to determine how extensive the need for health assistance in South Africa is. There are numerous methodological issues that need to be addressed by epidemiologists in developing countries. One of these, the former race segregation of public hospitals and mental services described a decade ago by Brown and Nell (1991:283), is unique to our "rainbow" country, and continues to linger and haunt us. Others are common to all developing

countries, such as incomplete and unreliable archival information in hospital records, inadequate research funding (which necessitates low cost epidemiology), a colonial legacy that has skewed health care structures in favour of the colonial rulers and their successors, and the very high rates of violence-related injury and death in these countries. Current and relevant data for South Africa is therefore lacking, particularly with regard to mental and spiritual health, since there seems to be no comprehensive mental health information management system (Pretorius-Heuchert & Ahmed 2001:27).

If, however, epidemiological research figures with regard to mental health obtained from other countries are extrapolated to determine the rate and distribution of different disorders in a community, and we presume the rates are similar in South Africa, this would indicate that about eighteen million South Africans may be in need of psychological intervention at some point of their lives. There is reason to believe that such epidemiological figures can be extrapolated to the South African context, as mentioned by Reeler (1993 in Pretorius-Heuchert & Ahmed 2001:27). Another indicator could be the prevalence rate for specific serious and debilitating disorders If schizophrenia is taken as an example, at about one per cent of a population, it means that there are about 380 000 people in South Africa who need care for this disorder alone, if the traditionally Western definitions of mental health and mental illness are accepted and one can accurately extrapolate from data generated in other countries. Pretorius-Heuchert and Ahmed (2001:27) also stress that in a country characterised by oppression and racism, a country trying to recover from a particularly vicious and oppressive political dispensation, poverty and unemployment, crime and violence, there are probably millions more people in need of healing in South Africa, even where there is no classifiable mental disorder, and this is where pastoral counselling can play a role.

Another factor that causes doubt about whether traditionally Western or standard therapies can develop a relevant praxis in a new South Africa with regard to our various racial groups is the reality that most South African psychologists are still white and trained to work with middle-class people from similar backgrounds to their own. Psychotherapeutic work in psychiatric hospitals has, for a long time, been practically the only place where psychologists had any contact with black people, and even there, such contact was just about all but non-existent (Swartz & Gibson 2001:40). If indigenous and traditional African ways of life are not taken into account, standard psychology [therapies] can be accused of scientific colonialism since it lays down Western formulations and conceptualisations as standards against which the behaviour of all the people in the world should be understood and explained (Viljoen 1997b:645).

The term “African” is used here to refer to a polymorphous grouping of the indigenous peoples of the sub-Saharan region of Africa. This includes geographic differences as well as the human diversity of different population groups, linguistic diversity, and religious diversity, together with the diversity that comes with ways of life that fall somewhere between traditional and Western (Viljoen 1997b:645).

Nobles (1976 in Viljoen 1997b:645-646) warns that even as black psychologists and researchers ask the same questions and theorise using the same theories as their White counterparts, black counsellors and researchers themselves continue to be part and parcel of a system which perpetuates misunderstandings of black reality and consequently contribute to the degradation and oppression of black people in need of assistance.

Swartz and Gibson (2001:39) also claims that hitherto, challenges to conventional psychology have been marginalised by the dominance of white psychologists in both mainstream and other progressive health and mental health organisations. The inadequacies of a conventional psychology create particular difficulties in the attempt to invent a more appropriate kind of psychology for the South African context. Whereas traditional therapies function mainly from a Western, individualistic approach to human beings who separate the spiritual domain from “concrete” life, the daily functioning of traditional African people is fundamentally a religious functioning. Africans are “notoriously religious” and all levels of life are imbued with religion:

> Where the African is, there is his religion: he carries it to the fields where he is sowing seeds or harvesting a new crop; he takes it with him to the beer party or to attend a funeral ceremony; and if he is educated, he takes religion with him to the examination room at school or the university; if he is a politician he takes it to the house of parliament.
>
> (Mbiti 1989:2)

My quest of “a thousand and one nights” has centered thus far mainly on the availability and controversies surrounding the relevance of standard health services and therapies to Africans in particular. My research curiosity also wants to include other marginalised voices. It should not be forgotten that South Africa, for example, also houses a variety of Eastern cultures, which, in many cases, have also been marginalised by the previous regime. Moreover, in the term “marginalised communities” I also wish to include gay communities, transvestites, prostitutes and others, such

as individuals who are in need of help but who are not receiving it or are not able to utilise the currently available services.

According to Sow (1980:125), as well as Gyekye (1987 in Viljoen 1997b:645), it is also possible to talk of an overarching eastern perspective that can be distinguished from the African and western perspectives. Whereas Western psychology comes from a philosophical and scientific tradition which can be typified as analytical and reductionist, Eastern psychology originates from a religious and metaphysical tradition with subjective observation and direct experience as its paradigm (Viljoen 1997a:619). Eastern perspectives could thus be typified as intuitive and integrating. However, the stronger disposition in Eastern perspectives towards collectivism and spirituality does not signal an absence of individuality or self-actualisation, but that self-actualisation here refers to the transcendence of the self rather than the extension of the self as understood in Western thinking (Viljoen 1997b:620).

Atwood and Maltin (1991:369) summarise a key aspect of an Eastern worldview as becoming "aware of the unity and mutual interrelation of all things, to transcend the notion of an isolated individual self…the cosmos is seen as one inseparable reality…spiritual and material at the same time".

This does not mean that colonial influences have not left their stamp on many Eastern psychologies. This takes the form of Western psychological traditions that are still drawing from the intellectual legacies of Plato, Aristotle, Hume, Kant, Darwin and Helmholtz, which reveals little evidence of the influence of Buddha, Confucius or Sankara. It is only relatively recently that Eastern psychologists such as Sinha (1965, 1984), Hsu (1971), Ching (1980) and Ho (1988) have started to point out how inappropriate Western psychological models and theories are for the functioning of an Eastern person (Viljoen 1997b:620).

Here I have to acknowledge that a white woman might not be the most suitable researcher to do this type of research. A postmodern paradigm, however, frees a researcher to take into account the diverse and different realities of people. Because I also subscribe to a participatory ethical approach, it is my personal belief that any researcher can, at the same time, be both suited and not at all suited to do this type of research.

In this study, my research curiosity was kindled by the possibility that pastoral counselling can attempt a more relevant praxis to the South African context by rejecting professionalism in favour

of participation, elitist academic knowledge in favour of lay or local knowledges and experiences, and an individual autonomous self in favour of a poststructuralist relational self, as also followed by African and Eastern perspectives. Mead (1934 quoted in Gergen 1991:119) states "Selves can only exist in relationship to others". She (1991:119) claims there is no thinking, any sense of being a self that is independent of social process. Gergen (1991:147) also explains that in a relational self, one's sense of autonomy gives way to a reality immersed in interdependence, in which it is relationship that constructs the self. The latter conceptualization closely approximates an African as well as an Eastern view of the self (Beyers 1995:30-31). According to Mbiti (1990 in Viljoen 1997b:649), the African's identity is fully anchored in his collective existence. Hsu (1971:23) also agrees that Eastern cultures are more interested in a person's harmonious connectedness to fellow humans, society, nature and the cosmos. It would probably be foolish to propose at this point that a consciousness of relational selves is already widely shared in Western culture – Gergen (1991:157,160) claims that the development of relatedness as a fundamental reality will proceed slowly but surely. Unfortunately, the Western vocabulary of understanding persons is robustly individualistic. We have an impoverished language of relatedness, and relationships cannot become the reality by which life is lived until there is a vocabulary through which they are realised. This vocabulary is slowly but steadily starting to emerge which should allow for a sensibility that should render relationships as palpable and objective as the individual selves of previous eras (Gergen 1991:160).

These arguments, however, do not marginalise Western people from pastoral services, as pastoral work embraces diversity, based on ethical and value-based responsibility (Application Draft for the Establishment of a Professional Board 2002:6). Denominations involved in pastoral services then include but are not limited to Christianity, Muslim, and Hinduism, Judaism as well as minority and indigenous traditional denominations. Despite the seeming differences between Western, African and Eastern views of humankind then, Ho (1988:70) also makes a plea that, in acknowledging differences, we should not exclude one approach to the detriment of the other. He believes that different approaches should be seen as complementary because "neither, when taken alone, is capable of yielding a complete account of the complexity of psychological [or spiritual] phenomena". I have wondered if the view of a relational self, over and above the inclusion of spirituality, can then not add a further multi-cultural touch to pastoral counselling which would make these services possibly even more relevant in our multi-cultural country. Utilising the dimensions of faith, spirituality, religion and values in the lives of people would also mean following a more inclusive practice which could allow pastoral workers to acknowledge the spiritual domains in the lives of South African people. One of the problems Africans constantly

seem to be confronted with is the destruction of a solid religious base, leaving them to struggle with the conflict of losing the historical rootedness provided by the ancestors (spirituality), while confronting the demands of a technological society whose foundations seems flimsy indeed (Viljoen 1997b:647).

A failure to recognise the impossibility of imposing standard psychology in black or other marginalised communities (in particular if such Western approaches neglect addressing the spiritual domain) could also be another way of simply extending the medical gaze (Swartz & Gibson 2001:40) as portrayed by Foucault (http://www.sun/edu/~hfspc002/foucault.home.html), a mechanism of the production of desire and hence of social control.

Foucault claims that knowledge is power, and power is knowledge (http://www.mpaterson.co.uk/foucault.html). This contributes to an attitude of the expert versus the "other", oppression and exploitation. Not confronting these power/knowledge relations is not challenging that dominance, but colluding with it (Chamberlain & Friends 1997:132).

In order to deconstruct the power/knowledge relationship which could enforce the oppression of people already subjugated during the previous regime, a more power-sharing approach is followed especially by pastoral counsellors who have received training in the postmodern paradigm. These counsellors regard the client as a colleague on the therapeutic journey. While there are clear differences in roles and responsibilities, there are ways in which these two are fellow pilgrims, or travellers together on a journey of self-confrontation and healing (http://www.pastoral therapy \Colleague.htm). This stance forces us to acknowledge that standard therapies might be a value-laden and potentially oppressive enterprise, as they are centrally concerned with the production and reproduction of a particular moral order (Swartz & Gibson 2001:40).

In this regard my research curiosity also focused on the possible contribution of pastoral work to reconciliation, transformation, and healing in a still recovering country by promoting and achieving dignity, respect and equity through a more power-sharing approach. According to Cochrane and others (1991:2), transformation in our country must mean a dismantling of the edifice of apartheid and the reconstruction of a society built upon different principles than that of division and domination. Transformation has a far wider meaning than simply redressing past racial and gender imbalances. It also refers to the new breeze of transparency and accountability for our actions and practices (Mmope 2002:2). Hence, against the backdrop of a land and its people still

experiencing an extended social crisis (Cochrane et al 1991:5-6), which includes a collapse in the norms and values of family life and a legacy of suspicion and division between people, I would like to explore this idea of transformation in therapeutic settings also.

The issue of professional pastoral counselling practices in South Africa is further complicated by the publication of the Medical, Dental and Supplementary Health Service Professions Amendment Act, Act 89 of 1997 (Republic of South Africa 1997), which categorises counselling as one of the functions of psychologists only. One of the exclusions stipulated in Section 34 (d) (ii) merely refers to "the performance of any act by a person holding office in a religious denomination which exists for the purpose of worshipping, provided it is performed for that purpose and in accordance with the normal pastoral practices, of that religious denomination" (Republic of South Africa 1997; Kriel 2001: 2). The implication of Act 89 of 1997 is that there is no legal recognition of pastoral counselling as a helping profession and that there is at present a controversy in South Africa regarding the legality of private pastoral practice (Kriel 2001:8).

Kriel (2001:8-10) refers to De Jongh van Arkel (1998:1) when she says that the consequence of Act 89 of 1997 of South Africa is that, for the first time, counselling is now regulated by law and "given" to registered psychologists. A huge resource in the country has been effectively paralysed and eliminated from the provision of the kind of service pastoral counsellors may have been offering. Pastoral counselling as a ministerial function is not affected, but the public status of pastoral counselling as a contributor to mental health is affected negatively.

Inspired therefore by my search for my own voice as a pastoral counsellor in a country where the helping professions are predominantly and legally "ruled" by standard Western linear approaches to healing, I became curious about what aspects in South Africa lend themselves to opening up room for pastoral counselling. In this study I am led by the following questions (by no means an exhaustive list): Is there a space, or need, for pastoral work in our country, especially with regard to our multiplicity of racial and ethnic groups, and our possible different needs? Could pastoral work, by including spirituality, offer more inclusive services applicable to the diverse cultures and ethnic groups in South Africa? What services does pastoral work offer, which other helping professions do not address? Could pastoral work contribute in any way by providing accessible and affordable services, particularly to the poor and poorly educated groups which have previously often been excluded from receiving standard therapy or health services? And could pastoral work contribute to reconciliation and healing in a country previously torn by apartheid and oppression?

If the answer to some of these questions is “yes”, why are/can the contributions of pastoral work not be professionally recognised? And (how) can this study, contribute to the legal recognition of pastoral work as a profession?

These questions, however, might be too broad in their scope to be addressed in a dissertation of limited length. I have therefore decided to be led mainly by the information gathered from participants. Unlike quantitative research methods (which follow reconstructed logic), qualitative research methods follow logic in practice (Neuman 1997:330).This type of logic relies on the informal wisdom that has developed from the experience of researchers. Hence, the above questions only guided my research and there were no fixed hypotheses that needed to be proven. Meaning was captured and discovered only once the researcher (myself) became immersed in the research descriptions that were retrieved (Neuman 1997:329).

My quest for the endings of the tales of a thousand and one nights was fed by the possibility that pastoral counselling raises the hope of more affordable and accessible care, particularly for the poor and poorly educated groups who have often been excluded from receiving standard therapy. Access to services would be made easier, since pastoral assistance could be made available also through local religious communities.

Working in a postmodern approach, I also believe that the various forms of spirituality and different realities of South African people should be accommodated in the health services provided to them. In the postmodern era there is much greater openness toward non-conceptual ways of knowing (Herholdt 1998b:223). In post-structuralism we live in an integrated world where spiritual reality and a worldly reality are part of the same multi-layered reality, similar to the view that the functioning of Africans as well as Eastern people is fundamentally a religious functioning (Mbiti 1989:2). Consequently, spiritual matters are not approached as an esoteric realm (Herholdt 1998a:468). In this study I am led by the belief that all people have a right to acceptance for their different orientations, beliefs, and spirituality, and to receive (concrete) services accommodating their differences. Against this background, then, I argue that pastoral work could provide a possible accommodation of these differences. I also propose that in a multiverse of realities, space should be created for pastoral work as a professional occupation.

In short, I believe that pastoral counselling in South Africa, as opposed to standard therapies, is about trying out new roles, and discovering knowledges that could probably never be discovered

in the safe haven of laboratories or single clinically sterilised consulting rooms. My own answer to the question "is pastoral counselling relevant in South Africa?" is an emphatic "yes!" I believe it offers a non-mechanistic and contextual approach which focuses spirituality, and sits well with the political context as a defining feature of people's lives in South Africa.

It is therefore one of my aims here to explore and illuminate contexts in South Africa which open up room for pastoral work with regard to pastoral counselling, thereby also assisting pastoral and spiritual workers in their negotiation to obtain professional status in this country. This study will hopefully make a contribution to demonstrating that pastoral work can contribute to the healing and recovery in our broken country.

In order to accomplish my research goals, my arguments are supported by references to relevant literature. I believe, however, that the most compelling evidence of spirituality's importance comes from those directly involved in the process: people sharing moving stories of suffering, survival, and redemption, and of how spirituality can offer a practical, personal means to recovery. I hope that the interviews recorded in this study have created a space for them to retell their alternative preferred narratives in order to demonstrate the relevance of pastoral work in South Africa.

1.3 PURPOSE AND RATIONALE: THE DESTINATION UNFOLDS

With regard to the above discussion, in this study I wished

1. to differentiate between pastoral counselling and other mental health professions, in order to argue the special contributions pastoral counselling can offer which other health professions might not;

2. to indicate where pastoral counselling can contribute to already existing social and health professions by illuminating possible limitations of the mainstream helping professions; and

3. to explore the South African context for the possible need for professional pastoral counsellors with regard to:

    (i) pastoral counselling as a multi-cultural approach;
    (ii) pastoral counselling as a national health resource;
    (iii) cost-effectiveness in relation to other health services;

(iv) pastoral counselling as a human right and freedom of choice; and

(v) pastoral counselling as a source of social transformation and reconciliation.

4. to support the above discussions with vignettes of suffering, survival and redemption in spirituality – in this space participants express and retell their experiences of various events of counselling, how spirituality contributed to their recovery or conquering of their problems; they speak of the meanings that they have been attributed to these events, and explore the real effects of these experiences and meanings in shaping their lives. This includes participants' specific definitions of spirituality.

In South Africa, unfortunately, no occupational or professional councils for pastoral work exist as yet. Whereas the professionalism and identity of the other helping professionals in South Africa is protected and guaranteed by professional associations or councils in order to control training, conduct and admission to these professions, pastoral counsellors in South Africa are still negotiating for professional status (De Jongh van Arkel 2000:196; Kriel 2001:3).

A profession refers to a vocation or form of employment that requires specialised knowledge and skills. It is characterised by and conforms to academic, technical and ethical procedures, standards and codes which articulate the professional culture of a specific group of peer professionals. That profession is not open to everyone and the educational processes, training and skills needed are well defined and controlled. A profession is also both the principal occupation of and source of income or financial gain to those who practise it (De Jongh van Arkel 1999:95).

At present, there is a process afoot to gain official recognition for pastoral workers, primarily driven and initiated by the Southern African Association for Pastoral Work (SAAP). This process may lead to the registration of pastoral workers at a variety of levels. The SAAP is an organisation that embraces diversity, based on ethical and value-based responsibility (Application Draft for the Establishment of a Professional Board 2002: 6). The SAAP also subscribes to the principle that there should be accountability and control within the profession. Prospective clients, if they may be called such, as well as religious communities should then also benefit from this study, if it can be used as argument to assist in the registration of pastoral counsellors. The regulation and controlling of services rendered to the various individuals and communities will assure ethical and responsible practices towards all people. In the present unregulated situation, the accountability of people who call themselves pastoral counsellors has now become a burning issue. Guidelines

should be developed to indicate to whom such people should be accountable: institutional churches, an interdenominational national organisation of pastoral counsellors, the state, or a combination of these (De Jongh van Arkel 1999:91).

This study, however, does not pretend to provide conclusive and definite proof that pastoral work is relevant in this country. It should be seen as part of a process with the aim of developing pastoral counselling as a profession.

1.5 MAPPING THE JOURNEY

In this study, then, I am trying to write about people who, in the face of their most trying obstacles, have found the hope and love and courage to tell significant stories of reconnection to, and support by, their spirituality. In sharing with you, the reader, these intimidate details of people's lives, in consultation with the participants I have changed any identifying information. I have also sought, and attained, the permission of the people whose stories are told here to tell these stories and use them in this study.

In Chapter Two, I explore the interpretative paradigm that I followed, explaining the postmodern approach and its influence on research, theology, practical theology and pastoral care and its relevance to this study. In Chapter Three, the roads taken and travelled on during this research journey are explored with regard to the methods used, the participants, and how the study was conducted. Chapter Four sets out conversations in terms of the purposes and goals of this study, as explained in "Purpose and rationale: a thousand and one nights" (see Section 1.3 above).

A postmodern approach, however, suggests that no study is complete without reflection on the research process, and this is done in Chapter Five: "Commitment to the conversations". In "A looking-glass universe", I reflect on personal aspects of the journey, while in "The roads travelled", I reflect on what has been accomplished by this journey, and how or if I have managed to reach at least some of the goals and purposes of this study. In "From a distance", I supply a short summary of the limitations of this study, mainly from a positivist perspective, if only for the reason that any researcher should also be aware of the limitations and drawbacks of his/ her methodologies chosen and used.

These reflections are followed by the Appendices which were used for directing this study, while in "Narratives: A multiple of stories", the narratives of the participants can be found. Readers are

strongly recommended to read through these narratives before embarking on the rest of the travelogue through my quest of a thousand and one nights to familiarise themselves with the participants and their experiences (see Section 3.6).

CHAPTER TWO

INTERPRETATIVE PARADIGMS: TOWARDS A POSTMODERN APPROACH

The purpose of this chapter is to contextualise this study in a relevant paradigm. It proposes an alternate mode of inquiry derived from an interpretive framework which is consonant with a view of counselling and research as a process involving the resymbolisation or reconstruction of experience and behaviour in the context of dialogic interchange, such as the postmodern paradigm. The influence of this paradigm on theology, practical theology and pastoral care and ethics is also discussed. The chapter presents a summary of the various levels of pastoral work and its relevance to the professionalisation process.

2.1 LIVING IN STORIES

Interpretive paradigms refer to the beliefs that shape the way a qualitative researcher sees the world and acts in it. My research was conducted as narrative research within a postmodern paradigm.

The postmodern paradigm not only indicates the course of actual history following the death of modernity which lasted from 1789 to 1989, but also reflects a different way of thinking about the world, introducing a "new" epistemology. In general, postmodernism may be characterised as pluralist, pro-metaphor, relational, holistic, relativistic, indeterminate, evolutionary, post-critical, and participatory (Herholdt 1998a:457).

According to a postmodern paradigm, we live our lives by the narratives (stories) we create in language and in our relationships with others. Since we construct our own realities in stories, we are also able to re-create those stories and choose the lives we wish to live by more effectively. The narrative is the basic figuration process that is used to produce the human experience of one's own life and action, and the lives and actions of others. Narratives then refer to the stories people create and live in. For postmodern counsellors or therapists, these stories consist of "events, linked in sequence, across time, according to a plot" (Morgan 2000:5).

Gergen and Gergen (1988:23) argue that there is a significant sense in which our relationships are lived out in narrative form. We live immersed in narrative, recounting and assessing the

meanings of past actions, anticipating future outcomes, and situating ourselves in several incomplete stories. In this regard, pastoral counselling might possess the ability to facilitate the further development of people's spiritual stories and identities and of a dialogue with their tradition, while simultaneously facilitating the growth and development of particular life stories (Gerkin 1997:113). Ignoring people's spirituality could result in incomplete preferred narratives. In this research, my aim was to explore the unique outcomes and alternative stories of people who have experienced recovery through alternative stories (in this case, spirituality) which lie beyond the pale of dominant (scientific) stories.

Sometimes the counsellors or researchers of our time make the "mistake" (presuming that so-called mental problems are of a single sort) reflected in the thinking proposed and categorised in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, the well-known DSM classification (http://www.psychologytoday.com/htdocs/prod/PTOArticle/PTO-20030523-000002.asp). The DSM is frequently described as psychiatrists' or clinical psychologists' bible. They were trained with it; they have to use it in their professional work and it is occasionally helpful to refer to when talking with patients; but they often do not think it provides any deep insights at all. It is, however, the document that has been adopted by most bureaucratic and legislative organisations to determine when people are entitled to treatment or when their psychological state may be relevant to assessing their responsibility for their actions (http://www.human-nature.com/nibbs/03/dsm.html).

A postmodern and in this case narrative approach to people's lives, performs a public health function quite different from that of the DSM: it destigmatises. It gives voice, in turn, to the variant of problem any client is likely to suffer from or struggle with. It forms a striking patchwork, forcing us to see how various, how ubiquitous, how influential "mental disorders" are as an element of contemporary life. To me it is therefore only ethical to adhere to an approach that would support and respect the multiverse of realities, problems and experiences or stories. In a postmodern paradigm there is no single reality, no single truth out there waiting to be discovered.

I consider traditional positivist methodology to be incompatible with a postmodern, narrative approach in various ways. If we construct our own realities, no objective reality as proposed by quantitative methodology can exist "out there" waiting to be discovered, measured or quantified (Becvar & Becvar 1996:333). Positivist methodologies are designed to determine quantitative differences between phenomena by means of objective measurements. These methodologies attempt to explain phenomena by establishing (linear) causes and effects. Results should be

verifiable by other, objective observers (Viljoen 1997c:29-30). Thus psychological events and processes are described by taking into account only limited general principles that apply to everyone (presumably) without attempting to accommodate individual differences – silencing many voices and struggles, and ignoring local knowledges and practices in the process. Quantitative methodologies are based on a determinist view of man, and propose that any given psychological phenomenon is determined by specific factors. This determinism contrasts sharply with other approaches that prefer to attribute individual functioning and differences to the operation of personal freedom, relationships and the human will – such as postmodernism.

I do not challenge the logical positivist-empirical tradition as a viable way "to know". But, as with other world views, I consider the positivist-empirical tradition as only one of many ways of knowing, not as *the* way of knowing (Becvar & Becvar 1996:337). Gergen (1992 quoted by Freedman & Combs 1996:21) also writes that "the postmodern argument is not against the various schools of therapy [research methodologies], only against their posture of authoritative truth".

In a postmodern paradigm then, the idea of "objective" knowledge or reality no longer exists when a constructionist position is assumed. Qualitative methodologies do not impose absolutist reality norms either. According to Becvar & Becvar (1996:329), it is in accordance with the spirit of qualitative research to see data and interpretations of data as valid only under the unique conditions of a particular project at a particular time and place. Capra (1983:48) also claims that what we can, at best, hope to achieve are "approximate descriptions of reality". From a constructivist point of view, Maturana and Varela (1980,1987 in Kotzé 1994:28-29) also warn that objective truth cannot exist, that knowledge is relative and that our actions are ethically important. They stress the importance of taking responsibility for one's own choices.

What I do believe then is that if one works using a postmodern paradigm, a qualitative approach is a more accommodating way to do research with individuals and their experiences within the larger social contexts (in which) they live. I make no claim to deliver positivist "proof" that pastoral counsellors are needed in South Africa. Instead, I merely intend to offer rich descriptions of the relevance of pastoral care for South Africa, supported by narratives/vignettes by people who have experienced healing in spirituality. In line with a qualitative approach, their stories present their lived realities rather than presupposed categories, or any hypotheses' guiding this research. I use these experiences to argue the possible need of South African people to be cared for spiritually

and their right to obtain such care, thus arguing the relevance of pastoral work in South Africa with reference to counselling in particular.

2.2 PASTORAL CARE IN THE FRAMEWORK OF A POSTMODERN THEOLOGY

Theology, as the name indicates, is concerned with God (Heyns & Pieterse 1990:3). It literally means to study God (Kotzé & Kotzé 2001a:1). At best, however, theology can study people's statements about God and their faith in God. Theology does not invent its own questions; these questions arise from the religious contemplation of believers (Heyns & Pieterse 1990:3). Theology then is a human construction about spirituality in and through which the living Word of God is known and communicated (De Gruchy 1994:5). Heitink (1993:14) argues that the direct object of theology is to be found in the study of faith texts: religious, pastoral, ecclesiastical and theological. These texts, which include oral presentations, prayer, music, and so on, function as manifestations of religious experiences and of relationships between God and human beings.

Different interpretations of the types of texts mentioned above, however, have led to the establishment of different theologies. Diversity and pluralism are simply a given, even within religious traditions. Diversity has been evident within Christian traditions from the beginning (Cochrane et al 1991:21).

My chosen theology, Postmodernism, is generally known by its disenchantment with the critical consciousness of modernism, the fragmentary perspective of reality, and its reductionism (Herholdt 1998b:215). So, for example, a postmodern theology sees the will of God not as a predetermined decision people need to discover in a passive mode of mere obedience. People are afforded the right to human input that co-determines the "plan" for their lives (Herholdt 1998b:226). God is seen as a creative participant in their lives instead of as an authoritative figure in charge. In a sense postmodernism is a rediscovery of the value of human participation, a quest for wholeness and meaning, a perspective on the continuity between all levels of a multi-levelled reality (Herholdt 1998b:218-219).

Revelation in postmodern theology is therefore not simply a "given" in the past (or in traditions) but is an event that is still unfolding. Postmodern theology argues that there is no fixed body of theological truth available to be communicated from generation to generation. The onus is on every generation to discover meaning for itself by means of metaphoric reference, as revelation continuously unfolds (Herholdt 1998b:224). The emphasis is no longer on dogma to explicate the

nature and activity of God on rational grounds, but rather on a more poetic literary approach where the sacred can be imagined. Knowledge as a way of knowing now includes personal experience. In this study, the idea was not to provide a rational or exact explanation of religions or spirituality "as it is", but to point to coherence between the physical and spiritual experiences of people as these people define and experience; or as it is revealed to them, in their particular relationship with their God/s.

The contextual and liberating aspects of postmodern theology also render it applicable to our diverse South African context. It acknowledges contextually (Herholdt 1998b:219) and has an activist component (the liberation of God's people at all levels), which includes social transformation (Herholdt 1998a:460). South Africa, in particular, is a country with vastly different cultures and traditions. White Western theologies are no longer the only yardstick by which we can "evaluate" other communities or people. Nor can these theologies necessarily assist people in dealing with their unique problems, especially since during the previous regime various racial groups were marginalised and oppressed in the name of (white) religious interpretations and the resulting norms which viewed apartheid as "right" (Cochrane et al 1991:40). Kritzinger (1998:234) claims that it is theologically irresponsible to ignore pluralism or different orientations. God cannot be communicated, or utilised as support, if the different ways of practising spirituality are not acknowledged.

In my view then, postmodern theology assists us to cross the boundaries of different religions and world views respectfully in order to acknowledge and validate individuals' right to their own spirituality. It assists us in our attempts to support them, to strengthen them and to live according to their respective religious or spiritual orientations. In dealing with clients, therefore, we need to respect all different forms of spiritualism and ways of living. Postmodern theology urges us not to impose our own religion or beliefs on other people; it warns us not to moralise, nor to be enticed into the trap of "knowing" what God is like for other people (Griffith 1995:138). This would be religiously oppressive and an unethical way of being with people. Griffith (1995:126-127) also remarks that "if I think I know … [how the person experiences God]… I then risk joining forces of cultural oppression …".

My chosen theology therefore informed my reflections and my actions during the research process. According to De Gruchy (1994:2), the phrase "doing theology" indicates that theology is not simply something one learns about through reading textbooks or listening to lectures, but something one does by engaging in doing theology in particular contexts and situations. Doing

theology included reflecting on the meaning of my chosen theology for my situations, which includes the research contexts. In accordance with Kotzé and Kotzé (2001a:1), I therefore also prefer the term "spirituality" to refer to "theology" as this concept is "more inclusive and focus[es] on any of our experiences including theological ideas and narratives about the Other whom some call Friend/ God/ Goddess/ Divine and so forth".

For the purposes of this study then, in order to be respectful of the participants' different spiritual experiences in pastoral care, I have chosen a postmodern theology as my epistemology. "Every person imagines God personally and differently," says Herholdt (1998b:225). I believe that this paradigm is the best suited to embrace the multiple spiritual realities that there are and therefore also to meet the aims of the study. I believe strongly that postmodern theology in South Africa offers a solution to accommodate different theological (spiritual) orientations, as well as a way of living with different cultural groups whose world views might not necessarily match the counsellor's own. I believe that postmodern theology is extremely relevant in a South African context to acknowledge and support various cultural aspects, different religions and forms of spirituality. We are a highly pluralistic country, an aspect both pastoral counsellors and pastoral researchers have to deal with daily on an ethical basis.

2.3 RELATEDNESS AND ENCHANTMENT IN PARTICIPATORY PRACTICAL THEOLOGY AND PASTORAL CARE

To be consistent with my chosen epistemology and theology, I have further situated this study in a participatory practical theology, as well as in a participatory pastoral care approach.

A participatory approach to practical theology reaches beyond a mere practice of theology, it refers to a shift to true participation among all participants of practical theology (Roux, Myburg & Kotzé 2001:64). Such a participatory approach, takes the ethical position of introducing previously unheard voices to the realm of theology – encouraging all voices to be heard and to be listened to by all (Roux, Myburg & Kotzé 2001:65).

Punctuating from such a participatory approach, Poling (1991:186) describes participatory practical theology as follows:

> Practical theology is critical and constructive reflection within a living community about human experience and interaction, involving a correlation of the Christian

> story and other perspectives, leading to an interpretation of meaning and value, and resulting in everyday guidelines and skills for the formation of persons and communities.

As I have already mentioned in Section 1.2, in order to deconstruct power/knowledge relationships which could enforce the oppression of people already subjugated during the previous regime, a more participatory and thus "power-sharing" approach is followed especially by pastoral counsellors who have received training in the postmodern paradigm. Research activities in a participatory mode now become a relational activity, "a relation that acts the world ...blurring the boundaries between self and other" (Heshusius & Ballard 1996:172). This type of relatedness in research enchants, when "the effects on the participants and their [the researchers'] own lives enchant all involved" (Kotzé & Kotzé 2001a:10).

A key element of research done from a participatory practical theology and pastoral care approach, therefore, lies in questioning the research process (http:www.%20%anti-discriminatory %20 perspectives. htm/). All knowledge produced involves moral and political questions that affect the lives of the people who are "being researched", including using the language of power, oppression and domination. People who are the objects of research are more often than not those in relatively powerless positions who have no control over how they are represented in research reports. As a result some research results in misrepresentations, highlighting the notion that research is often done *to* people rather than *with* them. "The effects of these 'truths' [as presented by research findings/knowledge] include oppression, suffering, exploitation and marginalisation of those people positioned at the unfortunate side of these 'truths" (Kotzé 2002:13).

Instead, in a participatory approach, participation becomes very much a joint process involving participants, as example, in commenting on the findings before they are published and sometimes in listening to or reading through their own interviews (http:www.%20%anti-discriminatory%20 perspectives.htm/). Getting involved fully can be liberating and can increase people's self-confidence. Supporting research that is relevant to people who have "vested interests" can help to shape services (particularly mental health services) that are supportive and respectful. Doing research *to* people can be disrespectful and can be painful to these people, particularly if the research involves the revelation of personal information. "Power-sharing" entails more "ethical ways of being", or, "ethicising" with the participants (Kotzé 2002:1, 21), hence, an anti-

discriminatory perspective is followed in participatory research (http:www.%20% anti-discriminatory%20perspectives.htm/).

Participation in a participatory pastoral care approach as well as in participatory practical theology, therefore, stresses the above mentioned ethical practices towards and with the participants of the research undertaken. Ethical practices here refer not so much to caring *for* people, but to caring *with* people in need of care (Kotzé & Kotzé 2001a:7). In South Africa, in particular, this position would imply a move away from care given out of a sense of guilt (for a past of apartheid and oppression) towards caring with people. This approach calls for commitment to participation (Herholdt 1998b:218,224). According to Sevenhuijsen (1998:147) care should be considered (or experienced) as an integral part of human existence. In both a participatory practical theology and participatory pastoral care approach then, the caregiver, counsellor, or researcher, collaboratively negotiate alternative ways of being and doing, moving towards co-construction to ensure a respect for conversation (Roux, Myburg & Kotzé 2001:46) and the deconstruction of harmful practices or narratives. Hence, we are referring to care in a participatory approach here as a social practice, socially constructed by care-givers as well as by the receivers of care negotiated between care-giver and receiver (Kotzé & Kotzé 2001a:7; Roux, Myburg & Kotzé 2001:46), not merely as the handing out or giving of care in a patronising way that maintains hierarchical structures of power and subjectification.

Both participatory practical theology and participatory pastoral care as ethics are therefore not just some arbitrary system of professional ethics, resulting from a merely intellectual or rational process of analysis and interpretation or theology. Nor does it merely refer to an ethics in which the previously silenced voices of the disempowered "should also be taken into account" (Kotzé 2002:18). It is an ethics located in the discourse and praxis with those who are disempowered and have been marginalised in a community of care – especially those who seldom benefit from the ethics of discourses created and entertained by the powerful or knowledgeable. According to Kotzé (2002:18), one who has a voice and power has an ethical obligation to use that knowledge of knowledge/power to give a voice to those who are marginalised and silenced. Pastoral counselling, including research, becomes a "co-search" with people instead of a doing therapy (or research) *on* people. "Being committed to participatory ethical care provokes the urgency not to care *for* but to care *with* people who are in need of care" (Kotzé & Kotzé 2001a:7). And ethical research, therefore, "cannot but also be therapeutic for all involved" (Kotzé & Kotzé 2001a: 9).

I must stress, however, that this study cannot be described as participatory or power-sharing *per se*, since the participants were involved neither in deciding the purpose of this study nor in the writing up of the actual dissertation. Still, their contributions are regarded as belonging to them and have to be acknowledged as such.

An important ethical principle in this study was the right of the participants to engage in or to disengage from the research, and they were asked for their informed consent (Barret 1998:31-32; Neuman 1997:454; Rosnow & Rosenthal 1996:64). Written consent was therefore obtained from participants. Participants were requested to sign a consent form to the study after receiving an information sheet containing all the relevant information regarding the purpose of the study. This information sheet also addressed ethical principles (confidentiality, anonymity if so preferred, their right to withdraw from participation any time, and the right to indicate if they are comfortable [or not] with the use of any of the information that emerged).

In addition, the participants received an opportunity to comment on their contributions prior to submission, given that part of it is their contribution to knowledge, providing a further check on the interpretation process. According to McNamee and Gergen (1999 cited in Long 1999:s.p.), the power dynamics that are unavoidably played out between the client and the practitioner are reproduced in a subject (participant) and researcher, setting up hierarchical relationships of access to knowledge and truth which are criticized by researchers who aim to promote more egalitarian research. Hence, giving participants an opportunity to comment on their contributions, allowed a more participatory and ethical position, such as discussed above, in which notions of the power differential between the researcher and participants were addressed.

In conclusion, in line with the participatory ethics (Kotzé 2002:17-20) of participatory practical theology and participatory pastoral care, as opposed to prescriptive ethics resulting from "a process of deductive "truth" that are mostly embedded in scientific and/or religious discourse" (Kotzé 2002:13), I hoped that my research would come from a different context, recognising people as experts on their own experiences, valuing and respecting those experiences and their unique meanings, and attempting to involve participants in ways which are ethical, useful and sensitive to their strengths and needs.

2.4 THE DIFFERENT FACES OF PASTORAL WORK

In the spirit of a postmodern transparency I would like to present the various levels at which pastoral work functions and briefly explain some of the practices that are associated with these levels, as it is quite possible that not all readers are necessarily familiar with the different categories of pastoral work. These categories are increasingly relevant since the various dimensions of pastoral work are to some extent also entwined with the various levels of professional registration as proposed by the SAAP, as set out in Section 4.1. The reader is reminded that this study is partially an attempt to support pastoral and spiritual workers in their negotiation to obtain professional status in this country. If pastoral counselling is integrated into the primary heath care system of South Africa (Section 4.3), the various levels at which pastoral work functions might also be relevant to the different levels of prevention with reference to primary care, secondary care, and tertiary care.

There are numerous perspectives on pastoral work and it can be considered multi-dimensional. According to De Jongh van Arkel (2000:(x)), pastoral work is an inclusive concept which is used when referring to more than one of the levels pastoral work functions on, (with reference to mutual care, pastoral counselling, and pastoral therapy), and which is also open to all religions and denominations (Application Draft for the Establishment of a Professional Board 2002: 6). It does not refer to the activity of a specific religious grouping. By implication, this also includes all forms of spirituality. Louw (1998:19;256) defines spirituality as follows:

> Spirituality implies practicing faith in such a way that it creates an awareness of God's presence. It is "faith embodied" with the goal of developing congruency between faith content and daily life. It strengthens the "being" functions of a believer with the view of preventing problems.

Louw (1998:19;256) defines the term "pastoral" as follows:

> Pastoral refers to the support system of the faith community which has the goal of developing a mature faith and enhancing spirituality. This empowers the believer to address relationships, contexts and life issues from a faith perceptive.

Four levels of pastoral work can be identified: mutual care, pastoral care, pastoral counselling and pastoral therapy. These levels are discussed more fully below.

2.4.1 Mutual care

This is the most basic level of care provided when members of a faith community care for each other. This usually takes place within an informal network of communities – friendships, small prayer groups, telephone conversations and spontaneous reactions to crises (De Jongh van Arkel 2000:2). It emanates from "believers'" commitment to one another and is associated with an acceptance of the community of believers.

2.4.2 Pastoral care

According to Browning (1993:5), pastoral care is the most inclusive pastoral activity. The focus is the official caring for and strengthening of the members of a faith community by a recognised leader. It works towards "building up" people in a congregation, primarily through a dialogical caring action. These care providers can include trained lay workers and other leaders in the community. It requires greater expertise and training than mutual care (De Jongh van Arkel 2000:32).

2.4.3 Pastoral counselling

Pastoral counselling constitutes the third level of care. It is a more intensive and structured form of care than mutual care and pastoral care. The focus is on short-term, focused, goal-directed, contracted counselling, provided by a trained professional within the context of a spiritual community. Specialised knowledge of and training in counselling and their particular faith tradition is a prerequisite. It usually deals with specific personal, transitional, relational or situational crises. The pastoral counsellor needs to be aware of the limitations of such care and must know the criteria for referral. Pastoral counselling is similar to other forms of counselling (in technique, for example) but also differs from them due to its spiritual character (De Jongh van Arkel 2000:107).

2.4.4 Pastoral therapy

> This refers to a developing profession of people who are called to and practise therapy from a pastoral and spiritual perspective in a specialised, structured setting. For this level, there are limitations in access. This level presupposes intensive training in therapeutic techniques and spiritual care as well as extensive supervised training (often in a clinical context). The focus is on growth, transformations and healing from a spiritual perspective (De Jongh van Arkel 2000:184).

According to De Jongh van Arkel (2000:184-185), the distinction between pastoral counselling and pastoral therapy is sometimes more academic than practical. He believes that the basis for the distinction quite often lies in that the pastoral counselling is part of a larger ministerial function, while the pastoral therapist specialises and uses most of his/her time for therapeutic practice.

These distinctions, however, do not denote any hierarchy. De Jongh van Arkel (2000: 2) emphasises that mutual care is the most fundamental form. The Professional Board for pastoral and spiritual care will focus on practitioners involved in pastoral care, counselling and therapy, which in my opinion is directly related to the various levels of a primary health care delivery approach (see Section 4.3).

CHAPTER THREE

THE RESEARCH JOURNEY

This chapter provides an outline and discussion of the destinations of my research journey. In Section 3.1, I map out the strategies of inquiry and the methods chosen for the journey; and in Section 3.2, I take a closer look at the participants. How the interviews were scheduled and approached is set out in Section 3.3. Section 3.4 explains the narrating of interviews, while in Section 3.5, questions regarding the validity and reporting of the narratives is addressed. Finally, in Section 3.6, I argue that since we live in stories, each participant has the right to "copyright" his/her own narrative.

3.1 MARKING THE ROADS

Before embarking on any journey, a wise traveller chooses and maps his/her roads. Similarly, before embarking on research, a researcher must choose appropriate strategies of inquiry and the methods to be used.

Denzin and Lincoln (1994:14) describe a strategy of inquiry as all the skills and practices employed during the course of a research project. According to Eleen Polson (2001:4), this phase entails the research design and it involves the following:

> … A clear focus on the research question and purposes of the study, it describes a flexible set of guidelines that connects theoretical paradigms to strategies of inquiry and methods to the empirical world. The research design…specifies how the investigator will address the issues of representation and legitimating. [It]… is a bundle of skills, assumptions and practices……to move from the paradigm to the empirical world. [It]….include[s] the case study method, biographical and historical action, clinical methods and phenomenological techniques. Each of these strategies has a separate history, literature, and preferred ways of interpretation.

Denzin and Lincoln (1994:2) see qualitative research as "multi method in focus, involving an interpretative, naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in

terms of the meanings people bring to them". Routine and problematic moments and meanings are described by the collection and study of a variety of empirical materials. This includes case studies, personal experience, life stories, interviews, and different kinds of texts.

My research methods included, first, exploring relevant literature and research and, second, "multiple" interviews with various clients from different pastoral counsellors which varied from the Free State to the Northern Province, to tell their stories of how pastoral counselling assisted them in recovery.

In the next two sections, I take a closer look at the participants themselves, as well as how the interviews transpired.

3.2 FINDING TRAVEL COMPANIONS

I undertook the journey of this study with selected companions who have participated in pastoral counselling before, and who indicated a willingness to share their experiences of the therapeutic process.

At the end of March 2003, a list of pastoral counsellors was obtained from the Institute of Therapeutic Development in Pretoria, since this is where I received my own training and education in counselling, and I was already familiar with the Institute and its policies. In this study most participants had received counselling from narrative pastoral counsellors, as the Institute specialises in pastoral counselling with a special focus on the narrative approach.

The counsellors were approached by e-mail as well as telephonically, explaining the purpose and methods of the study. The cover letter (see Appendix A) and the interview schedule (see Appendix D) were forwarded to them in order to be as transparent as possible. Some counsellors did not respond, but others agreed to enquire from their clients whether they would be interested in participating. After consulting with their clients, the names of interested persons were supplied whom I then contacted personally to arrange for the ways the participants preferred the interviews.

Participants came from the practices of three different narrative pastoral counsellors. Two of these counsellors were women (white) and one was male (black).

Participants then received information letters (see Appendix A) and after a discussion with the aim of answering any queries, they were asked to sign letters of informed consent (see Appendix B) before interviewing commenced.

I originally intended for six to eight people to join in the research as participants in the interviews. Preferably, I wanted them to come from different walks of life to ensure a rich variety of experiences. No people from an Eastern background participated, however, nor could any participants be found who support an Eastern world view. Due to the time limit also, only five people could participate. The frequency distributions of the participants are set out in Tables 3.1 to 3.3 below.

Table 3.1: Frequency distribution: Age and gender

N=5

Age	Male	Female
20-30	0	2
31-40	0	0
41-50	1	1
51-60	1	0

Table 3.2: Frequency distribution: Ethnicity

N=5		
Age	**Male**	**Female**
Black	1	1
White	1	2
Other	0	0

Table 3.2: Frequency distribution: Geography

N=5		
Area	**Male**	**Female**
FS	0	1
Jhb/ Pta	1	1
NP	1	1

3.3 TRAVEL TALK

On this journey, our conversations, or talks, were conducted in the form of interviews. Interviews are a primary data collecting technique in qualitative research. According to Berg (1995:29 in KRM307-K [1997]:20), an interview can be considered simply as a conversation with the purpose of collecting information. Crowley (1994-95:60 in KRM307-K [1997]:20) as well, considers interviews to be one of the most powerful ways to collect information regarding human beings.

Clandinin and Connelly (1994:420) also see interviews as a valid method of collecting data regarding personal experience. However, they claim that the way an interviewer acts, questions, and responds in an interview shapes the relationship and therefore the ways participants respond and give accounts of their experience. The kinds of question asked and the ways in which they are structured provide a frame within which participants shape their accounts of their experience.

I utilised multiple interviews in order to let participants decide for themselves which accounts they wished to offer during the interviews, in language known and comfortable to them. Multiple interviews include semi-structured or unstructured interviewing, open-ended interviews and interviewee-guided investigations of lived experience (Reinharz 1992:37). These methods facilitate "free" interaction between the researcher and participants (Reinharz 1992:18). Semi-structured or unstructured interviews involve asking questions without the use of any fixed, preplanned schedules. The precise questions and their order are not fixed; they are allowed to develop as a result of the exchange with the respondent (Breakwell 1998:231). Some questions are developed beforehand in order to direct the course of the conversation to the relevant topic and each participant is asked these questions systematically and consistently, while the interviewer retains the freedom to probe further in response to the answers received in order to illuminate deeper meanings and experiences.

This preference for an unstructured and open-ended format of interviewing, which encourages participants to express themselves in ways they are most comfortable (by telling their stories or following digressions), is also regarded as a feminist approach to interviewing participants (Neuman 1997:262). Moving away from a preplanned structured interview schedule is also a move away from a social situation in which the interviewer exercises control and dominance while suppressing the expression of personal feelings and experiences.

Although I had selected a semi-structured/unstructured/open-ended approach to the interviews, I proposed the following points for discussion possibilities which were in line with my research curiosity:

- the interviewee's specific definition of his/her own spirituality;
- the person's experiences which urged her/him to seek assistance from the pastoral counsellor;
- the role of spirituality during the "healing" process;
- the possible emergence of spirituality during the process (if not experienced previously);
- his/her experience of the spiritual character of the therapeutic process as well as reflecting on the role of pastoral care – what he/she would expect from the latter;
- the reaction(s) of the pastoral counsellor he/she consulted; and/or
- any experiences of oppression or marginalisation during the process;
- previous experiences of counselling (which did not address spiritual dimensions);
- reflecting on his/her experiences – what he/she has learnt from the experiences;
- any considerations and suggestions for the therapeutic process; and
- any other relevant experiences the participant wished to share.

In line with the above points, an interview schedule with related questions was developed which I used as a map to guide me during the interviews themselves (see Appendix D). Each participant received a copy of the interview schedule beforehand to familiarise and orient him/herself in order to have full access to my intentions and goals, and so that he/she could word his/her narratives accordingly. Moreover, participants were allowed to negotiate throughout the journey which questions they preferred to address and which experiences they preferred to leave out.

3.4 NEGOTIATING THE JOURNEY

Summaries of the interviews were transcribed into narratives and made available to participants to review and to edit according to their understanding. In all of the cases, writing the narratives was a collaborative process and required constant negotiating with participants as to whether I

was still heading in the right direction, or might have become lost along the way. These narratives were negotiated via e-mail, standard mail, fax, telephone, or in person, depending on the preference of the particular participant. These narratives are reported separately in Appendix E: "Narratives: A multiple of stories".

All interviews were conducted between mid-April 2003 and mid-June 2003. Due to the geographical distances involved, I had several conversations with Ilze (Neethling & Schoeman 2003:XXIII-XXIX) by e-mail. Two participants were interviewed physically in Pretoria. Three face-to-face conversations were conducted with Derrick (Neethling & Du Toit 2003:III-X), and two face-to-face conversations with Sarah (Neethling & Motlhabi 2003:XXX-XXXIV). The final two participants, Bakela (Neethling & Motlathegi 2003:XIX-XXII) and Marelize (Neethling & Van der Westhuizen 2003:XI-XVIII) were interviewed locally at my own home which they considered a "safe place" for our gatherings, as they were previously my own clients, and we were therefore familiar with each other. Note that these names and surnames were chosen by the participants for themselves.

The study was furthermore explained in language accessible to each participant as far as possible. Some conversations were conducted in Afrikaans and then translated into English for the purposes of the study, as with Ilze, in which case my translations were edited by her. In Sarah's case, the conversations were recorded and transcribed, after which she had the opportunity to edit the summaries. In Bakela's case, he preferred to summarise and translate his own narrative with limited assistance from myself and his daughter. The language in his narrative forms part of the world Bakela lives in, and no changes were made to the language, in terms of Bakela's preference. I also did not want to make too many changes to any of the narratives, as the "atmosphere" created in these tales reflect participants' respective voices and their power to shape their own stories.

3.5 AFFIRMING MY COMPANIONS

As mentioned above (Section 3.4), each participant's story has been co-constructed in narrative form to be included in the research report. Participants were requested to sign consent forms for the release of information pertaining to their participation (see Appendix C) once they had read, edited, corrected or made comments on the final summaries to be included in the research project.

A postmodern approach views knowledge from the perspective of the social processes through which it is created. From this perspective, knowledge is not considered to be the objective reflection of a single external reality, but as a social construction by people in their attempt to live together in this world. Kotzé (1994:32) states that, according to Gergen (1982) and Hoffman (1990), knowledge is negotiated meaning within the context of linguistic interaction. Anderson and Goolishian (1992:30) say "…meanings…emerge from the dialogue…and thus are co-created"; and "[the] circle of meaning, refers to the dialogical process through which interpretation begins". Interpretation of any literature, research findings or experience is therefore just as much a social construction as the literature or research itself (Kotzé 1994:32).

According to Denzin and Lincoln (1994:15), "the interpretative practice of making sense of one's findings is both artful and political". Kincheloe and McLaren (1994:151-152) also claim that critical researchers award credibility only when constructions are plausible to those who construct/ed them. In this study, the emphasis is not on my observations or interpretations, but on the specific meanings generated by the participants. Therefore my interpretations of the presented experiences *cum* narratives were subject to validation and editing by the participants themselves and presented separately as discussed in Section 3.6.

3.6 JOURNEYS AND COPYRIGHT

Kotzé (2002:20) suggests that narrative is a meaningful way to present and procure ethical ways of being with each other in a research setting: "Stories can carry the ethical wisdom of people across generations and different cultures in a way quite different from purely logically and rationally organised normative systems." Stories offer richer possibilities for guiding people's struggles to find ways of living, of establishing norms and boundaries suitable to their own lives, than moralising practices or pre-established systems of norms that we are supposed to adhere or refer to. Schwandt (1996:158 in Kotzé 2002:29) says: "We are coming to realise the power of rhetoric and of narrative and dialogue for understanding….As social scientists and teachers …we have a special obligation to put the use of stories to good service in our bid to understand ourselves and others."

The different ways of being in the world then led me to report the interviews in narrative format, to enable participants to use their own languages in telling their stories. These narratives can be found in Appendix E: "Narratives: A multitude of stories", as already mentioned. In presenting the narratives I wished to stand back as participant in the process since it is my belief that these are

"their" stories and that they should be respectfully presented as such. I did not want to de-center the clients (or participants, in this case.) In the postmodern paradigm we live our lives in and through our stories, and as such should be acknowledged as the authors – and the leading actors – of our stories. Even if I, as researcher, may be the reporter to the scientific community to which I belong, a person still stays the creator of his/her own life. This distinction demands an ethical stand acknowledging the participants as "having authorial 'copyright' to the use of his/her case data [journey]" (Chamberlain 1990:42).

I therefore "publish" the narratives separately and refer to specific vignettes during and throughout the following chapters, where applicable, as I would to any other official works. However, readers are urged to read and familiarise themselves with these narratives if they have not done so already, as they might not be able to contextualise the excerpts from the conversations without a fuller picture of the unique experiences and contributions of the participants.

CHAPTER 4

GENERATING DIALOGUE

The following discussions were based on the purpose and rationale of this study which was to argue the possible relevance of pastoral counselling in South Africa. The differences between pastoral counsellors and members of other mental health professions are explored. The possible contributions of pastoral work are explored against the background of the presumed limitations, ineffectiveness and inequities of present mental health delivery systems as well as the experiences of the participants. The main limitations of mainstream mental health professions are listed here in order to explore pastoral counselling as a possible national health resource with reference to primary health care, human rights and consumer rights, as well as the cost-effectiveness of pastoral counselling. The role that pastoral counselling can play in social change and reconciliation and a possible multi-cultural approach to counselling, are also addressed. Religion and spirituality in healing and recovery are discussed. Throughout this chapter, arguments are embedded in relevant theory and supported by vignettes from participants' narratives.

4.1 RELATIONSHIP IN DIFFERENCE: DIFFERENCES BETWEEN PASTORAL COUNSELLING AND OTHER MENTAL HEALTH PROFESSIONS

There are several differences between pastoral counsellors and other health professionals (http://www.aapc.org/nmhr.htm). First, pastoral counsellors are generally trained in two disciplines: psychology and theology. Pastoral counsellors are trained to address individual clients holistically in order to be able to assist them on a spiritual level as well as with daily concrete problems.

Second, in some cases, pastoral counsellors have more education than social workers, for example. So, for instance, pastoral counsellors at the Fellow level in the American Association of Clinical Pastoral Counselors (AAPC) have completed a three-year Master of Divinity programme, plus an additional degree or the equivalent of four years of graduate academic work. By comparison, licensed clinical social workers have completed a two-year Master of Social Work degree beyond undergraduate coursework (http://www.aapc.org/nmhr.htm).

In South Africa it is not uncommon to become a pastoral counsellor with an honours qualification in Social Work or Psychology, and a Master's degree or Doctorate in Practical Theology. Where a student holds a Bachelor's or Honours Degree in a different study field, such students are normally required to do a bridging course in theological disciplines of approximately one year at the Honours level before commencing with a Masters Degree. However, each case is decided individually upon merit, depending on the background of the student as well as the requirements of the university concerned (De La Porte 2003: pers. com. 02/10/2003).

There are a variety of courses in pastoral care and counselling, with the option of recognising hours of supervised counselling in line with the different categories for registration with the SAAP. At the University of South Africa (UNISA) the Bachelor's Degree in Practical Theology (BTh) in Advanced Counselling entails a four-module undergraduate counselling course with two modules of supervised internship. The main focus of this course is Narrative Therapy. It is aimed at registering students at the Advanced level (Category 5/6) of the SAAP categories. The Master's Degree in Practical Theology (MTh) and the Doctoral Degree in Practical Theology (DTh), in cooperation with the Institute for Therapeutic Development, can lead to registration at SAAP levels 7/8 (Hugo 2003:13). An integrated MTh in Clinical Pastoral Therapy to integrate psychology and theology which will also lead to registration at the Specialist level (Category 7/8) is presently proposed for implementation (Hugo 2003:14).

Clearly, various universities have different requirements and education pathways for pastoral work. In general, the standard Bachelor's Degree in Theology with specialisation during the third year leads to admission to ministerial services (De La Porte 2003: pers.com. 02/10/2003). In this case, students can sometimes choose to specialise in different pastoral therapies, such as the Kerygmatic, Fundamentalist, Charismatic, African, Client-Centered, Bipolar, or any other therapy suiting to their own belief systems and/or religious orientation. The latter pathway can also lead to registration at Level 3 of the SAAP categories with reference to pastoral counselling (De La Porte 2003: pers.com. 02/10/2003). Churches further also have their own educational programmes or theological schools with accredited degrees.

At present, the SAAP proposes the following categories for pastoral workers (SAAP Categories for Pastoral Counsellors 2002:1-2) as presented in Table 4:1: Categories for pastoral workers: SAAP (overleaf)

Table 4:1: Categories for pastoral workers: SAAP

CATEGORY 1: BASIC LEVEL PASTORAL COUNSELLOR (level 2)	CATEGORY 2: POST BASIC LEVEL PASTORAL COUNSELLOR (Level 3)	CATEGORY 3: INTERMEDIATE LEVEL PASTORAL COUNSELLOR (Level 4)	CATEGORY 4: ADVANCED LEVEL PASTORAL THERAPIST (Levels 5/6)	CATEGORY 5: SPECIALIST'S LEVEL PASTORAL THERAPIST (Levels 7/8)
Knowledge (a) General knowledge and experience of pastoral counselling (b) Listening skills (c) Empathy (d) Twenty (20) hours of practical pastoral counselling (e) Ten (10) hours of supervision	**Knowledge** (a) Relevant theoretical and practical knowledge of pastoral counselling (b) Listening skills and an emphatic understanding of the situation (c) Thirty (30) hours of practical pastoral counselling (d) Fifteen (15) hours of supervision	**Knowledge** (a) At least an advanced knowledge of one theory of pastoral counselling and a general knowledge of two other theories of pastoral counselling (b) Knowledge of the theory of pastoral counselling practices/ methods of the choice in (a)	**Knowledge** (a) In-depth knowledge of at least three theories on pastoral counselling (b) Detailed knowledge of the theory of a specific pastoral counselling methodology (c) Detailed knowledge of a pastoral counselling model	**Knowledge** (a) A Master's degree in specialised pastoral counselling
		Skills and experience (a) Ability to apply the above knowledge in pastoral counselling (b) Fifty (50) hours of practical pastoral	**Skills and experience** (a) The ability to apply and integrate the above knowledge in pastoral counselling (b) Seventy-five (75) hours	**Skills and experience** (a) One hundred and sixty hours (160) of practical pastoral counselling

		counselling (c) Twenty-five (25) hours supervision	practical pastoral counselling (c) Thirty (30) hours supervision (d) Minimum of 6 months (20 hours) related pastoral counselling experience, including 50 hours of pastoral counselling in addition to the above-mentioned hours	(b) Forty (40) hours of supervision (c) Proven ability to integrate pastoral and counselling theories in practice (d) Hundred (100) hours or one year of pastoral counselling-related experience
Nature of processes (a) Skills: Moderate in range (b) Procedures: established and familiar (c) Contexts: routine and familiar	**Nature of processes** (a) Skills: well-developed range (b) Procedures: significant choice (c) Contexts: Range of familiar	**Nature of processes** (a) Wide-ranging scholastic or technical skills (b) Considerable choice of procedures (c) Contexts: Variety of familiar and unfamiliar	**Nature of processes** (a) Wide-ranging, specialised scholastic or technical skills and basic research, across the pastoral counselling discipline (b) Wide choice, standard and non-standard procedures in the pastoral counselling discipline. (c) Highly variable and a variety of routine and non-routine	**Nature of processes** (a) Expert and highly specialised scholastic, and advanced research across the pastoral counselling discipline and interdisciplinary (b) Full range of procedures, advanced in the pastoral counselling/therapy discipline.

				Complex and highly advanced (c) Complex, unpredictable and highly specialised context
Scope of learning (a) Basic operational knowledge (b) Basic processing of readily available information (c) Problem solving: a range of known responses to familiar problems, based on limited discretion and judgement	**Scope of learning** (a) Some relevant theoretical knowledge (b) Interpretation of available information (c) Problem -solving: A range of sometimes innovative responses to concrete but often unfamiliar problems, based on informed judgement	**Scope of learning** (a) Broad knowledge-base incorporating some theoretical concepts (b) Basic analytical interpretation of information processing (c) Problem solving: a range of sometimes innovative responses to concrete but often unfamiliar problems, based on informed judgement	**Scope of learning** (a) Broad knowledge based incorporating some theoretical concepts and with substantial depth in some areas (b) Analytical or basic analytical interpretation of a wide range of data and information (c) A range of innovative responses to concrete but often unfamiliar problems, based on informed judgements and the determination of appropriate methods and procedures in response to a range of concrete problems with some theoretical elements	**Scope of learning** (a) Specialised and in-depth knowledge of a specialised and complex pastoral counselling / therapy discipline (b) The analysis, transformation, evaluation, generation and syntheses of abstract data and concepts at highly abstract levels (c) Creation of appropriate responses to expand or redefine and resolve abstract and existing problems

				and knowledge
Responsibility (a) Orientation of activity: Directed (b) Under general supervision and quality control of a qualified pastoral counsellor/therapist with at least a level 5 qualification	**Responsibility** (a) Orientation of activity: directed, with some autonomy (b) Application of responsibility: under general supervision and quality checking Significant responsibility for the quality and quantity of output, and possible responsibility for the quantity and quality of the output of others	**Responsibility** (a) Self-directed activities but under broad guidance and evaluation (b) Complete responsibility for quantity and quality of output, and possible responsibility for the quantity and quality of the output of others	**Responsibility** (a) Self-directed, and sometimes directive and managing processes (b) Application of responsibility within broad guidelines or functions and parameters for largely defined activities (c) Fully responsible for the nature, quantity and quality of output, and possible responsibility for the achievement of group output	**Responsibility** (a) Planning, researching, managing and optimizing all aspects of processes engaged in (b) Application of responsibility within broad and complex parameters and unpredictable functions and context (c) Complete accountability for determining, achieving, evaluating and applying all personal and/or group output

Learning pathway	**Learning pathway**	**Learning pathway**	**Learning pathway**	**Learning pathway**
(a) Education pathway: Senior secondary study beyond entry level (b) Training pathway: Training towards certification in pastoral counselling skills.	(a) Education: continuing secondary study (b) Training: training towards certification in skilled pastoral counselling occupation	(a) Entry to undergraduate or equivalent higher education (b) Training towards certification in occupation characterised by advanced pastoral counselling skills	(a) Education: Continuing and completion of undergraduate or equivalent higher qualification and entry to honours, master's or equivalent higher education (b) Training: Training towards certification in pastoral counselling and therapeutic occupations. Subsequent completion of professional certification, and entry to professional practice and/or managerial position in the pastoral counselling occupation	(a) Education pathway: Academic leadership. Entry to doctoral and further research education, and to research-based and advanced research-based pastoral counselling occupations (b) Training pathway: Professional practice and/or senior managerial pastoral counselling occupations
				Research (a) Either a research paper, a paper read at a conference or an article in a research journal

Third, pastoral counsellors are not medical doctors and may not prescribe medication. In situations where a pastoral counsellor believes medication can be helpful, the client is referred to a psychiatrist, a medical doctor who specialises in treating mental, emotional and behavioural disorders. In most cases, therapy continues with the pastoral counsellor and the psychiatrist supervises the client's medication. This is just one of the places where the different professions can assist each other. Pastoral counsellors do not make clinical diagnoses or recommend any treatments. They aspire in their approach to be non-judgmental of their clients' beliefs, their cultural background and their physical, mental, economic and social status. If there is a desired outcome, it is to develop spirituality (Brown 1998:377).

Pastoral counsellors possess a depth of training that might be significantly beyond that of many other mental health professions. Pastoral counselling is a discipline which maintains the natural connection between the physical, mental, and spiritual dimensions. It is now recognised across the mental health field that this connection fosters a sound and lasting foundation for treatment of the whole person (Benn 2001:140-141). Various scientific studies indicate that there is evidence for a correlation between spirituality and health. These studies show that faith and religious (spiritual) practices are effective in preventing and treating a variety of diseases and disorders. These studies also indicate that spirituality extends life expectancy in general and that specific religious attitudes and practices are especially effective (Benn 2001:140-141).

The problems presented by care seekers to pastoral/spiritual counsellors, are in many cases the same problems which would be presented to another type of counsellor (a psychologist or social worker): loss, grief, guilt, meaninglessness, alienation, injustice, addiction, depression, violence, aging, and death, to name but a few (Application Draft for the Establishment of a Professional Board 2002:7).

Marelize (Neethling & Van der Westhuizen 2003:XI-XVIII) came to counselling out of guilt and the loss of a belief system. Derrick (Neethling & Du Toit 2003:III-X) needed help with aggression and cannabis addiction. Bakela (Neethling & Motlathegi 2003:XIX-XXII) struggled with violence and abuse; while Sarah (Neethling & Mothlabi 2003:XXX-XXXIV) originally visited her pastoral counsellor for trauma, only later addressing her marriage and gender discourses that influence her life negatively. Ilze (Neethling & Schoeman 2003:XXIII-XXIX) needed help with accepting her alternative lifestyle and sexual orientation, as well as with her relationship with her God. In most of these "cases", however, problems were addressed via spirituality as the participants saw it, rather than by utilising modern medicine or clinical diagnoses.

Though pastoral and spiritual work has a lot in common with the work of other "helping professions", it has unique dimensions not addressed in these professions. Pastoral work falls within the social sphere, because it deals with the vital connections between religious belief-systems and religious communities. In South Africa, as a developing nation, many people are caught between the dilemma of identification (group and community commitment) versus differentiation (striving for individual autonomy). Pastoral and spiritual work, because it embraces both dimensions from the perspective of the community of faith, has a unique opportunity to resolve this dilemma. The focus of pastoral work is therefore not primarily the "troubled" individual, but the individual-society nexus (Application Draft for the Establishment of a Professional Board 2002:7).

It is my belief then that the unique dimensions and attributes of pastoral and spiritual work, as explored above, can address some of the limitations of standard therapies, as set out in Section 4.2 and also throughout the rest of this chapter. Difference is not separateness – it is relationship (Becvar & Becvar 1996:357). By defining physical health and mental health differently, we risk upsetting the balance necessary for each of the "parts" necessary for such health and thus of the whole. The postmodern assumption that man, or woman, is a holistic being, suggests that there is a relationship – there cannot not be a relationship.

By incorporating the relationship between spirituality and health then, pastoral counselling acknowledges a vital "ingredient of health". This relationship also seemed important to the participants in this study. In support of the integration of spirituality with counselling, of spirituality and health, Derrick said:

> *I think one should not separate the "spiritual from the worldly". I already stated I believe all humans are essentially spiritual, what with having a soul and all. And if the body and soul is inseparable, then therapy should address both, right? Or one should have at least the choice to decide whether they want to explore the so-called spiritual realm as well.*
>
> (Neethling & Du Toit 2003:IX)

Sarah also believes that religion should be incorporated into the counselling process:

> *When people go for counselling I think they should talk about religion as well. It can help because you base everything on religion. Religion is part of your life and*

then it should be part of counselling as well. They go together: religion and counselling. The problems you encounter everyday is of the spirit also. Because of my experience I think there is place for pastoral counsellors in South Africa. It can make a difference because it can give people Hope.

(Neethling & Motlhabi 2003:XXXIII)

4.2 LIMITATIONS OF MAINSTREAM MENTAL HEALTH PROFESSIONS

For this study, I have identified several areas as relevant to pastoral counselling in South Africa. One of them, the integration of spirituality with "health", has been mentioned in Section 4.1 above. As this "conversation" progresses, it is, however, left to the reader to make his/her own interpretations and judgments, as I am punctuating from my own biased perspective.

According to Keeney (1984 in Moore 1997b:564), the term "punctuation" refers to the activity whereby events or experiences are organised in a particular way. What we know and can know, are based on the distinctions we make. The differences we perceive, make the difference, and determine the kinds of relationships or patterns we see. The idea of different possible punctuations therefore also underlines the existence of different realities.

In the following sections, I mostly use the concept "mainstream mental health professions" or "mental health systems" to refer to psychiatrists, psychologists, and/or other social or mental health workers who function mainly from a modernist, positivist, traditional epistemology. Once again, I approach this concept from my own postmodern perspective, without implying, however, that my perspective is the only one.

In South Africa large numbers of people with psychological problems and too few people who can help are only some of the reasons underlying the need for the development and professionalisation of pastoral counsellors. Pretorius-Heuchert and Ahmed (2001:23-24) summarise the mental health professions in South Africa at present as follows:

- The elitist and exclusivity of mainstream services many people, due to financial problems and inaccesability (see Section 4.5).

- There are not enough physical and financial resources to ensure the provision of help to the whole population (see Section 4.3).

- Too few people with problems seek help from traditional mental health systems for various reasons, such as a lack of accessible services, too few black psychologists, language and cultural barriers, inappropriate interventions or methods, or societal norms that lead to psychological services, being perceived as irrelevant or inappropriate (Sue, Sue & Sue 1994:585). In many cultures it is more acceptable to consult a "spiritual leader" such as a pastoral counsellor, than to consult a psychologist (see Section 4.4).

- Traditional mental health services function on a waiting basis, rather than a seeking and preventing basis (see Section 4.3).

- A need for intervention in the larger system is indicated (see Section 4.3).

- Prevention, rather than remediation, became a priority after democratisation (see Section 4.3).

- Traditional mental health services further provide inefficient, ineffective, and inappropriate services (see Section 4.6 as well as Section 4.8).

According to Sue and others (1994:585), the search for alternative approaches to traditional mental health care has been stimulated by a lack of sufficient professional personnel to meet needs on a one-to-one basis, dissatisfaction with present approaches, the high cost and ineffectiveness of psychiatric hospitalisation, and especially inequities in the delivery of mental health services.

The relevance of mainstream psychotherapy in particular is debated in a South African context as these theories originated in the cultural setting prevailing in Europe around 1890 to 1930, and it reflects the scientific views of that time as well as the moral standards, in particular, of its middle and upper classes. The cultural and moral values of a new South Africa are quite different (Meyer 1997:96-97). Furthermore, it can be argued that most personality theories prevalent in mainstream psychology were developed according to white male standards and development. This point receives further attention in the discussion of the relevance of pastoral counselling as a possible multi-cultural approach, in Section 4.8.

Seedat, Cloete and Shochet (1988:43) refer to Brown (1978), Reiff (1968), and Mann (1978) when they say that societal factors such as apartheid, oppression and poverty are starting to show up as the main causes of psychological problems and stressors, not neurobiological dysfunctions. According to them, traditional psychologies largely ignore the role of external socio-eco-political factors in the construction of human problems, following an individualist orientation that locates pathology solely within individuals.

South Africa has also, until quite recently, been characterised by greater need, fewer resources and fewer progressive psychologists to work for change. According to Berger and Lazarus (1987 in Pretorius-Heuchert & Ahmed 2001: 25), the system of apartheid compromised the mental health of all South Africans, including whites, in particular in the professional training and practices of psychologists and other health professionals.

Rappaport (1981 in Seedat, Cloete & Shochet 1988:48) agrees that psychology provides an impressive theoretical framework for transference in individual therapy but no systematic theory, of intervening social change as needed. It is true, though, that the field of psychology has attempted to develop a more "relevant" psychology in South Africa during the 1980's and 1990's especially in the form of especially Community Psychology. However, Seedat (1990 in Pretorius-Heuchert & Ahmed 2001:27) claims that certain problems still remain. Most professionals are white and middle class and there was, and possibly still could be, a silence around issues related to racism, political violence and collective action.

Doubts about whether psychologists can develop a relevant community praxis in a new South Africa have then already been addressed in my research curiosity (Section 1.2). Bulhan (1985:272) argues the impossibility of psychology in black or other marginalised communities, which could also be another way of simply extending the medical gaze, a mechanism of the production of desire and hence of social control (http://www.mpaterson.co.uk/ foucault.html), as I mentioned as part of the curiosity that informs my research. Bulhan (1985:272) claims that the hierarchical patient-relationship in individual therapy as practised by psychologists is suffused with the inequities, non-reciprocity, elitism and sadomasochism of the oppressive social order as experienced in South Africa. What is needed in such situations is a mode of intervention that bridges the separation of insight and action, internal and external, individual and collective. "The oppressed are economically and socially too pressed to wait indefinitely for an insight apart from lived realities" (Seedat, Cloete, & Shochet 1988:47).

In view of the above arguments, I thought it might be helpful to ask participants in this study about their views and experiences of the power/knowledge relationship between them and the pastoral that counsellor they consulted. I hoped that a more participatory, power-sharing approach would deconstruct the hierarchical power relationship, enabling clients to participate more freely with the counsellor.

Derrick was not comfortable with the way he was "treated" by mainstream approaches:

> *I visited some psychologists and each and every one had a different "cure" for me … I felt like an incompetent idiot, sitting there in the consulting rooms. As if I was being judged. I seldom went back more than twice to a specific psychologist. Why? I didn't like it there. I already mentioned it made me feel stupid. I felt as if I failed miserably as a human being. Now I needed somebody else to tell me how to live and save my life from totally going down the drain?*
>
> (Neethling & Du Toit 2003:V)

Derrick found pastoral counselling more deconstructive of the power relationship:

> *So I was pleasantly surprised to find that this therapy consists out of talking and speaking, just like normal people having a conversation. I never once felt that I was being judged. I was comfortable, and actually found that I enjoyed going there. I could be myself. She treated me as an equal rather than as someone with a disease.*
>
> (Neethling & Du Toit 2003:VI-VII)

He added, regarding the differences he experienced between pastoral therapy and mainstream approaches:

> *What I had to say was important. If I have to pinpoint exactly what had made the difference, I would say it was the things she did not do, rather than what she did do. I was not interrogated. I was not dissected. She did not make me feel as if there was something wrong with me, rather she sympathised about the things that*

had happened to me. Nor did she tell me what to do with my life, but left it up to myself to find the answers I was looking for, to make my own choices.

(Neethling & Du Toit 2003:VII)

I cannot really say psychology is bad for you, I do not know enough about that. But I liked the way the pastoral therapist talked with me. And let me talk. It felt like a journey, and as if I was acknowledged as a human being for once. I was given back my self worth.

(Neethling & Du Toit 2003:IX)

Ilze also preferred the equal relationship between her counsellor and herself to the hierarchical power relationships of mainstream approaches:

This therapist listened to my story. She was interested in hearing about me and what I had to say. I also found no difference in the power position between myself and her; meaning I never experienced an attitude of "I am the therapist and you the patient" (… "therefore you have to listen to me" – such as when with a psychologist, in my experience). Her policy was that she had no patients, only clients. Therefore you do not feel inferior when you knock on her door for help. This helps you to build esteem and respect for yourself.

(Neethling and Schoeman 2003:XXVII)

Closely related to Foucault's view of knowledge/power, Bruce Levine also links mental illness and the drugging of rebellious tendencies (http://www.lipmagazine.org/articles/feattalvi_141.html). In his new book, *Commonsense Rebellion: Debunking Psychiatry, Confronting Society,* author and clinical psychologist Bruce E. Levine (2001) (http://www.lipmagazine. org/articles/ feattalvi_ 141. html) tackles the prevalence of psychiatric disorders and the tide of prescription drugs prescribed for those disorders head-on. The societal emphasis on viewing mental disorders as diseases akin to diabetes or cancer is not only deeply flawed, Levine argues, but dangerously diversionary. He insists that the real issues underlying rising levels of mental suffering have much more to do with omnipresent and warped societal expectations than the psychiatric industry would care to admit. He frames such "illnesses" themselves as a rebellion against what he calls an "increasingly

impersonal and coercive institutional society" (http://www.lipmagazine.org/articles/feattalvi_141.html).

Ilze was also subjected to "damaging" societal expectations and guidelines for her life:

> *I still have to work very hard at not letting social discourses rule my life. I was so scared that people would not accept me, that I later (almost) conformed to societal standard just not to be rejected. I often feel torn between two worlds: the one I live in right now, which is considered "normal" in society; and "abnormal" accordng to society – but the one I want to live. True to the person I really am.*
>
> (Neethling & Schoeman 2003:XXVII)

Levine (2001) sees fundamental flaws in the ways that mainstream psychology treats those who grapple with mental suffering, pressuring them to return to "normal":

> The ultimate invalidation is to look at some kid who is refusing to pay attention or behave well, and not respect that there's something by way of rebellion and resistance going on there, and then to 'medicalise' it and then to drug it. [It's] no accident that the greatest growth in diagnoses and in our population of people on drugs [have to do with] kids and teenagers. One of the reasons is that there's more and more pressure on kids to conform and comply.
>
> (http://www.lipmagazine.org/articles/feattalvi_141.html)

The fact that Ilze also received medication in order to "normalise" her, supports Levine's argument:

> *This however was not the biggest reason for my depression! ... I was desperate for help and ended up visiting a clinical psychologist twice a week who simply fed me a variety of anti-depressants... actually my depression was caused by being gay. Its implications, rather. I needed help to cope with it and to accept it. But things did not work out this way and nothing was accomplished by my visits.*
>
> (Neethling & Schoeman 2003:XXIII)

4.3 PASTORAL COUNSELLING AS NATIONAL HEALTH RESOURCE AND PRIMARY HEALTH CARE

The presumed limitations of the present mental health care delivery systems in South Africa as explored above (Section 4.2) have led to the marginalisation of some people and groups in terms of accessible mental health care, whether it might be due to race, geography, discriminatory practices, financial reasons and other causes. This void has eventually given birth to the development of primary health care systems.

For the purpose of this study, I have accepted the definition of primary health care as defined in the Declaration of Alma Ata:

> Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in a community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.
>
> (Gilbert, Selikow & Walker 1996b:183)

The primary health care approach can be traced back in its applications to low-income countries with the aim of making general health care available and accessible to all citizens, regardless of income level or status (Pillay & Lockhat 2001:97). The New South Africa has also committed itself to supplying access to quality, as well as equal, health care to all its people (Gilbert et al 1996b:181) in line with the stipulation of the World Health Organisation (WHO) (1978) that quality care should be made accessible to all members of the community at affordable cost (Pillay & Lockhat 2001:97). It also affirms, as a matter of societal responsibility, that mental and emotional illness must be covered on the same basis and to the same extent as physical illness. It has been demonstrated that equitable coverage of mental and emotional illness results in lower utilisation of costly physical health care (http://www.aapc.org/nmhr.htm). A lack or inadequate mental health care means that many people go without the treatment they need or that they will receive inappropriate, costly and unnecessary treatment that is covered under a health care system.

Primary health care, however, does not only aim to deliver a cheaper, simpler approach to health care. Nor does it simply mean basic health interventions. Previously health care was centered

around health professionals where the community was a passive recipient. Health professionals alone were the dispensers of health, inadvertently contributing to the perpetuation of lingering colonial attitudes and racist or discriminating habits of relating (Griffith & Griffith 2002:179). This is changing with the focus on community participation (Gilbert et al 1996b:183), which I believe resonates well with pastoral care approaches where caregivers and counsellors presumably function at a local level and at professional levels, as well as with a postmodern approach of participation where communities of concern are utilised in health and healing. Engaging the voices of such communities also assists in balancing power in the therapy relationship (Griffith & Griffith 2002:179), as discussed in Section 4.1.

Non-western cultures in Africa, Asia and Latin America have already demonstrated the importance of the community in the promotion of health (Benn 2001:144-145). Here the individual is rooted in the community much more firmly than in Western cultures. This insight is the basis for the concept of community-based health care, which has been accepted as the primary foundation of health care, particularly in developing countries, including South Africa. This type of care means that health is the primary responsibility of all people living in a community. The support or social networks and help, knowledge and skills people can offer each other, are the key factors leading to improved health (Benn 2001:144-145).

Placing responsibility for health in the hands of the community is closely linked to the concept of the relational self (Gergen 1991:147) as discussed in Section 1.2. In this sense, I propose that "autonomous health" gives way to health immersed in interdependence, in which it is relationships that contribute to the success of health and healing.

This sense of community is reflected in Bakela's explanation of his many children:

> *I have a wife and plenty children. Not all of them are mine. Some belong to my sister. After she died of Aids I had to raise her children since I am the oldest of our brothers and we always take care of each other. It is our culture to take care of family.*
>
> (Neethling & Motlathegi 2003:XIX)

Even if it may still be so that a consciousness of relational selves is not yet widely shared in Western culture (Gergen 1991:157), there already seems to be an unconscious awakening to and

recognition of these types of relationships and support. As example, Ilze bemoaned the lack of such a "relational" support system:

> *Nobody seemed interested in hearing what I wanted to say. And nobody seemed to care about the pain I was going through… The worst of it all was that…people you would expect to stand by you and support you did not do so.*
>
> (Neethling & Schoeman 2003:XXV)

Marelize also experienced the "relational need" when she could not carry her burden alone anymore, supporting the notion that health is immersed in interdependence:

> *But I needed to talk to someone. This has finally become too much for me to bear on my own.*
>
> (Neethling & Van Der Westhuizen 2003:XV)

The primary (mental) health care approach functions at three preventative levels:

- Primary prevention is an effort to lower the incidence of new cases of behavioural disorders by strengthening or adding to resources that promote mental health and by eliminating features of a community that threaten mental health, for example the implementation of interpersonal, social, problem-solving or skills-training programmes (Sue et al 1994:588).

- Secondary prevention is an attempt to shorten the duration on the problem and to reduce its impact by early detection and treatment, therefore preventing it into developing into a more serious and debilitating form, for example, alcohol abuse programmes, suicide hotlines, lifeline, and so forth (Sue et al 1994:590).

- Tertiary prevention attempts to facilitate the readjustment of the person to community life after hospital treatment for mental disorders/problems, thereby reversing the effects of institutionalisation and providing a smooth transition to a productive life in the community, for example, "passes" from hospital, public education, halfway houses, night hospitals (Sue et al 1994:592-593).

Primary health care also refers to front-line health care that can be accessed in the case of any health problem. In South Africa, this includes district hospitals, health clinics or traditional healers (Pillay & Lockhat 2001:96). Once incorporated in the professional stream, pastoral care workers (mutual care and pastoral care in terms of Section 2.1) can be considered part of this level. Pastoral care workers at these levels can be considered paraprofessionals, people who are taught by professionals to provide some mental health services (emotional support and so on), but who do not have extensive formal mental health training (Sue et al 1994:593) such as required for registration as "professional" pastoral workers at the higher SAAP levels (see Table 4.1). The advantages of such para-professionals are that they develop intimate knowledge of and experience in the community itself which can assist them in understanding clients and their environment. They also do not typically trigger the reluctance of many clients to enter therapy due to distrust, suspicion or other reasons.

Secondary level care refers to care generally provided by relatively more specialised providers for cases that cannot be managed at the first level, such as general hospitals, guidance clinics, and specialist welfare services (Pillay & Lockhat 2001:96). Depending on the level of accreditation with reference to the various categories of registration at the SAAP as described in Table 4.1, some pastoral counsellors already do function at this level, such as the pastoral counsellor Sarah visited at the Kalefong Hospital:

> *I took my children to see a pastoral counsellor at the Kalefong Hospital after we had an armed robbery at the house.*
>
> (Neethling & Mothlabi 2003:XXX)

She was aware that the hospital offered counselling services, and after visiting a clinical psychologist she preferred an alternative:

> *I have not even told him this yet, but I have been to a clinical psychologist before…I was not very happy with the treatment I received… I did not want to go back to them because they have a different way of doing things and I did not feel comfortable there.*
>
> (Neethling & Mothlabi 2003:XXXI-XXXII)

Tertiary level care occurs at a provincial level and is often provided in academic hospitals with highly specialist staff and facilities. Referral to this level occurs mainly from the secondary level. The emphasis is on a consultative, highly specialised approach that keeps in-patient care to the minimum. Follow-up treatment and rehabilitative care is usually rerouted to secondary or first care levels (Pillay & Lockhat 2001:96). Pastoral counsellors functioning on this level will have to be registered at levels 7/8 of the SAAP categories (Tabel 4.1).

In the United States, pastoral counselling is already recognised as a national health resource in the public's preference for a spiritually-oriented modality of treatment, as demonstrated by a 1992 Gallop poll (http://www.aapc.org/nmhr.htm; De Jongh van Arkel 1999:90). According to this survey, 66% prefer a professional counsellor who represents spiritual values and beliefs, and 81% prefer to have their own values and beliefs integrated into the counselling process. No such survey has been conducted in South Africa as yet (or could be located for the purpose of this study).

Sarah also prefers counselling which integrates spirituality and values into "everyday" life:

> *Religion is part of your life and then it should be part of counselling as well. They go together: religion and counselling.*
>
> (Neethling & Mothlabi 2003:XXXIII)

Most religious leaders, however, do not have the time or the specialised training in counselling and (psycho)therapy to do extensive, in-depth work such as needed for crisis or follow-up consultations. Since government-sponsored systems and programmes for healthcare are under threat, the time is ripe to consider how pastoral programmes and public health might intentionally collaborate with each other (Couture 1995:65). Both primary care and pastoral care are re-evaluating and moving beyond the "medical model" followed by mainstream professions, emphasising what individuals and communities can do to improve their own health status in line with a focus on prevention rather than cure by experts (Couture 1995:68-69). Pastoral care and counselling can help public health develop more realistic ways of approaching religion and health; public health in turn can draw from established practices of pastoral care and counselling to guide public health in creating effective methods of helping people transform their lives (:70). Working in an interdisciplinary fashion is also not new to either pastoral counselling or public health.

Integrating into public health then broadens that partnership, expanding resources available for health: "Care becomes care in and through all of society" (:78-79).

Some people also prefer professional pastoral counselling separate from "church" counselling, like Marelize:

> *I did not want to visit a minister of the church. I still feel uncomfortable in the house of God, or in any of the so-called holy places.*
>
> (Neethling & Van der Westhuizen 2003:XV)

Far too often, individuals or groups are disillusioned by their own faith communities (Couture 1995:70).

It is my sincere belief, therefore, that professional pastoral counselling in South Africa could represent a vast national resource for community mental health services, both therapeutic and preventive. This is because religious communities are still one of the principal gateways for those seeking relief from human suffering, including mental and emotional illness, drug and alcohol abuse, family conflict, depression and suicide, child and spousal abuse, juvenile delinquency, and other societal problems of our day (http://www.aapc.org/nmhr.htm).

In the United States pastoral counselling has now become a major provider of health services, accounting for over three million hours of treatment annually in both institutional and private settings, offering individual, group marital, and family therapy (http://www.aapc.org/nmhr.htm).

4.4 HUMAN RIGHTS AND CONSUMER RIGHTS

According to De Jongh Van Arkel (1999:103), pastoral counselling as a unique helping profession has been legally marginalised thus far to such an extent that the process can be rectified only by a counterprocess of responsible professionalisation. Furthermore, for pastoral counsellors to respond unconditionally to those who are in need, means maximising its accessibility to all. If pastoral work becomes integrated into the national health resource and primary health care systems, especially as discussed in Section 4.5 below, it becomes even more important for their services to be available to anyone, regardless of race, religion or creed (http://www.aapc.org).

Derrick agrees that pastoral counselling should be available to everyone:

> *I think everybody should be able to visit a pastoral therapist or whatever when they experience problems. Or have the option to. People have rights man. I myself will definitely make use of pastoral therapy again, if the need arrives. Why doesn't the Government just give them the status or profession or what it is you call it? They can help people.*
>
> (Neethling & Du Toit 2003:IX)

Accessibility, availability, and accountability are especially important in South Africa. Health issues are now, more than ever, also issues of social justice and peace, of values in respect of human life and dignity, and of the striving for "wholeness" which includes spirituality. The need for care of the marginalised increases daily, as is shown by the societal devastation accompanying the AIDS pandemic (De Vries 2001:149).

Mental health services unfortunately seem to have a poor track record for their discriminatory and unresponsive quality of services to members of minority groups and especially the poor (Sue et al 1994:584). As example, Sue (1971 in Sue et al 1994:584) shows that, in the United States an analysis of the community mental health system based on nearly 14 000 patients (clients) indicated that minority group patients tend to drop out of therapy after one session at almost twice the rate of white patients. Discriminatory and unresponsive quality of mental health services to members of minority groups and especially the poor can also be seen in South Africa, as discussed in Section 1.2 and Section 4.2.

Heitink (1998:212) claims there is less resistance in societies to pastoral work and a great demand for different forms of spiritual care in the mental health field, presumably due to the already mentioned gap in the mental health system. There is an enormous amount of suffering, pain and problems in our society, compared to the few trained counsellors (therapists, psychologists) available. The demand for well-trained pastoral counsellors to address this gap in the mental health system is enormous (De Jongh van Arkel 1999:90) especially with the new focus on spirituality. Every person has the right to achieve optimal health (Gilbert et al 1996b:182), as is implied in the South African Bill of Rights, Act 108 of 1996, Section 2.27:

1. Everyone has the right to have access to -

(a) health care services, including reproductive health care;
(b) sufficient food and water; and
(c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.

2. The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of those rights.

3. No one may be refused emergency medical treatment.

(Republic of South Africa 1996:13)

A healthy population is also necessary for social and economic development (Gilbert et al 1996b:181). Denying a society the right to choose service providers of their choice in any health care delivery system is also denying them the right of freedom: freedom, I believe, which has been struggled for during the previous regime and has been guaranteed in a new South Africa. Denying any community the right to choose pastoral counselling instead of mainstream mental health care services is also denying them this freedom.

In this regard I would like to refer to discussions and dialogue regarding the possible professionalisation of traditional healers. The vast majority of African South Africans seek help within the framework of traditional African mental health systems. They do not perceive Western practitioners as offering treatment responsive to their needs (http://www.shr.aaas.Org/loa /sector.htm). The Pan African Council (PAC) has already expressed its view that African people have the right to express their value systems unhindered, and as traditional healing and African culture are inseparable, traditional healers should be given the same status in society as healers from the modern health sector (Freeman 1992:80).

The same argument can be applied to pastoral counselling. As counselling and spirituality are deemed inseparable, and people have the right to express their value systems unhindered, why are pastoral counsellors not given the same status and opportunities in society as mental health professionals from other sectors?

The South African people have sought and embraced the principle of freedom of choice for many decades. This should, I feel, be carried forward to our right to select providers of our choice in any health care delivery system, especially with regard to culturally and religiously relevant services:

> Persons belonging to a cultural, religious or linguistic community may not be denied the right, with other members of that community, to enjoy their culture, practise their religion and use their language; and to form, join and maintain cultural, religious and linguistic associations and other organs of civil society.
>
> (Republic of South Africa 1996:15)

Denying pastoral counsellors the right to practise their trade professionally, can also be considered or interpreted as opposing the South African Bill of Rights, Act 108 of 1996; Section 2.22:

> Every citizen has the right to choose their trade, occupation or profession freely.
>
> (Republic of South Africa 1996:10)

Furthermore, it is important that political parties seriously consider the future of all mental health practitioners so that the health of all citizens will benefit and clients can be protected from malpractice. It is my personal opinion that consumer rights should also entail the right to obtain ethical, accountable and responsible services. One of the rationales for this study then was also that prospective clients might also benefit from this study if it can be used as an argument to assist in the registration of pastoral counsellors to regulate and control services (counselling) rendered to the public.

The danger of uncontrolled services is addressed by Sarah:

> *I think there is a place for pastoral counsellors in South Africa. It can make a difference because it can give people hope. Sometimes it can be dangerous, it depends. It should not be in the form of a sermon. People are sensitive about religion. As long as it does not become an occasion where people preach to you and try to convert you to their specific way of believing it will be good to speak about spirituality in counselling too.*

(Neethling & Mothlabi 2003:XXXIII)

Marelize also believes clients of counsellors should be protected against malpractice:

> *I do not know enough about pastoral therapy to judge whether it should receive professional status in South Africa. But based on my experience this far, I cannot see why not. I know enough about people to know that you cannot really generalise (although I still do so myself at times) so I would guess you would get good pastoral therapists as well as bad pastoral therapists. If I had connected to one who might have judged me, or tried to convert me, it would have hurt me more than it would have healed me. So I would say professionalising them will at least control the profession and establish codes for conduct. Protect the clients.*

(Neethling & Van der Westhuizen 2003:XVIII)

Ilze also warns against unethical and uncontrolled services after a particular negative experience with a so-called pastoral counsellor:

> *I definitely believe that pastoral therapists can contribute to the health sector, but then the person has to know what he/she is doing. Not everybody who believes themselves to be good therapists are good therapists.*

(Neethling & Schoeman 2003:XXVIII)

Unfortunately, in any profession there are also some who abuse their knowledge and power. Using a postmodern paradigm which focuses on consequences of the deeds done *to* people, it is also my belief that not all approaches are beneficial to the receiver. Ilze, for example, was previously subjected to exorcism under the guidance of a charismatic pastoral counsellor:

> *This time I was subjected to an exorcism. For two hours he attempted to exorcise the demons responsible for my problems. It was a terrible experience…one I do not want to repeat or relive.*

(Neethling & Schoeman 2003:XXVI)

Religious teachings here are based on “hellfire and brimstone prophecies” and function from the belief that all problems are directly related to sin or to the possession of an evil spirit which has to be exorcised.

Women functioning under fundamentalist teachings, in particular, often do not do well because they have internalised the notion that they are inferior to men which contributes to ongoing abuse and sexual exploitation, according to Karren Baird-Olson, K-State assistant professor of Sociology (http://www.spub.ksu.edu/issues/v100/sp/n146/cam-native-american-Liveng.html), who is researching the spiritual beliefs of women on reservations and how these spiritual beliefs help them cope with discrimination, domestic violence and substance abuse. In Sarah’s case, for instance (Neethling & Motlhabi 2003: XXX-XXXIV), it might be argued that both her religious and cultural context might have contributed towards her accepting her husband’s adultery and her inferior position in the household. Such religious doctrines encourage power inequities toward women and children, and such inequities lead to abuse, whether physical or emotional. Christian doctrine emphasises submission and teaches that the exemplary Christian is to follow like a sheep, which is how the words "become as little children" (Matthew 18:3) is interpreted (http://www.ffrf.org/articles/pedo1992.html).

Fundamentalist teachings are also linked to the abuse of power and trust in congregational counselling (fffrf.org/articles/pedo1992.html), which might be another reason why Marelize (Neethling & Van der Westhuizen 2003:XI-XVIII) preferred not to seek help from her parish. In her case, even the most respected and upstanding citizens were at some stage her customers, which further corrupted her trust in humans and religion.

Ilze was also severely hurt by and disappointed with the treatment she received from her church when she sought help and understanding:

> *I had to appear in front of a church commission who decided that, if it is not possible for me to follow certain "rules” as decided by them, if they decided in my favour, I would have to resign and leave the community…I was not even given the opportunity to defend myself properly.*
>
> (Neethling & Erasmus 2003:XXV)

Churches are not necessarily able to police themselves and are often in the news regarding malpractice, often in the regard to the sexual abuse of women and children in counselling situations. A survey of United States pastors during 1993 (http://www.freejesus.net/home /viewtopic.php?t=914), revealed that 14.1% of ministers surveyed admitted to "engagement in sexual behaviour which was judged by the individual pastors to be inappropriate".

The hierarchy of, for example, the Catholic Church also insists that each diocese must make its own policies and determinations. The clergy, whose role includes pastoral counselling, are trusted and sought after for confidences and guidance. Yet being a pastor is no guarantee of having had professional training, not even necessarily a degree, much less professional counselling licenses, or the academic credits. Furthermore, churches do not necessarily have the knowledge or abilities to monitor the pastoral counselling services provided to the congregation. In order to "cover up", they also sometimes hide crimes committed by their counsellors. In 1990, Auxiliary Bishop A. James Quinn of Cleveland told a conference of canon attorneys to consider hiding crimes by sending files on priests accused of child molestation to the Vatican Embassy in the District of Columbia, which he maintains is outside the reach of the U.S. Courts. "If there's something there you really don't want people to see, you might send it off to the Apostolic Delegate," said Quinn (http://www.ffrf.org /articles/pedo1992.html).

In summary, human rights should include the right of freedom of choice and access to services supportive of people's individual cultural and religious orientations. They should also include the right of pastoral counsellors to practise their profession legally. Furthermore, when powerful cultures meet, syncretism or an integration of world views is often the better way. Both African and Western patterns of treatment have much to offer. The same goes for traditional mental health approaches and pastoral counselling. There are models of successful integration in various societies. So, for example, the health of the Chinese people improved under a system able to integrate traditional and modern treatment systems. Indeed, the World Health Organisation has called for dialogue toward integrating health care (http://www.shr.aaas.org/loa/sector.htm). With its rich, culturally-grounded systems of healing, South Africa too may find in this strategy a key to the provision of urgently needed care for its wounded. South African citizens have the right to a mental health system which is responsive and respectful to their individual needs, which includes the right to integrate spirituality in the counselling process.

I have to stress that I am not implying that the narrative pastoral counselling approach, which I myself am working from, is above corruption or malpractice as mentioned. The above

conversations and experiences illustrate and underline the necessity for pastoral counsellors, whether they function independently or as part of a congregation, to be accountable to a uniform professional board in order to protect prospective clients' rights and well being. It is my personal opinion then that all individuals also need to be afforded the right of protection against malpractice as mentioned above, especially if South Africa considers health issues to be entwined with issues of social justice and peace (De Vries 2001:149).

4.5 COST EFFECTIVENESS

The cost effectiveness of services rendered is another component of primary health care in its attempt to make services accessible to everyone. The ability of consumers to choose pastoral counsellors for mental health services could have a positive impact in terms of cost-containment because of the relatively low cost and high accountability of pastoral counselling (http:www.aapc.org). Pastoral counselling represents a paradigm for primary health care in line with the present South African focus of prevention (see Section 4.3), including the emphasis on affordable care.

From the perspective of community prevention, early and easy access to pastoral counselling centered on the family and church-based or other referral services will provide people with early intervention before an illness or a problem becomes chronic and/or resistant to treatment. The accessibility of pastoral care and assistance appears to be in line with the promise of the Department of Health to challenge the face of health care in the country by providing affordable and accessible service to the majority of people who have not had it before (Sidley 1995:116).

The affordability of pastoral counselling is also linked to promises of more affordable (and sometimes free) care, as was the case with Derrick:

> *It was free. Otherwise I would not have been able to afford it. I had no money for such things.*
>
> (Neethling & Du Toit 2003:VI)

Marelize also claimed:

> *Visiting a psychologist, however, would have meant spending a lot of money, and questions afterwards which I could ill afford.*
>
> (Neethling & Van der Westhuizen 2003:XV)

Ilze also believes that

> *…it would be fantastic if pastoral therapists could receive professional status, especially if they could work through medical funds. That way they can reach more people. It is because of the affordability especially of the narrative pastoral therapist, that I was able to visit her…psychologists are simply too expensive.*
>
> (Neethling & Schoeman 2003:XXVIII)

In South Africa at present, pending new tax laws on medical fund contributions, the rapidly escalating costs of services as well as the high cost of belonging to medical funds, will continue to limit people's access to mainstream quality mental health services (FedHealth Newsletter 2003:1). It is my informed belief then that access to health services might become even more of a problem in the future as third-party payments become less available. The pressure mounts to find solutions that will not leave poorer patients and the uninsured without the quality services they need.

Pastoral counselling is one of the most cost-effective modalities of treatment in the field of mental health in the United States. One factor that makes this possible is the willingness of pastoral counsellors to work at modest salaries, compared to other mental health professionals (http://www.aapc.org/nmhr.htm). The not-for-profit orientation of pastoral counselling centers and the decreased overhead costs, especially when working in partnerships with congregations, also contributes to this cost-effectiveness. It is the prevailing ethic of pastoral counselling that every effort is made to treat everyone, regardless of their ability to pay.

It might, however, be argued that people are allowed to receive pastoral counselling via a congregation. Churches are a natural community gateway through which millions of persons pass each week and through which a wide spectrum of mental health and societal problems are dealt

with, many of which are amenable to early intervention and treatment. Why then would pastoral counsellors need a professional board and recognition?

The economic situation in South Africa is also strongly reflected in churches and their priorities, which has a negative influence on the amount of counselling provided by spiritual leaders. Churches are cutting back on "luxuries" and anything beyond what is classified as basic is considered a luxury. Churches cannot provide the medication or extensive therapy or hospitalisation that some people might need (Couture 1995:65). A specialised ministry which could include counselling is therefore under threat (De Jongh van Arkel 1999:92).

In addition to church settings, it must be mentioned that pastoral counsellors also provide outreach preventative services in hospital settings, in prisons, at the universities, in the military, and in primary and secondary schools. However, according to publication of the Medical, Dental and Supplementary Health Service Professions Amendment Act, Act 89 of 1997 (Republic of South Africa 1997), these pastoral counsellors may now be seen as working illegally. They would be able to continue in their functions only if professionalisation succeeds (De Jongh van Arkel 1999:90). Sarah (Neethling & Motlhabi 2003:XXX-XXXIV) was able to obtain services from a pastoral counsellor in a hospital setting only. If the counsellor she visited, however, is legally prohibited from practising, his services would not be available to any other people in distress, further marginalising people such as Sarah who would like to receive help.

At present, training and education for pastoral counsellors is also freely available. They are however, not able to claim a legal income from their counselling services if these are practised outside a congregational set-up, a situation which could be considered unethical in itself. Most churches cannot afford specialised services any more (De Jongh van Arkel 1999:92), which limits possible congregational job opportunities for pastoral counsellors. Why then should expensive training be provided for people if they are not allowed to practise the profession?

Yet another point to consider is the protection of clients against malpractice. Such ethics have already been discussed in Section 4.4. Is it ethical to allow pastoral counsellors, whether in or separate from a congregational set-up, to work without a uniform body to which they all are accountable? What about a professional board for pastoral counselling which in turn is accountable to its members?

Professionalising pastoral counselling could furthermore contribute to revenue. Legalising the profession and allowing pastoral counsellors to earn a legitimate income, would mean that such an income can be regulated and taxed.

In view of the above discussion, I believe pastoral counselling is a discipline consistent with the goals of managed care, providing quality service with preventative care, working with the total person, and producing cost-effectiveness. Provider processes involved in patient care such as an utilisation review, cross-disciplinary co-operation and referral, goal-oriented continuing education, on-going quality improvement, and operational efficiency have long defined the proficiency processes of pastoral counsellors. In an era when managed care is assuming an ever-growing role in the present pluralistic health care delivery system, and at a time when the majority of clients prefer to be treated by a professional counsellor who represents spiritual values and beliefs, the services of pastoral counsellors should be made available in all possible managed care settings (http://www.aapc. org/nmhr.html). I would therefore argue that pastoral counselling could be a valuable national health care resource in South Africa. It should be integrated into the national health care delivery system as that system is being reshaped to make it more responsive and accountable to the needs and desires of the South African people. There is clear evidence that the spiritual element in pastoral counselling can be effective, non-invasive, relatively risk-free, and needs minimum resources. It can be utilised to support medical and surgical procedures and aid recovery from illness. In particular, it can produce significant savings in medical care (Brown 1998: 376).

4.6 SPIRITUAL TALK

There seems to be a need for a more culturally sensitive approach to the classification and diagnosis of mental health problems (http://www.tnet.com.au/~attfield/mental%20health.htm). The tendency has often been to ignore or psychopathologise spiritual experiences, classifying mystical experiences, for example, as symptoms of ego regression, borderline psychosis, psychotic episodes or temporal lobe dysfunctions. According to Lukoff, Francis and Turner (1992 at http://www. tnet. com.au/ ~attfield /mental%20health.htm), this approach has often shown an insensitivity to the religious and spiritual dimensions of culture that are "among the most important factors that structure human experience, beliefs, values, behaviours and illness patterns". Spirituality here refers to the transcendental relationship between a person and a Higher Being or Power, going beyond religious affiliation.

As an example of this type of spirituality, Marelize sees her own spirituality as more than institutionalised religion:

> *My spirituality is [now] more than religion. Maybe it is taking religion and building your own beliefs within or around that religion, to something more and larger than the religion itself. It could be that it is building a personal relationship with God, rather than following the prescribed ways of how to believe, unquestioningly.*
>
> (Neethling & Van der Westhuizen 2003:XVI)

Spirituality and religion, as in Sarah's case, are often seen as the same (Brown 1998:377). Even if academics or those involved in healing make a distinction between the two, it is not the case with all people. Sarah said:

> *My religion is my spirituality, because it is part of my life always and not only when going to church.*
>
> (Neethling & Mothlabi 2003:XXXIII)

Derrick also struggles to differentiate between religion and spirituality:

> *So… we started discussing religion. Only, she kept calling it spirituality. I got the idea that spirituality means more than religion. I am struggling a bit with this one, but it is beside the point (to me it is still the same as the religion thing but I know now it means different things to different people).*
>
> (Neethling & Du Toit 2003:VII)

Yet at the same time Derrick also acknowledges a broader conception of spirituality:

> *I cannot say I am a good Christian, for that I do not visit the church enough or read my Bible enough. But I do believe in a higher power than myself. And for me my spirituality then lies in the belief in this power which guides me in my actions and thoughts, whether they be right or wrong according to others.*

(Neethling & Du Toit 2003:III)

In the history of the theory, research and practice of psychiatry, however, there has been a view that religion [spirituality] is associated with psychopathology. Freud viewed religion as a "universal obsessional neurosis", while Behaviourism and the empirical experimental approach focused exclusively on observable behaviour (Viljoen 1997c:39). Sociology offers yet another view on religion. Marx viewed religion as the “opium of the people” (Giddens 1993:464). Religion in this sense teaches the resigned acceptance of existing conditions in this life, diverting attention from inequalities and injustices by the promise of what is to come in the afterlife. Marx, Durkheim, as well as Weber, viewed religion as an illusion and thought that the significance of religion would decrease in modern times (Giddens 1996:463). Marx was not dismissive of religion though. He also considered religion as “the heart of a heartless world” - a haven from the harshness of daily reality (Giddens 1993:464). In this sense, his view on religion and thus spirituality can be interpreted as acknowledging the importance of spirituality in the daily existence of people.

Is it a possibility then, that it could be considered morally irresponsible to ignore the spiritual side of humanity as doing so might dehumanise and demoralise? Marelize acknowledged the detrimental influence of ignoring her spiritual side:

> *But this thing with God was eating at me, slowly, a cancerous thing. The body eating itself…is that not what cancer is? My spirit eating away at my body…*
>
> (Neethling & Van der Westhuizen 2003:XV)

In this regard, Derrick also questioned the division between body and soul:

> *I would like to know why we have been taught that the body and soul are separate. My experience now is that the two are inseparable. If only I had realised this at an earlier stage of my life, I might have been able to fight back earlier. I mean, my every day life is spiritual, if that makes any sense.*
>
> (Neethling & DuToit 2003:IX)

Weber has also argued that religion has often produced dramatic social transformation (Giddens 1996:467). He was certainly correct in emphasising the unsettling, and often, revolutionary impact

of religious ideals on pre-established social orders. The relevance of pastoral counselling to social transformation and reconciliation is addressed in Section 4.7.

Durkheim, on the other hand, emphasises above all the role of religion in promoting social cohesion (Giddens 1996:465). Social cohesion and community participation have been addressed in Section 4.3 with reference to the relational self.

Recent studies have shown that, although (religious) psychopathology may occur with the seriously mentally ill, for most people religiosity is associated with mental health (http://www.tnet.com.au/~attfield/mental%20health.htm). Jung and Maslow also regarded mystical experiences as a sign of health and transformation (Viljoen 1997c:39).

According to Jung (1958a:24 cited in Viljoen 1997a:132)

> Just as man, as a social being, cannot in the long run exist without a tie to the community, so the individual will never find real justification for his existence, and his own spiritual and moral autonomy, anywhere except in an extramundane principle capable of relativizing the overpowering influence of external factors. The individual who is not anchored in God [Lord, the Other] can offer no resistance on his own resources to the physical and moral blandishments of the world.

Sarah explained her religion as an "anchor" in her life, claiming that this is where hope and strength to endure comes from:

> *And he gives you hope in your heart to face the problem[s].*
>
> (Neethling & Mothlabi 2003:XXXIV)

She also sincerely believes that

> *…It [religion/spirituality] gives you hope…It is someone to trust, to like, to keep you going…hope is there and in your heart and it is doing something for you. Hope just makes you go on with your life because you have got hope.*
>
> (Neethling & Mothlabi 2003:XXXII)

Marelize also found her anchor in spirituality:

> *Discussing my spirituality in therapy was probably the best thing we could do. Therapy gave it a safe place to be born again. My problems were prevailing over my spirituality, now my spirituality is starting to prevail over my problems. They cannot be there at the same time. And as long as I can hold onto it, I will have the power and courage to fight the problems. Therefore, I am glad to have discovered that my spirituality is still part of my life. I do not know why I expected it to be something separate. It is easier to live life with God in my life every day and not only, for instance, when occasionally reading the Bible. It gives me something to hold on to.*
>
> (Neethling & Van der Westhuizen 2003:XVI)

Maslow's holistic approach also stresses integration as opposed to dichotomous thought. He acknowledges that for some people religious life is so deeply and authentically experienced that it must be placed at the level of self-actualisation (Moore 1997a:452-453). After his experiences in the Nazi concentration camps during World War II, Victor Frankl, a Jewish psychiatrist and the founder of Logotherapy, also accentuated spirituality as a crucial factor to help people find meaning in life. He believed that humans are primarily motivated by a will to meaning (Shantall 1997: 529). "Man's heart is restless unless he has found, and fulfilled, meaning and purpose in life" (Frankl 1969:31 quoted in Shantall 1997:533). Frankl regarded spirituality as one of the answers to an existential crisis and concluded that the loss of meaning was the most existential crisis of our age (Benn 2001:146).

In support of the above argument, Derrick (Neethling & Du Toit 2003:VIII) claims that *"without meaning, there is nothing to live for."* He was only able to effectively confront his problems once he started utilising his spirituality as support system. This example links closely to Viljoen's (1997b:647) argument as discussed in Section 1.2, that one of the problems South African people seem to be constantly confronted with is the destruction of a solid religious [spiritual] base.

According to Nigel Copsey (2001 in Petit-Zeman 2001:s.p.), an ordained minister and resident of London's east end, religion "is inextricably bound with culture, and as fundamental to the lives of many minority [and other] ethnic communities as food and drink. Faith communities are the most significant group within the local population. People understandably become suspicious when the

secular and spiritual are separated". The western psychiatric models, however, traditionally exclude spiritual dimensions and overlook the significance of religion and spirituality in people's lives. Indeed, in many cases, Copsey found that faiths attribute what British society would describe as mental illness to "spiritual sickness" (Petit-Zeman 2001:s.p.).

Derrick's success in standing strong against his addiction by utilising his spirituality provides support for comments by Christopher Ringwald (2002), who recently published a broad ethnographic study in which he describes the role of spirituality in a number of addiction programmes (http://www.human-nature.com/nibbs/02/ringwald,html). In his book, he demonstrates how addicts recover through practices such as self-examination, meditation, prayer and reliance on a self-defined higher power. Going as far back as the Washingtonian Total Abstinence Society in 1840, Ringwald explores the use of spirituality within a wide range of treatment options – from the famous Twelve Step-style programmes to those tailored to the needs of addicted women, Native Americans, or homeless teens not ready to quit. Ringwald (2002:6) sees spirituality as beliefs that lead to values through personal verification. He contrasts spirituality to religion in that he sees religion as a set of beliefs about the cause, nature and purpose of the universe, especially if the world is considered to be the creation of a superhuman agency/s, usually involving devotional or ritual observances and often containing a moral code for the conduct of human behaviour. Spirituality, again, can exist outside institutionalised religion. For the non religious however, spirituality might be the search for a power, cause or being that is within our reach but beyond our grasp. For addicts, drugs or alcohol then become a counterfeit spirituality and rather than seeking "escape" from a harsh world per se, addicts are usually seeking God or serenity or a spiritual life: "Addicts discover the cure for their symptoms in substance abuse…trying to satisfy the hunger of the heart" (Ringwald 2002:13).

Ringwald's argument seemingly receives further support when Derrick says:

> *Originally I thought it spiritual to be in a different place after smoking. Everything looked better. The world, and people too, was a beautiful place.*
>
> (Neethling and Du Toit 2003:V)

Vicky Nicholls, a researcher at the Mental Health Foundation's "strategies for living" project in the United Kingdom, also claims that their research has found that religious beliefs are important to many people with mental health problems (Petit-Zeman 2001:s.p.). She claims that they have

looked in depth at how religious and spiritual beliefs and practices are sustaining and supportive. The situation according to her is complex, because some people have negative experiences with religious communities.

Ilze struggled to identify with the rejection of an "Unforbidding God" as pushed upon her by her religious community:

> *I so badly wanted to feel his love, but people always made me understand that he would not be able to love me especially since I am gay.*
>
> (Neethling & Schoeman 2003:XXVIII)

> *When going to church, people openly stared and discussed me behind cupped hands. Whispering and pointing. It was quite plain that anybody who did not conform…had no part, no breathing rights, in this community. The worst of all was that so-called Christian people, people you would expect to stand by you and support you, did not do so…There was no place for people like me…I became an outcast from the community as well as my church. Nobody was worried that my world was collapsing around me. Never in my whole life have I come so close to committing suicide…*
>
> (Neethling & Schoeman 2003: XXV)

Positive findings on the other hand include giving a sense of purpose and meaning to life, peace and comfort, inner spirituality, the support of others and their personal experience or sense of the presence of God (Petit-Zeman 2001:s.p.).

When Ilze started to build her own relationship with her chosen God, she started to find healing and meaning in her life:

> *So, step by step, I dared to approach his feet again with my imperfect little face full of tears…since I have discovered that he accepts me, things are going much better! … God touches me even in the most difficult times of my life…*
>
> (Neethling & Schoeman 2003:XXVIII)

The question is this: how can spiritual experiences be accepted and understood within the area of mental health? Currently the medical model is still the mainstay of psychiatric theory and practice, while treatment or therapy is determined by the diagnosis of the psychiatrist or psychologist. Organically oriented psychiatrists, for example, may prescribe electroshock therapy for neurotics, while psychologically oriented psychiatrists may use psychotherapy with psychotics. Surely it is not appropriate for a patient to be prescribed medication and labeled schizophrenic simply because the psychiatrist does not accept the concept of spiritual emergency? (http://www.tnet.com.au/~attfield/mental%20health.htm).

In view of the arguments thus far, I would propose that at present spiritual needs and concerns are still very much divorced from accepted mental health training and practice. The perception is often that spiritual matters are the concern of the church and not relevant to psychiatry or psychotherapy.

According to Aldridge (1991), however, the old order of spiritual healing occurring only in church and not part of "medicine" is now being challenged (Brown 1998:373). If we then separate religious from spiritual concerns and acknowledge that spirituality goes beyond the boundaries of religion, matters of a spiritual nature could be addressed by professionally trained spiritual (pastoral) health practitioners, with the care and delicacy required to be careful not to encroach uninvited into the beliefs of the client. The mental or social health practitioner's role then is to approach the subject of the mind from a scientific perspective, while the pastoral counsellor's approach should entail a caring, understanding and human science perspective while co-operating with the inner healing forces (spirituality) of the client. It is my belief that pastoral counsellors are trained as mentioned and fulfill the requirements to address health at this level.

4.7 SOCIAL CHANGE AND RECONCILIATION

Referring back to Durkheim's emphasis on the role of religion [spirituality] in promoting social cohesion (Giddens 1996:465), as mentioned in Section 46, as well as the discussion of community participation in Section 4.3, perhaps one of the most important contributions to social change pastoral counsellors can make in South Africa is to help develop a sense of community in a country steeped in decades of conflict and animosity. With reference to the relational self and interdependence (Section 1.2 and Section 4.3), in particular, this sense of community, I believe, should include developing the perception of similarity to others, an acknowledged interdependence by giving to, or doing for others what one expects from them and the feeling that

we are part of a larger dependable and stable structure. The importance of a sense of community is vital for the promotion of [mental] health (Benn 2001:144).

One aspect of social change that deserves attention entails inequality amongst South African people. Pastoral counsellors are not interested in addressing oppression and inequality purely for the sake of repentance for a past colored with apartheid, but rather because inequality threatens a sense of community as mentioned above and also appears to do consistent and profound damage to health. Richard G. Wilkinson (http://human-nature.com/nibbs/02/kohn.html), one of the leading interpreters of inequality research, puts it bluntly: "Inequality kills". The costs of inequality are not confined to health. Homicide and violent crime are also higher where the range of incomes is wider. At bottom, according to Richard Wilkinson, it is a matter of trust: Health and harmony are nurtured by trust, the thread of social cohesion. A society rich in social capital, measured by indices such as the strength of civic associations, is likely to be a healthy society. A society rich in material capital, but short of social capital, is likely to be unhealthy. One of the central foci of pastoral counsellors then is the focus upon the relations within a society, and the effects of these relations upon the well-being of individuals and communities (http://human-nature.com/nibbs/02/kohn.html).

In Neethling and Motlathegi (2003:XIX-XXII), Bakela expressed his dislike for white people for what they have done to his people. However, after building a relationship of trust with his pastoral counsellor and exploring how he would feel if people simply judged him by the colour of his skin, or especially by how he beat his children, he admitted:

> *This woman then asked me if I think the white and black people understand each other better now that they have stopped fighting and started to talk… I said I think so but I still don't like white people very much. But if the rest of them are like her I may have been wrong about them. Just a little bit. She laughed and said I may feel that way but she hopes we can talk about it… she asks do I think I want people not to like me only because I am black or beat my children, or do I want people first to talk and understand me before they see if they like me or not. I think I want them first to talk to me. So maybe I will first talk to the white people and then see if I like them or not.*
>
> (Neethling & Motlathegi 2003:XXI)

Bakela also stated:

> *White people are not so bad anymore. I start to think that some of them you can trust.*
>
> (Neethling & Motlathegi 2003:XXII)

Sarah also thinks reconciliation and change can be brought about by sharing stories of struggling and survival:

> *Talking to a white person about my story … now is not like they see anything different about you or you about them. But it is a long way still for black and white people to understand each other. We have a lot of work in this country still. Maybe if we share our stories, it will help people to understand each other better.*
>
> (Neethling & Mothlabi 2003:XXXIV)

Deconstructing the traditional power relationship between counsellor and client in particular can also assist in addressing equality and a new relationship between different cultural groups, as discussed in Section 4.2. Narrative pastoral counsellors such as the one Bakela visited follow a not-knowing, power-sharing (participatory) approach respectful of the client's local knowledges. Bakela acknowledged this respect:

> *I started to enjoy going there because she was always respectful of me. She treated me like the head of the house and always listened to what I wanted to say. So I think I respect her because she respects me.*
>
> (Neethling & Motlathegi 2003:XXI)

Respectful relations can also go a long way towards reconciling gender differences, especially in the context of opposing traditional beliefs:

First I did not want to do it because then everybody will know that I went to see a woman for my problems … And now I also think it is not so bad to talk to a woman because sometimes they can make you see things you do not see before.

(Neethling & Motlathegi 2003:XXII)

4.8 A MULTI-CULTURAL TOUCH

After witnessing Sarah and Bakela's experiences in counselling, such as explored above (Section 4.7), I am more convinced than ever that in South Africa, the delivery of culturally and spiritually appropriate services can no longer be regarded as optional. Health services need to reflect our country's diversity, moving away from linear, traditional psychological services that in many cases are not applicable to the majority of cultures in the country. Health services should respond holistically to the specific needs of people from all religious, spiritual and cultural backgrounds, supporting them during and after treatment; they should offer people receiving mental health care a befriender from their own background, as well as contact with their own faith group in the community (Petit-Zeman 2001:s.p.).

In my original research questions (see Section 1.2) I have wondered whether the inclusion of spirituality does not add a multi-cultural touch to pastoral counselling which makes these services possibly more relevant to our multi-cultural country. Mbiti (1989:2) states that the daily functioning of Africans is fundamentally a religious functioning. I then mentioned that utilising the dimensions of faith, spirituality, religion, culture and values in the lives of people might follow a more inclusive practice than conventional psychology, which could allow pastoral workers to acknowledge the spiritual domain in the lives of our South African people.

Sarah explained her spirituality as follows:

My religion is my spirituality, because it is part of my life always, not only when going to church… spirituality which is living your whole life ever yday with Him and not only when we need Him. … you base everything on religion. Religion is part of your life…

(Neethling & Mothlabi 2003:XXXIII)

Because of this fundamental, daily religious functioning, Sarah then also believes that religion (spirituality) should form part of counselling:

> *So when people go for counselling I think they should talk about religion as well. It can help because you base everything on religion. Religion is part of your life and then it should be part of counselling as well. They go together: religion and counselling. The problems you encounter every day are of the spirit also. Because of my experience I think there is place for pastoral counsellors in South Africa.*
>
> (Neethling & Mothlabi 2003:XXXIII)

In Neethling and Motlathegi (2003:XIX-XXII), a traditional psychologist might have brought to the conversation explanations of personality traits or previous childhood abuse, together with scientific guidelines for behavioural change. Bakela's problem, however, highlights the tension between traditional cultural beliefs and alternative functional (effective) ways of relating:

> *I was very confused. I do not understand this law. How will I make the children listen to me or respect me if I cannot beat them?*
>
> (Neethling & Motlathegi 2003:XX)

Most psychologists trained in the late twentieth century pursue a professional identity of an applied scientist (Griffith & Griffith 2002:173) who would value foremost a scientific understanding of Bakela's "sickness". Such a psychologist very likely would most probably utilise the "best" scientific "facts" and convey these to his client. Treatment would be organised by these scientific principles. Yet following this route of action would not have opened up possibilities of dialogue relationship and understanding, which also acknowledges local wisdom and knowledge on the client's part or utilise his natural support systems.

Most traditional psychological theories further are developed against a European background and are limited in their application to African cultures (Meyer 1997:96-97). Viljoen (1997b:622) refers to Ruch and Anyanwy (1981), Pasteur and Toldson (1982) and Sogolo (1993) when he says that Africans, in contrast with Westerners, rely more on intuition and emotion in their cognitive functioning than on pure rationality. This difference is an offshoot of the different views of

humankind that underlie behaviour. By implication, Cognitive Therapy, for example, might not be effective in African therapeutic contexts as it is anchored in the Cartesian reification of reason in terms of Descartes' maxim "I think therefore I am" (Viljoen 1997b:622), as opposite to the African maxim of "I am because we are; and since we are therefore I am" (Viljoen 1997b:620).

Cognitive therapies share an emphasis on the priority of changing cognitions as the key to bringing about changes in patterns of dysfunctional emotional reactions and symptomatic behaviours. Cognitive therapies, however, are based on a limited model of mental functions that must sometimes be supplemented by broader psychodynamic, socio-cultural or other concepts if lasting changes are to occur (http://mentalhelp.net/poc/view_doc.php?type=news&id=34117). It is also a commonplace that there are historical and cultural factors that have precipitated the development of such therapies and that not all cultures have engaged in. Which cognitive factors are important, and to whom? (http://human-nature.com/nibbs/03/stjernberg.html).

Bitter and Corey (1996:474) view psychoanalytic therapies in general as not applicable to clients in particular lower socio economic classes. Meyer (1997:88) agrees that even if psychotherapy is still used in Western countries, it is a protracted and expensive process used chiefly in affluent communities. Bitter and Corey (1996:474), therefore, seriously question the application of psychotherapies to different ethnic and cultural groups due to their focus on intra-psychic explanations, whereas Africans function from a meso-cosmos level where behaviour is explained with reference to supernatural beings and powers that influence and determine human behaviour (Viljoen 1997b: 619). The psychoanalytic model also stresses biological and instinctual factors rather than social, cultural and interpersonal ones (Bitter & Corey 1996:474).

Yet it is the law that took away Bakela's manhood, not something inside him or something that he has done:

> *The court now takes away my power as the man in the house. They make me a woman. Now the children can do what they want and I can not stop them.*
>
> (Neethling & Motlathegi 2003:XX)

The South African situation is made more complex by the context of previously marginalised groups who have been disadvantaged with regard to educational upbringing, in particular the

older generations. Bakela never had an opportunity to finish primary education. When comparing Bakela's story with the stories of the other participants, it especially underlines the already mentioned arguments regarding the applicability of mainstream therapies to all ethnic groups. I do not argue though that exceptions might occur, as the mental health professions deal with individuals: people differ even within specific cultures. Nor do I contest the validity and usefulness of standard therapies. However, I have to question whether psychoanalytical or other Western approaches would have been of assistance to Bakela.

Instead, when following a not-knowing approach instead of applying "scientific guidelines" for mental health care, opportunities for understanding and dialogue may develop:

> Not-knowing requires that our understandings, explanations, and interpretations in therapy not be limited by prior experiences or theoretically formed truths, and knowledge.
>
> (Anderson & Goolishian 1992:28)

Bakela said:

> *What she did good was to respect me … She also give me plenty time …white people does not always understand that black people see time a different way. Most white people never have time and always run for time while the black people like me make time for what we want to do. White people never listen because they don't know how to make time. So it is good she gave me time because now I think she understands the black people and if she understands she must respect us.*
>
> (Neethling & Motlathegi 2003:XXII)

The above vignette also focuses the attention on the different ways cultures view time. Time for an African is not a mathematical concept, but is instead associated with the natural rhythm of the universe. Mibiti (1990 in Viljoen 1997b:623) points out that in Western society time is seen as a commodity that can be bought and sold, because time is seen as "money". Africans see time as something that has to be created and produced. Africans are not enslaved by time, since they create time to suit themselves. Westerners seldom understand this difference, which may lead to misunderstandings between people from different cultures. In this regard the approach of pastoral

counselling might be more applicable to multi-cultural use. According to Viljoen (1997b:624), the African view of time also struggles to accommodate the notion of a future orientation, as expressed in the notions of Western psychological theories.

Sarah also mentioned the time difference in pastoral counselling:

> *The pastoral counsellor worked together with me and gave me time. It was nothing like "ok, next!" He could communicate and listed, and he cared...This is something that bothered me with the psychologist. I had the feeling that it was just another job to him, that counselling was only business [money wise] to him, nothing else. But here at the pastoral counsellor I was never rushed. I had the feeling I was important and no matter how long a session took, he never made me feel that this was a business transaction.*
>
> (Neethling & Mothlabi 2003:XXXII)

4.9 CODA

To summarise this chapter, in Section 4.1 some of the differences between pastoral counselling and other mainstream health professions were explored and illustrated to familiarise the reader with the characteristics and categories of pastoral work. In particular, the integration of spirituality with counselling, or rather the holistic approach to man (and woman) as spiritual beings, were central.

In Section 4.2, I highlighted some of the limitations or problems of mainstream mental health professions at present. I also focused on the relationship between the counsellor and client, and the participants' views and experiences of the power/knowledge relationship between them and the pastoral counsellor they consulted. The mentioned limitations of the present mental health care systems, namely inafordability of quality service, the lack of relevance of (white) mainstream psychotherapies in South Africa, the lack of a present systematic theory of intervening where social change is needed; and the limited numbers of progressive psychologists who work for change gave impetus to an exploration of whether pastoral counselling can be integrated in the primary health care systems of South Africa (Section 4.3).

Human rights and consumer rights were explored in Section 4.4. It was argued that the right of consumers to select providers of their choice in any health care delivery system, and in any

system of national health insurance, is generally a universally articulated desire and is especially relevant to South Africa, where freedom in general has been struggled and fought for. I have also argued the right of clients to be protected against possible malpractice by a uniform professional board to which pastoral counsellors should be accountable, whether they practise independently or as part of a congregation.

The cost-effectiveness of pastoral counselling was explored in Section 4.5. I have argued that pastoral counselling could be a valuable national health care resource in South Africa, especially with regard to affordability.

In Section 4.6, the importance of the spiritual dimension of health came to the fore again. I proposed that at present spiritual needs and concerns are still very much divorced from accepted mental health training and practice and that pastoral counselling could address this gap.

The relevance of pastoral work to social change and reconciliation was explored in Section 4.7. In view of the forth going discussions, I argued the possibility that pastoral counselling could contribute to social change and that the building of a secure and stable society by helping to develop a sense of community in a country known for apartheid and violence.

Last but definitely not the least, in Section 4.8 we took a look at pastoral counselling as a multi-cultural approach. Health services need to reflect our country's diversity, moving away from the linear Western psychological services that might not be applicable to the majority of cultures in the country. I then suggested that the inclusion of spirituality might add a multi-cultural touch to pastoral counselling which makes pastoral services possibly more relevant to our multi-cultural country, especially when dealing with cultures whose daily functioning is primarily spiritual.

CHAPTER 5

COMMITMENT TO THE CONVERSATIONS

What assists us greatly in acknowledging people's experiences and in evaluating research conducted is the use of reflection on our participation in these processes. These reflections are always taken seriously, but also open possibilities for alternatives (Kolberg 1999:14). By committing ourselves absolutely to the conversations we have conducted, we also subscribe to accountability and transparency towards participants as well as readers and the scientific community. In this chapter I hope to render my involvement as transparent as possible. I also summarise and reflect on the goals originally set for this study, and to what degree I have managed to fulfill them. Finally, I reflect on some of the possible problems and limitations of this study from a positivist point of view, without subscribing to its underlying principles, as I believe any researcher should be aware of possible criticism which might come from the different scientific communities. Further motivation for this (seemingly inconsistent) decision, however, will be given in Section 5.3.

5.1 A LOOKING-GLASS UNIVERSE

Steier (1991 in McLean 1997:115) suggests that research from a postmodern position becomes a narrative of self-reflexivity so that we come to understand and become aware of our own research activities as "telling a story about ourselves". Becvar and Becvar (1996:334-335) also state that in the new physics, the characteristics of that which is being researched do not appear to be independent of the observer [researcher]. Accordingly, the observer and the observed influence each other and the activity of scientific study changes that which is being studied. This has been referred to as a "looking-glass universe". This "universe" then requires self-reference, as the conclusions we draw in research and the "facts" we discern, are a consequence of the distinctions we draw based upon our own epistemological premises (Becvar & Becvar 1996:76).

I bring to the context of myresearch my own epistemology. I bring to my research a history of injustices and oppression, of being a white woman in a predominantly white male community. As a pastoral counsellor I also bring to this research the presupposition that pastoral work is relevant in South Africa, as well as my mission to assist attempts at changing present social structures denying pastoral services the right to obtain professional status in this country. During this process, it also became a burning issue and mission to change social structures which denies

individuals the right to equal services and health, and the right to live their lives effectively the way they prefer.

Criticising mainstream psychology or other mainstream mental health professions, as I did in Section 4.2 and especially in Section 4.8, was by no means an attempt to slander or undermine the various mental health professions. On the contrary, I am quite fond of some. I merely wished to argue possible limitations in order to explore the relevance of pastoral counselling with regard to the current mental health professions in South Africa. These mental health professions, to the best of my knowledge, contain valuable information and contributions for every individual's own life and may help people to develop their abilities and help them understand themselves and others.

During the course of this study it became increasingly clear to me that not all approaches are applicable to everyone, since these theories have different implications, depending on the emphasis or motivation, personality or developmental theories, or other aspects. I am only now starting to realise fully the limitations of "all" approaches – the realisation that humans are such complex beings that few theories, if any, would ever do them justice, and that I personally really have no option but to work from a "not-knowing" perspective when dealing with people. Anderson and Goolishian (1992:28) see the therapeutic [or research] conversation as a process striving towards what is "not yet known" and not asking questions to which we want specific answers. According to Freedman and Combs (1996:44), this implies asking questions not generated from pre-understanding, but questions generated from a genuine curiosity about the individual's unique answers. This implies acknowledging his/her local experiences and local knowledges. The individual is considered to be the expert on his/her own life experiences. The not-knowing perspective therefore creates a climate within which an individual may have the experience of being heard, confirmed and accepted. Anderson and Goolishan (1992 in Kotzé 1994:52) say it creates a readiness to explore multiple perspectives, and at the same time endorse the co-existence of various perspectives. The relativity of meaning itself comprises a change in perspective.

Operating in a postmodern paradigm, I also have to acknowledge the reciprocal influence between the researcher and the participant. In terms of social construction, people are shaped in and by language in relationship with others. Hence, it follows that the researcher is a participant in that which is observed. Furthermore, all assertions become self-referential in that I am making them based on my own epistemological premises (Becvar & Becvar 1996:76-77), as mentioned

above. Assertions are therefore paradoxical in the sense that I cannot know them as true in any absolute way, and their truth exists only as I choose to punctuate reality. This kind of paradox is inevitable in any process of research inasmuch as any research project includes the researcher.

In this research journey, I hope I have acknowledged the influence of my own subjectivity. My own distortions and biases are inevitable (one can never escape oneself). What I hoped to accomplish was to also render my own assumptions and agenda as transparent as I am able in order for the reader to draw his/her own conclusions.

Hollway (1989 in Tefanis 2001:5;8) argues that in order to separate opinion from analysis, the researcher's experience needs to be imbued with theory. Part of this study is to reflect on and to take the above into account. Tefanis (2001:9) further refers to Ople (1992) and Wetherell and Potter (1992) when he suggests that this can be accomplished by applying selected techniques or offering enough descriptions so that the reading can be accepted or modified by the reader.

My conversations with the participants were opportunities to learn more about the problems they were facing. It is one thing to read case studies and articles on human problems; it is another to witness their destruction first hand. In "Hope in my heart", I struggled with the weight of the oppression of cultural expectations and discourses of "how to be a woman". In "I can see now", I was disempowered by the realisation that we live in a country which still adheres to physical violence as *the* solution to a problem. I was rendered voiceless in "Step by step" as part of a society which marginalises and ostracises people for being different to prescribed expectations and norms, while in "Standing strong against aggression and cannabis" I could not help but bemoan again a society which creates such rigid norms and expectations that men and women should adhere to, to their own detriment.

I could not have predicted the process of change that occurred as time went by and a story line developed through an interview/s. As the plots unfurled and thickened, I was privileged to witness processes of healing taking place over a couple of weeks, during our conversations or correspondence. Little nuances, little changes from one conversation to the next indicating a change in the status quo. A flickering of a hope long forgotten or courage was kindled and sparked again. What never failed to surprise me was the hope spirituality offers people in their resistance to the problems they have been sucked into and their courage in opposing the effects of these problems in their lives. The growth of spirituality, it seems, has many functions. For people with limited or few other resources, spirituality appears to provide a source of energy and

sustenance that enables them to confront the myriad tasks associated with "living life on life's terms" (Green, Fullilove & Fullilove 1998:330). A relationship with a higher power provides a process for finding meaning in often incomprehensible situations. Far from being an abstraction, it becomes a daily presence in the individual's life (Green et al 1998:331).

I also simply stood amazed at how participants seemed to find new meaning in having an opportunity to share their stories with others, at how reliving and revisiting those stories, could actually contribute to a thicker script, more fitting of their potential and ideals. I found it spiritual in itself, to be the "perturber" of a story rather than an "agent of change". When a client chooses to enter into a therapeutic relationship with us, we may consider that we "have been invited to co-drift with them" (Efran & Lukens 1985:74) rather than thinking of ourselves as "expert" change agents. We merely provide a context in which change can happen, "presenting information in such a way that a client can find meaning in it and thereby create and perceive a new reality [narrative]" (Becvar & Becvar 1997:105).

Derrick said:

> *Sharing my experience now for this project was quite exhilarating. I enjoyed being the author of my own story, and appreciate that my knowledge is considered as valuable.*
>
> (Neethling & Du Toit 2003:X)

Bakela found pride in sharing his story:

> *And now I also feel proud of my story because I write it… if my story helps other people it will make them see that one way is not always the right way. There are other ways that will not hurt people. It will also make them respect me. It makes me a man to tell them how I fight this thing and won it.*
>
> (Neethling & Motlathegi 2003:XXII)

Sarah found "sharing" especially significant:

> *I enjoyed sharing my story because I am a very social person…Maybe if we share our stories, it will help people to understand each other better.*
>
> (Neethling & Mothlabi 2003:XXXIV)

Marelize discovered new meaning in her own story:

> *Sharing my story this way now maybe will lead to the redemption of others too, others who walk the same road I did. I feel at peace now, after revisiting my story again, realising that there are sparks of hope and courage and perseverance in between which I have not noticed before.*
>
> (Neethling & Van der Westhuizen 2003:XVIII)

Ilze found healing in sharing her story:

> *So this is my story… it is amazing after all the cutting and pasting, and translating, to see how this plot which is my life, unfolds. At one stage I could barely believe that all this had happened to me! It felt as if I was reading somebody else's story. Participating in this study really was wonderful. Sharing my story, I think, is also part of the healing process… The story writing made me look again at my life from a different perspective*
>
> (Neethling & Schoeman 2003:XXVII-XXIX)

When we honour participants' voices, and their wisdom, we empower them in many ways, and the research journey becomes a positive and rewarding experience for all involved.

5.2 THE ROADS TRAVELLED

In this study I wished to argue the special contribution pastoral counselling can offer which other mental health professions might not. I wished to explore the possibilities that pastoral counselling can be as relevant to South Africa as other mental health professions.

When looking back, there were parts of the journey that flowed steadily.

The narratives of the participants in this study have in common the experiences of people who found meaning in addressing their spirituality rather than in "mental health constructs" or prescribed medication, as provided by several mainstream approaches. In each story, the person became reconnected to his/her spirituality as he/she saw it, and in so doing, was able to take back control of his/her life.

There were also parts of the journey that ran faster.

In Section 4.1, we took a look at the differences between pastoral counselling and other mental health professions and noticed that participants especially preferred the integration of spirituality into the acknowledgment of people as spiritual beings, as well as the counselling relationship, which in my opinion is the most outstanding feature of pastoral counselling. There are a lot of commonalities with the other mental health professions as well, such as the type of problem a client might bring to the counselling situation. However, what participants wanted, and needed, was the integration and acknowledgement of their spiritual side.

We can very well ask, if clients bring us the same type of questions they take to other mainstream health professionals, why bother to establish a separate profession at all?

At present, health departments in the new South Africa are still undergoing major restructuring and, in some cases, there have been severe financial cutbacks, as new policies attempt to redress the inequities of the past. A district system is being phased in, with a shift in funding from academic hospitals to secondary and primary level care. The process is undermined by the current recession, which also affects welfare and education facilities, and by widespread poverty, violence, and other adverse conditions (Milne & Robertson 1999:128).

According to Kriegler (1994:64), such structural problems in mental health services conjoined with attitudinal barriers are the cause of inadequate mental health care in South Africa. In spite of the potential cost benefits of psychotherapy and prevention by way of counselling and educative interventions, psychologists are not perceived or employed as primary members of mental health teams. Kriegler (1994:64) therefore claims that the psychological profession as such is disempowered to become a significant role player in the new South Africa. The latter argument, I

believe, opens up space for pastoral counselling to contribute to the healing of South African people, especially if the pastoral profession can be integrated with primary health care approaches.

Against this background, it seems to me that the special emphasis on equal relationships between pastoral counsellor and client, the integration of the spiritual component, the possible contributions to the primary health care delivery system, cost-effectiveness, respect for the human rights and the protection of prospective clients, the possible contributions to social change and reconciliation and the multi-cultural aspects of spirituality, are important aspects of pastoral counselling that we should not overlook.

Then there were also landmarks along the course of the journey. Some of them were seemingly insignificant, like a pile of rocks next to the road, but they were large enough to grab the attention of the traveller.

In Section 4.2 it was the deconstructing of the power relationship between counsellor and client in particular which enabled participants to disclose their stories fully, and to trust and build relationship with counsellors. Participants were not comfortable with the standard hierarchical relationships found in mainstream mental health services. I am tempted to believe that, this study has managed to highlight that a more equal relationship between counsellor and client could make a definite difference in the therapeutic relationship. Research then also indicates that the relationship between counsellor and client plays an integral part in healing: "Recent research has shown that the technique of psychotherapy is not as big a factor in your healing as the 'therapeutic alliance' you form with your therapist. It is the relationship between you that heals" (http://www.Internet Therapy is it effective.htm).

Some of the landmarks were even bigger, though, rock altars with crudely fashioned wooden road signs which hinted at options and alternative roads.

Several other limitations were also highlighted in Section 4.2, which I think merely highlights the ongoing problems experienced with the South African mental health care delivery systems at present. Even if some of these problems are unique to our pluralistic country, I have come to see many as universal rather as unique to South Africa. Other countries such as the United States are also at present exploring the possibilities of incorporating pastoral counselling services into their national health care delivery systems in order to address these problems (http://www.proaxis.

com/~ jefff/bkltnmhr.html#anchor503367). Hence, I believe that in Section 4.3, the possible integration of pastoral counselling in the South African primary health care delivery system is an important sequel to the discussion of possible limitations of the mental health care professions. If South Africa commits herself to providing accessible and affordable care to all communities and people, this commitment should be extended to mental health care as well and not only physical medical care as we know it. This raises more questions though, for instance, does South Africa have the necessary infrastructure to manage such an integrated mental health care system effectively? Can South Africa really afford not to?

In Section 4.3 we also looked at the implications of the law of 1997 (Republic of South Africa 1997) in terms of the marginalising of people such as Sarah who might not have access to care and counselling if pastoral counsellors are prohibited from working independently. In this space we also discussed the relational self, which formed part of my original research curiosity in Section 1.2, and the importance of a sense of community. Although exploring the sense of community did not form part of my original goals, this to me seems important, as the relational self and a sense of community are imbedded in the primary health care delivery system. This concept is rooted firmly in most African cultures, and also very much forms part of the postmodern era that we are embarking on.

And then there were landmarks as big as headlands.

The right of consumers to select the providers of their choice in any health care delivery system, and in any system of national health insurance, is also generally a universally articulated desire. If South Africa follows the example of other leading countries, which she inevitably almost always does in other matters, according to my knowledge, government should also endorse the principle of consumer choice as one of the foundations of health care reform. A consumer-sensitive health care system should provide for consumer participation in treatment planning decisions, including service selection, service provider, service timing, and service setting. It should also ensure a range of service settings as part of an integrated delivery system, and should ensure that services are delivered in the least restrictive environment practicable. In Section 4.4, Derrick in particular pointed out that all people should have the right to obtain the services of their choice. In general, participants then felt that they should have the right to make use of pastoral services when they need it, instead of being “forced” tomake use of mainstream health services.

Sometimes we also crossed rivers on this journey, and in the rivers there were whirlpools.

Participants' reactions as well as the relevant literature regarding malpractice in Section 4.4 emphasised the need to control of the profession. In this regard it is therefore my sincere belief that this study indicates a need for freedom of choice, as well as people's rights to be legally and ethically protected against possible malpractice.

I must admit that when reviewing the relevant literature, I was quite shocked by the extent of power abuse that occurs in pastoral counselling situations. Believers in our society are indoctrinated to ignore the bloody history of religion, and to pay effusive lip service to belief in God, Jesus, the Bible, and God's holy representatives on earth. Ordained ministers and priests are "men of God", "God's holy instruments", a race apart, anointed. It is then no wonder that clergymen who wish to misuse power and betray trust are in a unique position to do so (http://www.ffrf.org/articles/pedo1992.html).

However, I will not fool myself by believing that power or sexual abuse occurs only in congregational settings. I am quite convinced that such abuse also occurs in mainstream mental health services. This discussion therefore strengthened my belief that the pastoral profession also needs a professional board to which it should be accountable, not only to its particular church if the counsellor is in the service of a congregation. To a certain extent, it remains socially unacceptable to point out objections to religious institutions or church services, but can we really afford to simply believe that if something is connected to a church, it must be good?

Sometimes there were small islands in the rivers; at which weary travellers could catch their breath for a moment or two, if they were not smashed against the rocky boundaries.

Due to cost-effectiveness as discussed in Section 4.5, it was possible for the participants to visit a pastoral counsellor and obtain help which they otherwise might not have had access to. I found it especially enlightening that few participants were willing to make use of congregational counselling, but instead preferred to see an independent pastoral counsellor (whether he/she practised legally or not). To me this also indicates a movement towards spirituality as people experience it subjectively, and a possible move away from institutionalised religion. Once again I have to stress the importance of accommodating spiritual and cultural orientations different to our own. In South Africa the alternative – punctuating from only a Western perspective – is no option anymore (see Section 2.2).

And sometimes we managed to secure bridges over these rivers.

All participants also agreed, as in our discussion in Section 4.6, that human beings are integral spiritual beings and that spirituality (or religion) should also form part and parcel of the counselling process. It seems to me that prominent thinkers such as Jung, Maslow, Marx and Durkheim long ago reached consensus on the importance of spirituality (or religion) in people's lives. Yet I see few if any integration of this in mainstream theories. I cannot help but wonder if this might not be an additional reason why the psychological profession struggles to be seen as part of the mental health system, with reference to our discussion in Section 4.6, as well as Kriegler's (1993:64) claim above that psychologists are not perceived as primary members of mental health teams.

Both Sarah and Bakela further commented on how pastoral counselling could assist this country and its people in making a difference to social change and reconciliation, as discussed in Section 4.7. In particular, it also contributed to Bakela's changing his negative views not only of white people but also of women in general into more positive ones. In Section 1.2, I have mentioned that a white woman might not be the most suited to do the type of research I had in mind. After travelling with Sarah and Bakela, I have to ask whether another researcher from a similar culture to themselves would have contributed to social change and reconciliation. Would Bakela have been able to cultivate a more positive view towards Europeans and women in particular, as he did, if he travelled the counselling and research journey with perhaps a male from his own culture? And how did Sarah's counsellor manage to create a safe environment for her, one in which she was able to grow spiritually and trust, while he was from a different gender to herself? Would a woman maybe have "understood" better, would Sarah have felt more comfortable with someone else? I repeat that a postmodern paradigm frees the researcher to take into account the diverse and different realities of people. In also subscribing to a participatory ethical approach (it is still my personal belief), any researcher can simultaneously be completely suited to the client and not at all.

Sarah's experiences also highlighted important multi-cultural aspects in Section 4.8. Her daily functioning is fundamentally a religious one. I then pointed out that the inclusion of spirituality might add a multi-cultural aspect to pastoral counselling which makes these services possibly more relevant to our multi-cultural country. However, spirituality is possibly not the only area of concern in multi-cultural counselling contexts, to African South Africans in particular. Should I not perhaps have been more persistent in asking participants more about what else they would expect from a counselling process in order to be more accommodating of difference and preference? Would this not have opened up more space for possible relevant areas in pastoral counselling?

Sometimes, though, we were not sure with which current to flow.

As this study was conducted in a qualitative approach, it is not possible for me to say that it was proven "beyond a doubt" that pastoral counselling is relevant to South Africa. Nor can I claim the opposite, however. Reflecting on these points is difficult for me, if only for the reason that I am biased and struggle to move towards a position where I might have to admit that pastoral counselling might *not* be relevant to South Africa! Because of that, I will leave it to the reader to judge the study according to his/her own interpretations.

Looking back even further down the roads travelled, I could also have handled the study quite differently. I could have asked different questions, I could have involved more participants. There is also the possibility that each of the different paragraphs as in Chapter 4 could have been addressed as a separate and more in-depth study. Furthermore, it might have been beneficial to make use of an interpreter when in conversation with either Sarah or Bakala. There is always the possibility of misunderstandings in language, even in our own, and even if the participant edits his/her own story. Sometimes the presumed hierarchical role of a researcher still inhibits participants to speak up for themselves, however sensitive we may be to this possibility. On the other hand, would Sarah and Bakela have been as comfortable in sharing their experiences with me if they were in the presence of yet another stranger?

The questions mentioned in Section 1.2, furthermore, were too abundant to be addressed in a dissertation of limited scope. However, I have said then and will repeat that these questions were only to guide my research and were not fixed hypothesis that needed to be proven. For in a qualitative study, meaning and relevance are only captured once the researcher becomes immersed in the research experience (Neuman 1997:329).

Finally, at the end of the journey, the rivers plunged over the last waterfall and swept us into seas and beaches of possibilities.

Maybe my final question here then should be "Have I reached the thousand and first night yet?" Have the roads travelled and rivers crossed saturated my thirst for stories about pastoral counselling and mental health services in South Africa; has the princess finally spun a tale which has provided the magic and answers I was looking for?

I do not feel as if I have reached my thousand and first night yet. Nor have I found all the answers to the questions raised in this study. Instead, it seems to me that it has raised even more. I just hope that in naming these questions, new conversations or discussions and new roads to travel on might become possible.

5.3 FROM A DISTANCE

Working in a postmodern paradigm frees us to punctuate from different perspectives and move logically between research methods and theories as long as we acknowledge where we are "coming from". When punctuating from a both/and position especially, which is one of the general assumptions of the postmodern approach (Becvar & Becvar 1996:11), it implies we can move freely between paradigms and make use of their research techniques and strategies without necessarily subscribing or adhering to the underlying theoretical principles (Vorster 2003:105). It is this both/and assumption then also, in my opinion, which contributes to us being able to acknowledge different forms of spirituality and being in the world with reference to our discussion in Section 2.2. By subscribing to a both/and position we attempt to transcend either/or dichotomies by acknowledging the complementarity of both sides of a coin (Becvar & Becvar 1996:11) or different interpretations of contexts. In this respect I believe the postmodern approach could be regarded as an approach into which other theoretical approaches can be fitted. In the following discussion I then wanted to reflect on some of the possible problems and limitations of this study from a positivist point of view without subscribing to its underlying principles, as I believe any researcher should be aware of possible criticism which might be forthcoming from different scientific communities.

There is no evidence to suggest that interviews as a data elicitation technique yield data which are less valid or reliable than other methods (Breakwell 1998:238). Like any self-report method, interviews also rely upon participants' being able and willing to give accurate and complete answers to questions posed, no matter what their format. Interviews also involve researcher effects. In an interview the characteristics of the researcher as well as of the participant will influence willingness to participate and to answer truthfully (Breakwell 1998:239). Suggestive interviewing or even only an awareness of the purpose of a study may also reliably prompt false memories instead of real ones: "From kissing frogs to demonic possession, people are [sometimes] led to believe they experienced the improbable" (http://www.eurekalert.org/pub_releases/2003-02/uoc--fkf021303.php).

However "false" these memories might appear to be, though, they are real and valid to the individual experiencing them and must be approached as such. Coming from a postmodern approach I have also never tried to imply the opposite or tried to imply an objective stance in this study. I have already acknowledged the reciprocal influence of both the researcher and participant in my personal reflections, also that all assertions become self-referential in that I am making them based on my own epistemological premises (Becvar & Becvar 1996:76-77).

Utilising a multiple and open interview format instead of closed-ended questions contributed to meaning-making and the reporting of data in narrative format in this study, while at the same time it cannot lend itself to numerical analysis such as required by mainstream positivist scientific communities for generalising to larger populations (Fife-Schaw 1998:178). However, qualitative research methods are also not interested in generating "the truth" or universal truths, instead the focus is in-depth analysis of an individual's subjective experiences and meaning-making, personal definitions, metaphors, symbols, and description of specific cases (Neuman 1997:329). Qualitative data therefore rarely uses the tools of quantitative research such as variables, reliability, statistics, hypothesis, replication, or scales (Neuman 1997:327).

Subject attrition (Barret 1998:22) has also occurred in this study, in that one participant had to drop out due to personal circumstances while the study was still in process. In a qualitative study involving selected case studies, this does not necessarily lead to systematic bias, although I feel it might have led to a loss of valuable information which could have contributed to the arguments made in this study.

Qualitative research also might gather a range of information about a few selected cases (such as in this study) instead of gathering specific information on a great many cases (Neuman 1997:329). In this study I have made use of purposive sampling to obtain participants who already participated in pastoral counselling, some who also made use of mainstream therapies. Purposive sampling is an acceptable kind of sampling for special occasions, selecting cases with a specific purpose in mind (Neuman 1997:206). The sample size in this study was small and non-representative: although a large sample size does not necessarily guarantee a representative sample (Neuman 1997:221). The information gathered from this study therefore cannot be generalised to larger populations. However, the "findings" in this study do support studies and observations that spiritual awakening transpiring for people during pastoral counselling does actually assist them in standing up against their problems (Green et al 1998:331). This study then

emphasises the need for further research in this regard as well as problems experienced in the mental health service sector, especially with regard to a public mental health needs assessment.

No other research publications regarding the relevance of pastoral counselling in South Africa could be found. This study should then also be considered a pilot or explorative study.

Ethical aspects have already been discussed separately, but necessitate further mention, due to the relatively new method of conducting interviews via e-mail. Research conducted this way highlights unique ethical issues such as signed consent and permission to release information. At present there are no standardised methods for the gathering of data and confirmation of informed consent on-line (http://www.apa.org/monitor.num). In this study the participant with whom interviews were conducted via e-mail (Neethling & Schoeman 2003: XXIII-XXIX) was informed that the return of the appendices and consent forms via e-mail would be considered a form of [passive] informed consent. However, she was also requested to sign and return the physical consent forms.

I therefore do not pretend to provide conclusive and definite proof that pastoral work is relevant in this country, but merely indicate contexts in South Africa which open up space for pastoral work with regard to pastoral counselling, thereby assisting pastoral and spiritual workers in their negotiations to obtain professional status in this country. This study should then be seen as part of a process with the aim of developing pastoral counselling as a profession. As a fragment of a process, the study may reach its end, while the story still continues: “Stories may have endings, but stories are never over” (Freedman & Combs 1996:33).

REFERENCES

African National Congress 1994. ANC Health Plan: A National Health Plan for South Africa, in Gilbert, L, Selikow ,T & Walker, L (eds), 1996b. *Society, health and disease: An introductory reader for health professionals*, 181-193. Randburg: Ravan.

Anderson, H & Goolishian, H 1992. The client is the expert: a not-knowing approach to therapy, in McNamee, S & Gergen, K J (eds), *Therapy as social construction*, 25-39. London: Sage.

Application Draft for the Establishment of a Professional Board in terms of Section 14A of the Social Services Professions Act 1978 (Act 110 of 1978) 2002. Pretoria: South African Association for Pastoral Work.

Atwood, J D & Maltin, L 1991. Putting Eastern philosophies into Western psychotherapies. *American Journal of Psychotherapy* XLV (3), 368-382.

Barret, M 1998. Practical and ethical issues in planning research, in Breakwell, G M, Hammond, S & Fife Schaw, C (eds), *Research methods in psychology*. 4th ed, 16-37. London: Sage.

Becvar, D S & Becvar, R J 1996. *Family therapy: A systemic integration*. 3rd ed. Boston: Allyn & Bacon.

Benn, C 2001. Does faith contribute to healing? Scientific evidence for a correlation between spirituality and health. *International Review of Mission*, 90 (356/357), 140-148.

Beyers, E 1995. Sosiale waarneming: Om ander te verstaan. In Appelgryn, A E M, Beyers, E, Mynhardt, J C & Nieuwoudt, J M. *Sosiale sielkunde. Enigste studiegids vir PSY313-D*, 24-45. Pretoria: Universiteit van Suid-Afrika.

Bitter, J M & Corey, G 1996. Family systems therapy, in Corey, G, *Theory and practice of counseling and psychotherapy*, 311-342. Boston: Allyn & Bacon.

Breakwell, G M 1998. Interviewing, in Breakwell, G M, Hammond, S & Fife Schaw, C (eds), *Research methods in psychology*. 4th ed, 230-242. London: Sage.

Breakwell, G M, Hammond, S & Fife Schaw, C (eds) 1998. *Research methods in psychology*. 4th ed. London: Sage.

Brown, C K 1998. The integration of healing and spirituality into health care. *Journal of Interprofessional Care* 12(4), 373-381.

Brown, D S O & Nell, V 1991. Epidemiology of traumatic brain injury in Johannesburg: Methodological issues in a developing country context. *Social Science and Medicine* 33(3), 283-287.

Browning, D S 1993. Introduction to pastoral counselling, in Wicks, R J, Parsons, R D & Capps, D E (eds), *Clinical handbook of pastoral counselling*, Vol 1, Expanded edition, 5-13. New York: Paulist Press.

Bulhan, H A 1985. *Frantz Fanon and the psychology of oppression*. New York: Plenum Press.

Capra, F 1983. *The turning point*. New York: Bantam.

Chamberlain, S 1990. The new ethnography: "Windmills and giants". *Dulwich Centre Newsletter* 2, 39-45.

Chamberlain, S & Friends 1997. Learning to walk the walk, in White, C & Hales, J (eds) *The personal is the professional: Therapists reflect on their families, lives and work*, 129-138. Adelaide: Dulwich Centre Publications.

Clandinin, D J & Connelly, F M 1994. Personal experience methods, in Denzin, N K & Lincoln, Y S (eds), *Handbook of qualitative research*, 413-427. London: Sage.

Cochrane, J R, De Gruchy, J W & Petersen, R 1991. *In word and deed: Towards a practical theology for social transformation.* Pietermaritzburg: Cluster.

Corey, G 1996. *Theory and practice of counseling and psychotherapy*. Boston: Allyn & Bacon.

Couture, P D 1995. Partners in healing: Bridging pastoral care and public health through practical and pastoral theology. *Journal of Pastoral Theology* 5, 65-80.

Davies, B & Harrë, R 1990. Positioning: The discursive production of selves. *Journal for the theory of Social Behavior* 20(1), 43-63.

De La Porte, A 2003. Personal conversation. 2 October 2003.

De Gruchy, J W 1994. The nature, necessity and task of theology, in De Gruchy, J W & Villa-Vicencio, C (eds), *Doing theology in context: South African perspectives*, 2-14. Cape Town: David Phillip.

De Gruchy, J W & Villa-Vicencio, C (eds) 1994. *Doing theology in context: South African perspectives*. Cape Town: David Phillip.

De Jongh van Arkel, J T 1999. The professionalization of pastoral couselling? An effort to define the issues. *Praktiese Teologie in Suid Afrika* 14(2), 88-111.

De Jongh van Arkel, J T 2000. *Caring for all: Exploring the field of pastoral work. Only study guide for CGM309-4*. Pretoria: University of South Africa.

Denzin, N K & Lincoln, Y S (eds) 1994. *Handbook of qualitative research*. London: Sage.

De Vries, C L 2001. The global health situation: Priorities for the churches' health ministry beyond AD 2000. *International Review of Mission* 90 (356/357), 149-160.

Efran, J & Lukens, M D. 1985. The world according to Humberto Maturana. *The family therapy networker* 9(3), 72-75.

Fed Health Newsletter 2003:1.

Fife-Schaw, C 1998. Questionnaire design, in Breakwell, G M, Hammond, S & Fife Schaw, C (eds), *Research methods in psychology*. 4th ed, 174-193. London: Sage.

Freedman, J & Combs, G 1996. *Narrative therapy: The social construction of preferred realities.* New York: Norton.

Freeman, M 1992. Negotiating the future of traditional healers in SA: Differences and difficulties, in Gilbert, L, Selikow ,T & Walker, L 1996b. *Society, health and disease: An introductory reader for health professionals,* 79-81. Randburg: Ravan.

Gergen, K J (ed) 1991. *The saturated self: Dilemmas of identity in contemporary life*, 139-170. US: Basic Books.

Gergen, K J 1999. *An invitation to social construction*. London: Sage.

Gergen, K & Gergen, M 1988. Narrative and the self as relationship. *Advances in Experimental Social Psychology* 21, 17-55.

Gerkin, C V 1997. *An introduction to pastoral care* Nashville: Abingdon.

Giddens, A 1996. *Sociology*. 2nd ed. Oxford: Blackwell.

Gilbert, L 1995. Sociology and the "New Public Health" in South Africa. *Suid-Afrikaanse Tydskrif vir Sosiologie*, 26(4), 115-124.

Gilbert, L, Selikow, T & Walker, L 1996a. A National Service and the future of the private sector: The case for a national health insurance, in Gilbert, L, Selikow,T & Walker, L 1996b. *Society, health and disease: An introductory reader for health professionals*, 165-167. Randburg: Ravan.

Gilbert, L, Selikow,T & Walker, L 1996b. *Society, health and disease: An introductory reader for health professionals.* Randburg: Ravan.

Green, L, Fullilove, M T & Fullilove, R E 1998. Stories of spiritual awakening: The nature of spirituality in recovery. *Journal of Substance Abuse Treatment* 15(4), 325-331.

Griffith, M 1995. Opening therapy conversations with a personal God, in Weingarten, K (ed), *Cultural resistance: Challenging beliefs about men, women and therapy*, 123-140. New York: Harrington Park Press.

Griffith, M E & Griffith, J L 2002. Addressing spirituality in its clinical complexities: its potential for healing, its potential for harm. *Journal of Family Psychotherapy* 13(1-2), 167-194.

Heitink, G 1993. *Practical theology. Manual for practical theology. History. Theory. Action domains.* Cambridge: William B. Eerdmans.

Heitink, G 1998. *Pastorale zorg: theologie, differentiatie, praktijk*. Kampen: Kok.

Herholdt, M D 1998a. Postmodern hermeneutics, in Maimela, S & König, A (eds), *Initiation into theology: The rich variety of theology and hermeneutics*, 451-469. Pretoria: Van Schaik.

Herholdt, M D 1998b. Postmodern theology, in Maimela, S & König, A (eds), *Initiation into theology: The rich variety of theology and hermeneutics*, 215-230. Pretoria: Van Schaik.

Heshusius, L & Ballard, K (eds) 1996. How do we count the ways we know? Some background to the project, in *From positivism to interpretivism and social research (The mind-body connection)*, 1-16. New York: Teachers' College Press.

Heyns, L M & Pieterse, H J C 1990. *A primer in practical theology.* Pretoria: Gnosis.

Ho, D Y F 1988. Asian psychology: A dialogue on indigenization and beyond, in Paranjpe, A C, Ho, D Y F & Rieber, R W (eds), *Asian contributions to psychology,* 36-98. New York: Praeger.

Hsu, F L K 1971. Psychological homeostasis and conceptual tools for advancing psychological anthropology. *American Anthropologist* 73, 23-44.

http.// www.aapc.org. Retrieved Saturday, 17 August 2002.

http:www.%20%anti-discriminatory%20perspectives.htm/. Retrieved Saturday, 22 June 2002.

http://www.apa.org/monitor.num. Retrieved Saturday, 17 August 2002.

http:// www.counseling.org/consumers media. Retrieved Saturday, 17 August 2002.

http://www.eurekalert.org/pub_releases/2003-02/uoc--fkf021303.php. Retrieved Saturday, 17 August 2002.

http://www.ffrf.org/articles/pedo1992.html. Retrieved Saturday, 27 September 2003.

http://www.freejesus.et/home/viewtopic.php?t=914. Retrieved Saturday, 27 September 2003.

http:// www.gov.co.za/key issues. Retrieved Saturday, 17 August 2002.

http://www.human-nature.com/nibbs/02/kohn.html. Retrieved Saturday, 28 June 2003.

http://www.human-nature.com/nibbs/02/ringwald.html. Retrieved Saturday, 17 August 2002.

http://www.human-nature.com/nibbs/03/dsm.html. Retrieved Saturday, 28 June 2003.

http://www.human-nature.com/nibbs/03/stjernberg.html. Retrieved Saturday, 28 June 2003.

http://www.InternetTherapy is it effective.com. Retrieved Wednesday, 24 September 2003.

http://www.lipmagazine.org/articles/feattalvi_141.shtml. Retrieved Saturday, 28 June 2003.

http://www.mentalhelp.net/poc/view_doc.php?type=news&id=34117.Retrieved Saturday, 28 June 2003.

http://www.metanoia.org. Retrieved Saturday, 17 August 2002.

http://www.mpaterson.co.uk/Foucault.html. Retrieved Saturday, 17 August 2002.

http://www.pastoral therapy\Colleague.htm. Retrieved Sunday, 8 September 2002.

http://www.pastoral/explorefaith. org.Pastoral Counseling.htm. Retrieved Sunday, 8 September 2002.

http://www.pastoral therapy\Preamble.htm. Retrieved Sunday, 8 September 2002.

http://www.proaxis.com/~jjefff/bklnmhr.html#anchor503367. Retrieved Wednesday, 24 September 2003.

http://www.psychologytoday.com/htdocs/prod/PTOArticle/PTO-20030523-000002.asp. Retrieved Saturday, 28 June 2003.

http://www.shr.aaas.org/loa/sector.htm. Retrieved Saturday, 27 September 2003.

http://www.spub.ksu.edu/issues/v100/sp/n146/cam-native-american-Liveng.html.Retrieved Saturday, 27 September 2003.

http://www.sun/edu/~hfspc002/foucault.home.html. Retrieved Tuesday, 5 August 2003.

http://www.tnet.com.au/~attfield/mental%20health.htm. Retrieved Saturday, 28 June 2003.

Hugo, C 2003. The Banyan tree and Unisa. *SAAP notes: South African Association for Pastoral Work*, March.

Isherwood, L & McEwan, D 1994. *Introducing feminist theology*. Sheffield: Sheffield Academic Press.

Jenkins, A 1990. *Invitations to responsibility: The therapeutic engagement of men who are violent and abusive*. Adelaide: Dulwich Centre Publications.

Kincheloe, J L & McLaren, P L 1994. Rethinking critical theory and qualitative research, in Denzin, N K & Lincoln, Y S (eds), *Handbook of qualitative research*, 138-157. London: Sage.

Kolberg, C 1999. Creating conversations in times of crisis. *Gecko* 2, 10-17.

König, A 1998. Biblical theology, in Maimela, S & König, A (eds), *Initiation into theology: The rich variety of theology and hermeneutics*, 11-26. Pretoria: Van Schaik.

Kotzé, D 2002. Doing participatory ethics, in Kotzé, D, Myburg, J, Roux, J & Associates (eds), *Ethical ways of being,* 1-34. Pretoria: Ethics Alive.

Kotzé, D, Myburg, J, Roux, J & Associates (eds) 2002. *Ethical ways of being.* Pretoria: Ethics Alive.

Kotzé, E 1994. The social construction of a family therapy training programme. DLitt et Phil Dissertation, Rand Afrikaans University, Johannesburg.

Kotzé, E & Kotzé, D 2001a. Telling narratives, doing spirituality, in Kotzé, E & Kotzé, D (eds), *Telling Narratives: Spellbound Edition*, 1-14. Pretoria: D & P Prepress.

Kotzé, E & Kotzé, D (eds) 2001b. *Telling Narratives: Spellbound Edition*. Pretoria: D & P Prepress.

Kriegler, S 1994. Options and directions for psychology within a framework for mental health services in South Africa. *South African Journal of Psychology* 23(2), 64-70.

Kriel, A C 2001. Proposed norms and standards for pastoral counsellors/therapists. MTh Dissertation (Practical Theology), University of South Africa, Pretoria.

Kritzinger, J N J 1998. The theological challenge of other religious traditions, in Maimela, S & König, A (eds), *Initiation into theology: The rich variety of theology and hermeneutics*, 231-256. Pretoria: Van Schaik.

KRM307-K [1997].Onderhoudvoering, in *Aktuele Kriminologie. Studiegids 2 vir KRM307-K*. Pretoria: Universiteit van Pretoria.

Long, C 1999. Now that you have come the baby will grow. MA Dissertation, University of Cape Town.

Louw, D J 1998. *A pastoral hermeneutics of care and encounter*. Wellington: Lux Verbi.

McLean, B A 1997. Co-constructing narratives: A postmodern approach to counselling. MEd Dissertation, University of Otago, Dunedin, New Zealand.

McNamee, S & Gergen, K J (eds) 1992. *Therapy as social construction*. London: Sage.

Maimela, S & König, A (eds) 1998. *Initiation into theology: The rich variety of theology and hermeneutics*. Pretoria: Van Schaik.

Mbiti, J S 1989. *African religions and philosophy*. London: Heinemann.

Meyer, W F 1997. Depth psychological approaches: The psychoanalytical theory of Sigmund Freud, in Meyer, W F, Moore, C & Viljoen, H G (eds) 1997a, *Personology: From individual to ecosystem*, 55-132. Sandton: Heinemann.

Meyer, W F, Moore, C & Viljoen, H G (eds) 1997a. *Personology: From individual to ecosystem*. Sandton: Heinemann.

Meyer, W F, Moore, C & Viljoen, H G (reds) 1997b. *Personologie: Van individu tot ekosisteem.* Sandton: Heinemann.

Milne, M & Robertson, B 1998. Child mental health services in the new South Africa. *Child Psychology and Psychiatry Review* 3(3), 128-134.

Mmope, P 2002. Editor's note, in *Student talk: News for the Unisa community*. Available at http://www.unisa.ac.za/dept/news.

Moore, C 1997a. The self-actualisation theory of Abraham Maslow, in Meyer, W F, Moore, C & Viljoen, H G (eds) 1997a. *Personology: From individual to ecosystem*, 437-460. Sandton: Heinemann.

Moore, C 1997b. The ecosystemic approach, in Meyer, W F, Moore, C & Viljoen, H G (eds) 1997a. *Personology: From individual to ecosystem*, 555-588. Sandton: Heinemann.

Morgan, A 2000. *What is narrative therapy?* Adelaide: Dulwich Centre Publications.

Neethling, I 2003. The relevance of pastoral counselling in South Africa: with reference to the South African Association of Pastoral Work. MTh Dissertation, University of South Africa, Pretoria.

Neethling, I & Du Toit, D 2003. Standing strong against cannabis and aggression, in Neethling, I, The relevance of pastoral counselling in South Africa: with reference to the South African Association of Pastoral Work. MTh Dissertation, University of South Africa, Pretoria, III-X.

Neethling, I & Mothlabi, S 2003. Hope in my heart, in Neethling, I, The relevance of pastoral counselling in South Africa: with reference to the South African Association of Pastoral Work. MTh Dissertation, University of South Africa, Pretoria, XXX-XXXIV.

Neethling, I & Motlathegi, B 2003. I can see now, in Neethling, I, The relevance of pastoral counselling in South Africa: with reference to the South African Association of Pastoral Work. MTh Dissertation, University of South Africa, Pretoria, XIX-XXII.

Neethling, I & Schoeman, I 2003. Step by step, in Neethling, I, The relevance of pastoral counselling in South Africa: with reference to the South African Association of Pastoral Work. MTh Dissertation, University of South Africa, Pretoria, XXIII-XXIX.

Neethling, I & Van der Westhuizen, M 2003. Selling my body, selling my soul, in Neethling, I, The relevance of pastoral counselling in South Africa: with reference to the South African Association of Pastoral Work. MTh Dissertation, University of South Africa, Pretoria, XI-XVIII.

Neuman, W L 1997. *Social methods: Qualitative and quantitative approaches.* 7th ed. Boston: Allyn & Bacon.

Paranjpe, A C, Ho, D Y F & Rieber, R W (eds) 1988. *Asian contributions to psychology*. New York: Praeger.

Pillay, A & Lockhat, R 2001. Models of community mental health services for children, in Seedat, M, Duncan, N & Lazarus, S (cons. eds), *Community psychology: Theory, method and practice. South African and other perspectives,* 87-106. Oxford: Oxford University Press.

Petit-Zeman, S 2001. Restored faith. *The Guardian*, 21 February.

Poling, J N 1991. *The abuse of power. A theological problem*. Nashville: Abingdon Press.

Polson, E 2001. Qualitative research for dummies. MA dissertation, University of South Africa, Pretoria.

Pretorius-Heuchert, J W & Ahmed, R 2001. Community psychology: Past, present and future, in Seedat, M, Duncan, N & Lazarus, S (cons. eds), *Community psychology: Theory, method and practice. South African and other perspectives,* 17-36. Oxford: Oxford University Press.

Reinharz, S 1992. *Feminist methods in social research*. New York: Oxford University Press.

Republic of South Africa 1996. South African Bill of Rights, Act 106 of 1996, in *The constitution of the Republic of South Africa*. As adopted on 8 May 1996 and amended and 11 October 1996 by the Constitutional Assembly, 6-24. Pretoria: Typeface Media.

Republic of South Africa 1997. *Medical, Dental and Supplementary Health Service Professions Amendment Act, Act 89 of 1997*. Pretoria: Government Printers.

Ringwald, C 2002. *The soul of recovery: Uncovering the spiritual dimension in the treatment of addictions*. New York: Oxford University Press.

Rosnow, R L & Rosenthal, R 1996. *Beginning behavioral research: A conceptual primer*. 2nd ed. Englewood Cliffs: Prentice-Hall.

Roux, J, Myburg, J & Kotzë, D 2001. *Engaging in pastoral care and counselling discourse. PCM301-S/501/2002. Part of the BTh programme in pastoral counselling.* Pretoria: University of South Africa.

Seedat, M, Cloete, N & Shochet, I 988. Community psychology: Panic or panacea. *Psychology in Society* 11, 39-54.

Seedat, M, Duncan, N & Lazarus, S (cons. eds) 2001. *Community psychology: Theory, method and practice. South African and other perspectives.* Oxford: Oxford University Press.

Sevenhuijsen, S 1998. *Citizenship and the ethics of care. Feminist considerations on justice, morality and politics*. Translated by Savage from the Dutch manuscript. London: Routledge.

Sidley, P 1995. New Health Care Plan: Deeble's spirit lives on, in Gilbert, L, Selikow ,T & Walker, L 1996b. *Society, health and disease: An introductory reader for health professionals*, 116. Randburg:Ravan.

Siegel, B & Siegel, S 1988. The storyteller, in Weis, M & Hickman, T (eds), *Kender, gully dwarves and gnomes*, 76-97. London: Penguin.

Shantall, T 1997. The existential theory of Victor Frankl, in Meyer, W F, Moore, C & Viljoen, H G (eds) 1997a, *Personology: From individual to ecosystem,* 529-550. Sandton: Heinemann.

South African Association for Pastoral Work 2002. Categories for pastoral counsellors. Pretoria: South African Association for Pastoral Work.

Sow, I 1980. *Anthropological structures of madness in black Africa.* New York: International Universities Press.

Sue, D, Sue, D, & Sue, S 1994. *Understanding Abnormal Behavior*. 4th ed. Boston: Houghton Mifflin.

Swartz, L & Gibson, K 2001. The "old" versus the "new" in South African community psychology: The quest for appropriate change, in Seedat, M, Duncan, N & Lazarus, S (cons. eds), *Community psychology: Theory, method and practice. South African and other perspectives,* 37-50. Oxford: Oxford University Press.

Tefanis, I 2001. Emerging narratives in the consultation relationship: Participatory action research as a process paradigm in community work. A research proposal. MA dissertation, University of the Witwatersrand, Johannesburg.

The Centre for Health Policy 1991. A National Health Service and the future of the private sector: The case for a National Health Insurance. *Critical Health* 35, 42-49.

Viljoen, H G 1997a. Die analitiese teorie van Carl Jung, in Meyer, W F, Moore, C & Viljoen, H G (reds) 1997b, *Personologie: Van individu tot ekosisteem*, 104-135. Sandton: Heinemann.

Viljoen, H G 1997b. Oosterse en Afrika perspektiewe, in Meyer, W F, Moore, C & Viljoen, H G (reds) 1997b, *Personologie: Van individu tot ekosisteem*, 619-656. Sandton: Heinemann.

Viljoen, H G 1997c. Historical overview of psychological thinking, in Meyer, W F, Moore, C & Viljoen, H G (eds) 1997a, *Personology: From individual to ecosystem*, 27-42. Sandton: Heinemann.

Vorster, C 2003. *General systems theory and psychotherapy: Beyond post-modernism*. Bloemfontein: Satori Publishers.

Weingarten, K (ed) 1995. *Cultural resistance: Challenging beliefs about men, women and therapy*. New York: Harrington Park Press.

Weis, M & Hickman, T (eds) 1988. *Kender, gully dwarves and gnomes*. London: Penguin.

White, C & Hales, J (eds) *The personal is the professional: Therapists reflect on their families, lives and work*. Adelaide: Dulwich Centre Publications.

Wicks, R J, Parsons, R D & Capps, D E (eds) 1993. *Clinical handbook of pastoral counselling.* Vol 1, Expanded edition. New York: Paulist Press.

APPENDIX A

THE RELEVANCE OF PASTORAL COUNSELLING IN SOUTH AFRICA

I, Ilze Neethling, would like to include your unique spiritual experiences during pastoral counselling in my research. This means that you will have an opportunity to retell your preferred narratives during an interview.

Please read this information sheet carefully before deciding whether or not to participate. You have the right to say no. There will be no disadvantage or consequences to you of any kind. If you decide to participate, I thank you and look forward to travelling this road together with you.

PURPOSE OF THE STUDY

This study is undertaken as part of the requirements for a Masters degree in Practical Theology with specialisation in Narrative Therapy. In this study I would like:

- to differentiate between pastoral counselling and other (mental) health professions, in order to outline the special contributions pastoral counselling can offer which other health professions do not;

- to indicate space where pastoral counselling can contribute to already existing social and mental health professions by revealing the limitations of the mainstream helping professions;

- to explore the South African context for the need of professional pastoral counsellors with regard to:

    (i) pastoral counselling as a multi-cultural approach;
    (ii) pastoral counselling as a national health resource;
    (iii) its cost-effectiveness in relation to other health services;
    (iv) pastoral counselling as a human right and freedom of choice;
    (v) pastoral counselling as social transformation and reconciliation; and
    (vi) ethical motivations for pastoral counselling in South Africa; and

- to support the above discussion with vignettes of suffering, survival and redemption in spirituality.

In South Africa, no occupational or professional councils for pastoral work exist as yet. Whereas the professionalism and identity of the other helping professionals in South Africa are protected and guaranteed by professional associations or councils which control training, conduct and admission to these professions, pastoral counsellors in South Africa are still fighting for professional status. At present, there is a process underway towards gaining official recognition, primarily driven and initiated by the Southern African Association for Pastoral Work (SAAP). The process may lead to the registration of pastoral workers at a variety of levels. The SAAP is an organisation that embraces diversity, based on ethical and value-based responsibility. The SAAP also subscribes to the principle that there should be accountability and control within the profession.

One of the main aims of my study is to explore contexts in South Africa which lend themselves to pastoral work, thereby assisting pastoral and spiritual workers in the struggle to obtain professional status in this country. This study then will hopefully contribute by demonstrating that pastoral counselling can contribute to healing and recovery in our broken country.

In this study you will have the opportunity to express and retell your experiences of various events of pastoral counselling, whether and how spirituality contributed to recovery or conquering your problem, to speak of the meanings that you attack to these events, and to explore the real effects of these experiences and meanings in shaping your life. This includes your specific definition/s of spirituality.

I do not attempt to deliver "scientific proof" that pastoral counsellors are needed in South Africa. I rather believe the most compelling evidence of spirituality's importance comes from those directly involved in the process, people sharing moving stories of suffering, survival, and redemption, and how spirituality offers a practical, personal means to recovery. Therefore I merely intend to offer rich descriptions of the relevance of pastoral care for South Africa supported by your unique experiences. I will use these experiences to outline the need of South African people to be cared for spiritually and their right to obtain such care.

PARTICIPANTS NEEDED FOR THE STUDY

Six to eight people who have previously joined in pastoral counselling are requested to share their spiritual experiences encountered during the course of the therapeutic conversations, or to illuminate the role spirituality played in healing and recovery from their problems.

WHAT WILL BE REQUIRED OF PARTICIPANTS

If you agree to take part in this project, you will be requested to sign the attached consent form for use the information obtained to be used in this study. Information will be collected from you by means of an interview. It is possible that more than one interview may be required. If you prefer, communication after the initial interview can be conducted by telephone or e-mail. If there is any aspect of the information collected you feel is personal to you, and that you do not feel comfortable about using in this study, you have the right to say this, and this information will not be used.

After the interview you will receive a summary of the interview which might include interpretations from my side. You will be asked to make comments, corrections where needed, and provide feedback regarding this. You also have a choice, about whether you want to conduct the session in Afrikaans or English. However, the report will be written in English to make it culturally and internationally accessible. Therefore all summaries and other correspondence will be in English.

After finishing the study, you will also have a chance to comment or change anything related to your experiences on the thesis, prior to submission, given that part of it is your contribution to knowledge. At this stage you will be requested to sign a "release of information" consent form, once you have satisfied yourself that the report of your experiences rings true and is valid.

FREE PARTICIPATION

An important ethical principle in research entails the right of the participants to engage or disengage. You therefore have the right to withdraw your participation any time without any consequences to you.

This study is also run as part of a Master's Degree and participants will therefore receive no financial benefit from participating.

CONFIDENTIALITY

The information obtained during our discussions will be discussed with my supervisor and will be used for this study. With your prior consent, I intend to tape the interviews. If you prefer otherwise, I shall make notes during our conversations.

It goes without saying that if we correspond further by email, I will have your comments, experiences, or feedback, on paper. This will be treated as data collection, as part of the research process. All information collected during the study will be securely stored, either in a locked cabinet, or on computer with a password known only to myself; and will be destroyed after conclusion of the project. If you choose to stay anonymous, but still want to participate in the study, a pseudonym chosen by you will be used and anonymity will be guaranteed.

RESULTS OF THE STUDY

The results of the study might be published in a journal, or any other psychological/ theological/scientific publication. Once again, at your request, a pseudonym will be used to ensure your anonymity.

QUESTIONS OF PARTICIPANTS

Should you have any questions or concerns regarding the project, now or in the future, please do not hesitate to contact me:

Ilze Neethling
Tel: 014 7790825 (all hours)
Fax: 014 7790714
Cell: 072 148 7048
E-mail: ilze .neethling@za.flextronics.com

Or my supervisor, Dr Johann Roux, at the Institute of Therapeutic Development

Tel: 012 4606704
E-mail: jpr@cybertrade.co.za

This study has been reviewed and approved by the Department of Practical Theology, Unisa, and the Institute for Therapeutic Development, Pretoria.

APPENDIX B

THE RELEVANCE OF PASTORAL COUNSELLING IN SOUTH AFRICA

CONSENT FORM FOR PARTICIPATION

I have read the Information Sheet concerning the study and I understand the purpose of this research. I consent to participate in the study subject to the following conditions:

a. I am under no obligation to participate.

b. Knowing I can choose to participate, or withdraw from participation at any time with no consequence attached to this.

c. I am aware that my personal information will be used for the purposes for the study. I am also aware that if there is any aspect of the information collected I feel is too personal to me, or that I do not feel comfortable about using in this study, that this information will not be used.

d. I am aware that all information regarding myself will be treated confidentially and be stored securely; and will be destroyed at the conclusion of the project. I am, however, aware that any raw data the project depends upon will be retained for three years.

e. I receive no payment or compensation for participating on this study.

f. I am aware that Ilze's supervisor will have access to all information regarding this study.

g. I am aware that I can choose a pseudonym in order to protect my identity.

I am willing to participate in this research study.

I choose to go by my given name: ……

I choose the following pseudonym (name and surname): ……

…… ……

Name of participant (capital letters) Signature of witness

…… ……

Signature of participant Date

APPENDIX C

THE RELEVANCE OF PASTORAL COUNSELLING IN SOUTH AFRICA

CONSENT FORM FOR RELEASE OF INFORMATION

I have read the summary of our conversations.

I have had an opportunity to correct or change, give suggestions, feedback, and/or withdraw information I did not want to be used in this report and to correct any misinformation or misrepresentation regarding my contributions.

I agree that my contributions can be used in the research report.

…… ……

Name of participant (capital letters) Signature ofwitness

…… ……

Signature of participant Date

APPENDIX D

INTERVIEW SCHEDULE / QUESTIONS

SPIRITUALITY

1. Is there a particular form of spirituality that informs your life?
2. How would you describe/define your idea of spirituality?
3. What does this spirituality mean to you personally?
4. Do you think all people experience spirituality the same way or do you think it is possible people may have different conceptions of spirituality? How and why?
5. Do you think it is OK to have different ideas of spirituality? Why?
6. At what times are you more in touch with your spirituality?
7. What helps you to get in touch with your spirituality?
8. Is spirituality important to you? Why?
9. Can you remember when you first became aware of your spirituality? Some background on the development of your spirituality?
10. What were the steps you took (or are still taking) to develop your particular form of spirituality?

COUNSELLING / THERAPY PARTICIPATION

11. What made you opt for attend pastoral therapy/counselling instead of visiting a traditional psychologist?
12. What experiences urged you to seek assistance from a pastoral therapist/counsellor?
13. Would you feel comfortable in sharing your story with me? You do not have to include any information you feel to be too personal or revealing.
14. During the therapy/counselling process, did you discuss the role of spirituality in your life?
15. Would you say that you experienced a “spiritual character” during the therapeutic conversation?
16. What effect did your spirituality have on the problem you experienced/experience?
17. Has your spirituality been an enemy or ally to the problem?
18. Can your spirituality and the problem be present at the same time, or does one block out the other?

19. What influence did therapy have on your spirituality? Why do you think so?
20. What influence did spirituality have on the problem? Why do you think so?
21. Which carries more weight in your life, the problem or your spirituality? Why?
22. If the problem tries to make a comeback some time in the future to rob you of your happiness or dreams, do you think that spirituality would assist you in standing up strongly against the problem? Why and how?

DISCUSSING THE COUNSELLING PROCESS

23. In general, can you tell me a bit more about the therapeutic conversations? Comment on anything you consider important.
24. Is the addressing of spirituality something you would want from therapy, or would you rather prefer spirituality to be separated and addressed as a separate domain (your spiritual life separate from your concrete life)?
25. Have you experienced any therapy/counselling previously or was this the first time you have made use of any type of therapy?
26. If you have previouslyattended traditional therapy (for example, a psychologist) would you say there are differences between pastoral counselling and standard psychological therapy? If so, how and why?
27. Do you think the way the pastoral therapist/counsellor talks with you, differs from the way a psychologist would speak to you? How and why?
28. Which do you prefer? Why?
29. Have you learnt anything from sharing in pastoral counselling that you consider valuable?
    What and why?
30. Would you make use of a pastoral counsellor/therapist again in the future? Why?
31. There is a strong belief that therapy is a business that should separate the spiritual from the worldly. What do you think of this idea, and why?
32. Have you experienced any feelings yourself (or actions from the pastoral counsellor's side) that made you feel uncomfortable (marginalised)? What and why?
33. Was there anything special during the process that you would consider important when a therapist deals with a client? If so, what and why?
34. Do you have any suggestions for therapists to conduct "better" therapy? For example, body language, language, attitude, sharing, etc.

35. Do you think people should be afforded the right to choose freely whether they wish to go to a traditional psychologist, or whether they could attend pastoral therapy? If so, why?

ACCOUNTABILITY

36. Did you find the conversation about spirituality and your experiences in therapy in any way helpful to you?
37. What is it doing to you now, actually reliving the story/ies you have shared with me?
38. What effects did talking about spirituality have on you? On your feelings? Thoughts? For the future?
39. Do you think that conducting research this way (making you a co-author of the process) is acknowledging of the wisdom and knowledge that you bring to the research context? Why?
40. Is there anything in the questions themselves that you found disturbing?
41. What does it do to you to be consulted about your views regarding the therapy process and role of spirituality, and to be asked for guidance this way?

APPENDIX E

NARRATIVES: A MULTITUDE OF STORIES

(i) Foreword: A window on stories

(ii) Standing strong against cannabis and aggression

(iii) Selling my body, selling my soul

(iv) I can see now

(v) Step by step

(vi) Hope in my heart

(i) FOREWORD: A WINDOW ON STORIES

Stories are the windows of life. They let everyone "peek inside to see that they are not alone in their suffering. It is that knowledge that gives them power when their world is bleak, makes them laugh when they see their own folly, and makes them cry when tears are the only answer. Without that window, the greatest emotions are sometimes never touched, never felt, and never shared" (Siegel & Siegel 1988: 83-84).

When I first heard the following stories, it was as if the first dragon had taken wing. The first tree has grown eyes and ears and the first flower has learnt how to speak. Only a stone would not be moved by the suffering, the hope, the love, and the courage, that are portrayed here. In these stories, the people are real. They have real lives, hopes, and dreams, just as we do. It is not make-belief, and it has really happened. It is still happening. And these people have taken the time to share these intimate details of their lives in the hope of making a difference to ours.

One rarely finds such opportunities nowadays, and they are to be savoured. I believe we are very privileged to share these journeys with the participants of this study. Very few people have the privilege to look through or in another's window, and to share the view from there.

To Derrick, Marelize, Ilze, Bakela and Sarah: thank you from the bottom of my heart! You have contributed to the history of whom I am and who I am becoming. By honouring the history of our connection, I can so doing also honour my own story. I am grateful for many of the ways your stories have influenced me, and hopefully the pastoral profession as well.

And to you, the reader, to you who have come this far, thank you for sharing the views from these windows, and for travelling this journey with us. Let us then go down the following roads and see who lives there, see what they are doing, and how they are doing it. May you wipe a tear with us, and may you rejoice with us in the sparkling moments of courage and hope. May these gorgeous moments, when the view becomes clearer and the events begin to form a pattern, also entice and lure you into its magical strange places. May they also contribute to your preferred ways of "being".

(ii) STANDING STRONG AGAINST CANNABIS AND AGGRESSION

Ilze Neethling and *Derrick du Toit

I guess every human being is a spiritual being. From childhood onwards, we are taught religious principles and how we have an immortal soul, which, one day, would go to heaven if only we believe and follow the Christian principles as laid out in the Bible. So, yes, I consider myself a spiritual being too. I do have a body as well as a soul. Is that not that what separates humans from animals, I mean, having a soul? So I guess I would describe my own spirituality as a belief in God and a belief in the afterlife. Being saved from going to hell, that is. I cannot say I am a good Christian, for that I do not visit the church enough or read my Bible enough. But I do belief in a higher power than myself. And for me my spirituality then lies in the belief in this power which guides me in my actions and thoughts, whether they be right or wrong according to others.

I do not think everybody experiences spirituality or religion the same way. I believe people experience spirituality different. In South Africa, it becomes all the more difficult to believe there is only one way of practising religion, what with the different race groups and all. The Blacks, for instance, have a different spiritual realm where the spirits of their ancestors play a role in protecting them (or tormenting them). I do not know much about it but I do believe there are different forms of spirituality, definitely. And I believe that for others then, their spirituality is as real and authentic for them as mine is for me. Whether I believed these ten years ago or so as well is a difficult question. Back then, during apartheid, I was aware of only one culture and religion - the culture I have grown up in. But after democracy and the accentuation on human rights, I guess all South Africans have learned that there is more than one way of living. Who is to say ours (Whites) is the only “true” way? We have become a rainbow nation in South Africa. If we have to accept the difference in cultures then that would include difference in religion, or spirituality as you call it, as well.

It is difficult to say where and when my ideas about spirituality emerged, or how it developed. If I think back, I guess I only really became aware how religion (spirituality) influences my life during my visits with the pastoral therapist. Maybe I should start my story at the beginning for it to make any sense?

**Author prefers pseudonym*

I grew up in a strict household where my father was the head of the household. We had to attend church religiously, and Sunday school too. Every night we read from the Bible as a family, and we were woken up if we failed to pray before going to sleep. This was the norm. This was what life was about.

Later, as a teenager, I was diagnosed with spinal atrophy. That is a form of muscular dystrophy. This is a disease involving the progressive symmetric wasting of skeletal muscles - the legs, arms, and chest. Sometimes the heart muscles. Most of the times the voluntary muscles are the most affected. Even if connective tissue and fat deposits sometimes make the muscle seem stronger and larger, the fact is that it is not so and that they are wasting away, slowly but surely. There are things you can surely do to try and ease the symptoms, such as a regime of physical therapy, limited exercise, healthy eating, but other than that there is no known means to stop the impairment. This I got from a book I am presently reading on muscular atrophy. Doctors seldom tell you everything you want to know.

I was given maximum ten years to live as a "normal" active person. According to the doctors, by the time I reach forty years of age I would be in a wheel chair, if I am still alive. At that stage, it did not bug me that much. Or so I thought. But I guess it must have worried me more than I thought since then I got involved with all types of drugs. The mystique of faith also dwindled away. I ceased going to mass or going to confession.

All my friends also experimented and I suppose I was just mixed up in the wrong crowd, nightclubs and parties and loose women. After experimenting with LSD and acid, I became hooked on cannabis. Guess I just thought it was less dangerous than other drugs! Overall, I think I habitually used it for at least twenty years of my life.

From what I have read, cannabis is not really dangerous or habitual forming, but from my own experience, I would say it is bad for you. I started forgetting things. This got so bad I could not remember from one moment to the next what I have said or where I placed things. I constantly was on the search for my wallet, or the car keys, even my drink. Or worse, watching the same movie three times without realising I have seen it before. Times just seemed to lapse and sometimes a whole weekend would go by without me realising this. I turned "NAFI" – as we used to say in the old army days "No ambition, little interest". Then the experts say, cannabis is not habit forming or dangerous?

I started acting out. I would turn aggressive at the least provocation. I lost friends. I lost good girlfriends. Even the so-called friends who used to smoke with me, kicked the habit and eventually got married and had kids and careers, and left - while I was still stuck in the waste lands. Yes, I visited some psychologists, and each one of them had a different "cure" for me. Maybe I was not ready. Maybe I did not want to be "cured". Half the time I felt like an incompetent idiot, sitting there in the consulting rooms. As if I was being judged. I seldom went back more than twice to a specific psychologist. Why? I did not like it there. I already mentioned it made me feel stupid. I felt as if I failed miserably as a human being. Now I needed somebody else to tell me how to live and save my life from totally going down the drain?

I already felt as if I failed as a human being since I had this incurable disease, you see. This meant that I would never be able to do what other men can do. There are rigid rules in society for what men are supposed to be able to do and do not. I miserably failed in this. My legs already were losing strength. I could not run anymore, I even struggled to get up from a chair. And I started struggling to perform in bed, if you get my meaning. And then I also believed psychologists are for "mad" people, weak people, and people with serious problems. Where I grew up, we called psychologists "shrinks" or head doctors. There was nothing wrong with my head! I was not mad, and my problem was not that serious. I just struggled a bit to lay off the dope. But each one of them tried to analyse me. And I am nobody's guinea pig, man.

However, things got so bad that I could not get up from bed without first smoking a joint. Where was religion, or spirituality in all this, I wonder? After leaving home I never even bothered to attend church again. I already OD'd on church going as a child. Originally I thought it spiritual to be in a different place after smoking. Everything looked better. The world, and people too, was a beautiful place. God was loving and kind.

But only when I smoked. When "clean" God was this totally scary figure who condemned me for deviling his temple (my body). So, as long as I smoked, I had no problems. I never got tired. I had visions, dreams, and ideas that, if only I could manage to act them out one day, would make me a rich and happy person. I even had this dream to write a book. But the half-finished manuscript has been lying in the back of a closet somewhere for more than fifteen years now. Eventually I could not get through the day without smoking at least five to seven joints. Half the time I was totally out of it. I could not even do my job properly. I wonder how many business or other opportunities I missed out, that way.

It is a miracle that I was not fired from my job or caught by the police. It was becoming increasingly difficult to hide my habit from the rest of the world, from family and friends. The smell, you know. It was a smell quite distinct from other smells, and it infiltrates your body odors too. One girlfriend told me my mouth tasted and smell like chicken pooh. I also was permanently on guard, hiding. I was hiding my stash in all possible and impossible places, and then rotated them the next day for in case of a police raid. It is funny how one becomes quite suspicious of everything and everybody when doing something illegal.

Sometimes I had to wait until two o'clock in the mornings just to make sure everybody is asleep, before I could smoke. My mother, in particular, has a very sharp nose and she sometimes, when visiting, did question the peculiar smells in my house. I then started to isolate myself socially just in order to smoke freely and peacefully. I hated people visiting. It felt like intrusion on my habits. When there were people around, I could not really smoke. My life was a mess. And all the while, I still believed I am doing okay.

I did not have particular reasons for visiting a pastoral therapist. Somebody close to me suggested it (a new girlfriend, actually). She insisted on it. And, it was free. Otherwise, I would not have been able to afford it. I had no money for such things. So, in the beginning it was, sort of a joke, and just to pacify her. I was a bit suspicious though. I was not in the mood of being preached at, or being read to from the bible. Actually, I thought it would be a waste of time (but then I have unwittingly wasted so much time in my life already a bit more would not have mattered anyway).

I was surprised at the therapist. She was genuinely interested in what I have to say. She did not try to tell me what is wrong with me, not did she tell me "God loves you too" or that "everything has meaning in life" or that "there is a higher meaning to all this". These things are clichés. And clichés, according to me, do not help you to solve a problem.

I had no idea what to expect from pastoral therapy. All I heard was that is was some sort of therapy that incorporates the spiritual aspects of human being. Whatever that meant. So I was pleasantly surprised to find that this therapy consists out of talking and speaking, just like normal people having a conversation. I never once felt that I was being judged. I was comfortable, and actually found that I enjoyed going there. I could be myself. She treated me as an equal rather than as someone with a disease.

I just wish the rest of the world could be so accepting. My parents still do not know about the problems I struggled with. One day, hopefully soon, I will gather together the courage to tell them. Maybe they read this and recognise me. Hopefully, not yet!

It is difficult to describe what I experienced during the conversations. It was like, somebody to talk to, somebody who finally was willing to hear what I wanted to say. As if what I had to say, was important. If I have to pinpoint exactly what had made the difference, I would say it was the things she did not do, rather than what she did do. I was not interrogated. I was not dissected. She did not make me feel as if there was something wrong with me, rather she sympathised about the things that had happened to me. Nor did she tell me what to do with my life, but left it up to myself to find the answers I was looking for, to make my own choices.

I never before realised the lies that cannabis was telling me. Cannabis was trying to make me believe, and most of the time succeeding in it I must admit, that I was not strong enough to cope with daily living. It was telling me that it could help me cope with my weakening muscles, that I was intelligent because of it (cannabis) and that, without it, I would not be special anymore. And cannabis used aggression to convince me that it would be my legs. Cannabis would make me strong. It would hide and protect me from realities I could not cope with. Aggression helped me to stand up against people and situations I otherwise would have ignored, or let go by, even innocent comments or situations. It also promised to help cannabis, to be the legs I did not have.

Then there was the one experience I would never forget in my whole life. Maybe this was the turning point, I do not really know. One night (I already started with this pastoral story, I think it was after the second visit) I smoked a joint spiked with acid. I had the weirdest hallucinations. A dead head skull grinning at me, following me wherever I went. This was weird, man. I could not get rid of the damn skull head! I still have dreams of this thing following me. So I mentioned it during the next visit with the therapist and we started discussing religion. Only, she kept calling it spirituality. I got the idea that spirituality means more than religion. I am struggling a bit with this one, but it is beside the point (to me it is still the same as the religion thing but I know now it means different things to different people). Then a funny thing happened. Man, I have never before realised that I could use my religion as a weapon against my problems! I never knew that drawing upon this spiritual side of me, as she called it, could help me in standing strong against the voices of cannabis and aggression.

Where were all the intelligent theories and labels from the university people? Why did not she tell me I am to blame, I have a serious problem, I need serious treatment, I do not have self-control, or such things? I fully expected to walk away being called something like obsessive-compulsive or something or schizophrenic. (Just about every second person I know has schizophrenia. Is this a new epidemic in South Africa?).

During therapy I have discovered that religion can be a freeing experience (sorry, spirituality). The religion I grew up with was nothing of this kind. Instead of a jealous God watching over my shoulder for every move I make, sadistically grinning when I get it wrong, I now have a kind elderly man smiling down at me. How I now judge whether my actions are right or wrong has changed as well. I just ask: "hey, pal, are you willing to join me in this venture?" If he declines, it normally is a good indication of how he feels about it. And I ask him simply to help me when things get tough. How is that song, when the going gets tough the tough gets going? Something like that. Only, he is there to help me when the going gets tough. This is not always easy. Do not get me wrong. And sometimes he feels I should do things on my own. But I know he is out there watching over me, but this time not to judge me, but smiling. And it makes it much easier to live my life with him in it. I kind of care what and how he feels about me. I have something to hold onto! I think everybody needs something to hold onto, somewhere in their lives. Without something to hold onto, I think your life becomes meaningless. And without meaning, there is nothing to look forward or to live for.

Sometimes I still feel like a joint. It is hard to say no. I still have friends coming over, thinking they do me a big favour by bringing some stash with. I have been clean now for only five months. Soon it will be six. And I struggle with aggression still. I also still have problems remembering. But it will get better. I hope. Struggling with my muscles is another problem. But at least now I know I can handle it. Or try to. I have no idea what the future holds in store for me. But, I have now turned forty and I am still not in a wheel chair. Maybe, with a bit of luck and hard work and some support from "The Man" himself, I will make it at least another ten years. And for the time I have had this far, I am grateful. Now I just hope I can do something worthwhile with the rest of it. And, maybe, in sharing my story, it will help somebody else also to overcome the same type of problem. One never knows. That on its own will make it worth the while. And maybe, just maybe, I will dust the old manuscript and give the forgotten dream another go.

I would like to know why we have been taught that the body and soul is separate. My experience now is that the two are inseparable. If only I had realised this at an earlier stage of my life, I might

have been able to fight back earlier. I mean, my every day life is spiritual, if that makes any sense. Why do psychologists not address the spiritual side of their patients too, by the way? I mean, if we involved my spirituality years ago, I might have been "made whole" a long time ago.

I have been asked what I think about pastoral therapy. Well, I can say it was something that made a profound change to my life. I enjoyed it. It helped. It gave me back a sense of meaning. I think everybody should be able to visit a pastoral therapist or whatever when they experience problems. Or have the option to. People have rights man. I myself will definitely make use of pastoral therapy again, if the need arrives. Why does the Government not give them the status, or profession, or what it is you call it? They can help people.

In answer to one of the other questions, I think one should not separate the "spiritual from the worldly". I already stated I believe all humans are essentially spiritual, what with having a soul and all. And if the body and soul is inseparable, then therapy should address both, right? Or one should have at least the choice to decide whether they want to explore the so-called spiritual realm as well. And I do not mean simply going to a church or minister – now that is scary, man.

Look at me: I have been from one shrink to another. Nothing helped. It only served to scare the hell out of me and to increase my feelings of incompetence. I would not say pastoral therapy is a quick cure for what ever ails you. I would not go as far as that. I cannot really say psychology is bad for you, I do not know enough about that. But I liked the way the pastoral therapist talked with me. And let me talk. It felt like a journey, and as if I was acknowledged as a human being for once. I was given back my self worth. Why could the psychologists not treat me this way? Was that that made the difference? Or maybe there was something spiritual in the pastoral process itself?

One would not know, I guess. But, I found the pastoral therapist better equipped and trained in dealing with addressing the spiritual side of my problems. I am also not always sure if psychologists are not more interested in conducting therapy for them rather than for me. Why else would I have felt so uncomfortable and guilty in their settings? Somehow, I always felt so much in the wrong that I felt I had to crawl back like a trained dog with a report of better behaviour, which would suit them, not me. I felt as if they looked down on me like some father figure to the neurotic, vacillating me, no ambition, no self-discipline, no goal, and no life. But maybe, it was rather a matter of matching imprints. Something in relation to the way animals recognise each other and distinguish friend from enemy, or family from prey. A matter of early mental imprinting. Something

unique about pastoral therapy matched an inner pattern (of spirituality?) that I have been carrying around with me all these years. Selfishly, I also want the emotion and structure of any therapy to be calculated in my own interests, whether I leave, or whether I stay.

Sharing my experience now for this project was quite exhilarating. I enjoyed being the author of my own story, and appreciate that my knowledge is considered as valuable. I think it a good idea to ask people about their experiences – that way we all learn from each other. It was quite different, being involved in the writing itself as well. I did not expect something like this. But then, I have learnt that pastoral things do not even come close to anything one expects from it al all!

(iii) SELLING MY BODY, SELLING MY SOUL

Ilze Neethling and *Marelize van der Westhuizen

I died when I was nineteen years of age. I died about a year after my wedding, at the high noon of day, when the harsh glare of the sunlight striking savagely through the window shutters while foreign hands raped and plundered my body. I could not understand why this should be so, for I was a good and loving wife and God fearing person, and did not ask for nor expect what was happening to me.

I was a serious child all my life. Unfortunately, I want to add, since serious people bore other people. Serious people do not know how to have fun, reckoned in non-serious people's terms. Duty and responsibility weighs heavily with serious people, their own pain and weaknesses did not exist, their thoughts mainly for others they are responsible for. For, serious people think there is deeper meaning to life, and if one remains sober and serious one could tease the meaning out into the open, like removing a snail from its shell, and then one would be in control of it. So seriousness leads to foolishness. To being vulnerable, becoming a target for abuse, to open your breast for a target, to being unaware that you are doing it, and to letting others fill your heart with lead. I never found the meaning I was looking for, or the control. I trusted everything. And it led to my destruction.

I guess I was also looking in all the wrong places. I seemed to believe that my redemption would lie in men. I was sitting at home, writing poetry, and reading classics, while waiting for that one dream man to show up and whisk me away to Eden. And of course, since I was a seriously boring person, nobody was interested. I would get a date and end up with a mouth full of teeth, not knowing what to say or do. After that one uncomfortable date full of stilted pauses and pregnant silences, I would never see the boy again.

At the end of the day I settled for the first man who bothered to come back twice, not realising I could do better. The marriage was a total sham. My husband was an alcoholic who also squandered our money at the racing track. And soon, he started offering me to his friends, to pay the rent.

Easy money for him. Blood money for me.

Author prefers pseudonym

Selling my body went against everything I was brought up to believe in. I was a strict Christian. And the onlyway I could reconcile myself with what I was doing, was to abandon my religion. I felt dirty, tired, washed out, contagious, rejected, and second-hand. God was dead. Why else would he ignore my prayers? Eventually I started to cut him out of my life. Father, now your child will simply stop asking. It never occurred to me to get out of the marriage. I was brought up to believe that marriage is for life; for better or for worse. And that the husband is the head of the household. I was his property, and he had the right to do with, or to me, what ever pleased him.

For six years, we settled into this "comfortable" routine of him staying at home while I went out at night to "work". He became my pimp. And, like any other pimp, he would beat me if I did not bring in enough to pay the rent, buy the food, and supply him with all the booze he wanted. Sometimes I hurt so badly, I could not move. The slightest effort brought a panting of breath, and sometimes it almost did not matter to me anymore whether I would continue breathing, or not.

I picked up several venereal diseases. Since I grew up quite sheltered, I had no idea what was happening until a customer complained to him that I have infected him as well. For that I received another beating. For treatment I had to go to an obscure downtown clinic in the township – I was too embarrassed to take my shame to our house doctor.

I do not know if my parents ever noticed anything. I started to visit them less. When I did visit, I would wear long sleeved dresses or shirts with buttons up to my chin. Overall, I think I camouflaged myself very good. I think the worst thing I probably did, was to eventually, totally isolate myself from my friends and family. If only I had turned to them for help at that stage, I think I would have been "saved" a long time ago. But my upbringing had taught me differently. I have been taught all the traditional womanly virtues, the standard female reactions and positions and ploys. No matter how bad I was beaten, or how bad I was treated, my conditioned instincts urged me not to burden others. My petty problems were beneath public notice. Marriage problems are private, right. A woman's place is under her husband, right. And the support of my husband and the continuance of the marriage were the only things I had been placed on earth to assure. The duty and responsibility of the serious person…

I fell pregnant twice. My husband forced me to undergo an abortion both times, since he did not want to raise someone else's "bastard." I still cry for my unborn babies. They were part of me after all... Sometimes late at night, I hear their unborn cries. My babies, crying in the darkness, lost anguished wailing in the night – but for them there never will be anyone to hear or heed.

And that is how my soul died. It simply must die, under this kind of inhuman torment. I looked and felt like an old woman. I was tired, terribly tired, tired to the point of uncaring exhaustion when nothing matters anymore and it is easier to keep stumbling along than to stop. My every action became unthinking, automatic. However, complete mental and psychological exhaustion carries with it its own blessing, its own drug, and anodyne. If you can survive the initial torment you can tolerate what ever follows to a degree. Accustomed, but not reconciled. That was what was happening to me. And whatever sufferings of the body I then endured, I stopped feeling. I stopped remembering. I no longer remembered my anger, bewilderment, despair, or my utter disbelief at what was happening to me. Most of the time, I was too dazed, too abused, and too wounded to remember.

But later I did, and I would never be the same again.

I was afraid to go and I was afraid to stay. Most of the time I was more afraid to go, than to stay. And then my husband – my pimp, my tormentor– decided to divorce me. I guess I should have felt grateful. But, I had no training, no skills, no qualifications, and I had nowhere to go. I was homeless, jobless, and without any money.

So I continued with what I did best: selling my body, and selling what was left of my soul.

I was fortunate. This might sound funny, but what I mean is I could have ended up in a low class suburb on the streets working for R50.00 per trick or gotten killed somewhere in a dumpster. Instead I managed to hook up with a prestigious house where the girls received protection, and not beatings, from the pimp. There were screenings of course. Only “intelligent” girls with “lady like” qualities were accepted.

We were what you would call “high class hookers”.

We had fixed schedules, which only could change with managerial consent. Usually I worked only Monday nights, Wednesday nights, and Friday nights. We each had our selected clients, we received good food and drinks, and we only had to pay a minimal fee each night: R250.00. We also had the use of any facility in the house, including a tennis court, saunas, a swimming pool, and a gymnasium. I suppose they believed it would pay for the girls to stay in shape. And

interestingly enough, we had no fear of being raided by the cops: we received protection from them. As a matter of fact, the manager of the house was a cop.

So much for honour and the morals of the police force. And so, I lost my faith in the police, too.

At the risk of sounding vain, it helped that I was quite good looking. I had no problem getting rich clients on the first night already. I built up a selected client base, which, of course, also lessened the risk of diseases. Some of the uglier looking girls were really struggling, going some weeks without getting clients. I suspect this is one way a pimp keeps a hold on his girls, since they still have to pay the nightly fee: and simply run up the bill. So they keep working until they can pay back the money. Which, of course, seldom happens, keeping her chained to the house forever.

I received good money, making up to R2000.00 per night. Back then it was rather a lot of money. I even managed to buy a car and a house. And this time, by playing the rules men created themselves. I became cold, scheming, calculated: exploiting men's weaknesses to my advantage.

There is a difference between being betrayed into prostitution by someone you cared about (someone you trusted) and freedom of choice. I sometimes wondered why the other girls turned tricks and what led them to this lifestyle. As for me, I was first "sold" into it. Later I chose to believe it was my own choice. Somehow it made things more bearable.

I even managed, eventually, to secure a daytime job as a sales person. Luckily everybody knows reps earn commission, so no one queried my income. Outsiders simply considered me a good rep.

Getting married again was a calculated decision, not love. Somewhere during all these years I must have become less serious, or less boring, since my husband fell in love with me at first sight. Once I met him, I did not go back to the house I was working at. By some grace, I never gave them my personal details, or my real name, so they did not know where to trace me. The house was also in a different suburb, which lessened the chances of anybody bumping into me on street considerably. I know what happens to girls who "disappear" – there are high penalties for "dros" (running away) in the business. Once we got married, we moved away to a different region.

My husband still does not know anything about my past. Yes, he knows I was married to an alcoholic, but he does not know anything about the prostituting. I finally grew to trust and love him

enough to share that with him, at least. But he does not understand why I cry at night or why I have nightmares. A churchman himself, neither does he understand why I do not join him in going to church on Sundays: I could not get myself to forgive God.

I have never consulted a psychologist before since I did not consider myself as having a “mental problem”. According to me, a psychologist helps people who have “mental problems” (giving them medication) while spirituality and religion do not fit in this category. But this thing with God was eating at me, slowly, a cancerous thing. The body eating itself…is that not what cancer is? My spirit eating away at my body…

Why did he abandon me? Why did not he help me when I needed him most? Why did he allow al those things to happen to me? And why today, when I am trying to have a baby of my own, am I sterile?

I considered telling my husband all this. But, would this not just serve to unburden myself and to selfishly place the burden upon his shoulders? Would he be able to accept me the way I am? Would he still love me? Or would he reject me the way one does with used, discarded items, with garbage?

Did my redemption then still lie in men, in wanting my husband to accept what I’ve done in the past: to accept me?

And maybe I simply wanted to burden him. Maybe I wanted to punish him for all the abuse I have received at the hands of other men.

I was torn between love and compassion for him, which have grown over the years, and my feelings of hate for all men.

Salvation came by sheer chance, measured in small doses. I took my questions and issues to a pastoral therapist. I did not want to visit a minister of the church. I still feel uncomfortable in the house of God, or in any of the so-called holy places. But I needed to talk to someone. This has finally become too much for me to bear on my own. Visiting a psychologist, however, would have meant spending a lot of money, and questions afterwards, which I could ill afford.

In pastoral therapy I have managed to identify the gargoyle. When he visits, I normally feel a line of cold across my shoulders, bearing down. Then I know he has returned; the gargoyle with his ugly stone grin and sulphurous breath, straight from hell. The gargoyle sits on my back and digs his talons into me whenever he feels like it. He whispers to me, long cold whispers that smell like rotten meat and death – whispers of betrayal and deep dark secrets to protect. He whispers lies. Lies of hell and damnation. Lies of dark and cold places, and lies of dank, dripping dungeons, which ensnare my soul. Lies I have come to believe over the years. Lies it took so long to unmask for what they were…

The question became, is it that I cannot forgive God for abandoning me, or is it that I cannot bring to forgive myself for what I had to do to survive?

Could I love myself enough to also forgive myself?

What qualities and gifts do I possess to help me to face the world, to confront the world, to live my life effectively, happy? To become a less vulnerable, less boring, serious person? To be able to have fun, glorious fun, without feeling guilty afterwards? To be able to make love without pretence or holding back anymore, without remembering all those dark oh so lonely and scared nights in the arms of strangers? Courage to carry these secrets, to know when to share which ones and to know when to leave them be. Courage to banish the gargoyle, or at least drive him back into his hellhole when he tries to lie to me again.

I still have a long way to go. But every day I am learning, learning about my soul, my life, my spirituality, and religion. My spirituality is more than religion. Maybe it is taking religion and building your own beliefs within or around that religion, to something more and larger than the religion itself. It could be that it is building a personal relationship with God, rather than following the prescribed ways of how to believe, unquestioningly. Discussing my spirituality in therapy was probably the best thing we could do. Pastoral therapy gave it a safe place to be born again. My problems were prevailing over my spirituality, now my spirituality is starting to prevail over my problems. They cannot be there at the same time. And as long as I can hold onto it, I will have the power and courage to fight the problems. Therefore, I am glad to have discovered that my spirituality is still part of my life. I do not know why I expected it to be something separate. It is easier to live life with God in my life every day and not only, for instance, when occasionally reading the Bible. It gives me something to hold on to. I do not grasp this concept fully yet. But it feels as If he is now with me constantly.

Was there maybe something spiritual in our conversations itself, in the slowly piecing together of the puzzle called my life, until it started to form a recognisable pattern, one I could live with? Blame was never in our lexicon, I could not be punished for self-preservation and survival. Finding sense in what had happened to me, I feel, was an open-ended pursuit, with definite answers left to faith. So yes, I would also say there was a spiritual element involved in the therapy. Rational investigation of a problem can only go so far, and then comes the giant step to belief for which there is most of the time, no proof. How does one prove spirituality? I will not say I understand it, nor am I able to explain it. However, it is there, and that is enough for me.

Therefore, I am slowly learning to love myself again, and to love others. Even to reconcile with the opposite sex. Moreover, to get to know God again, a different God. One who would accept me the way I am – a sinner at large. So maybe I would find my redemption in my newly found spirituality, instead of men. A spirituality that encompasses the hate and pain I have endured at the hands of others, at my own hands too; that encompasses trivial pursuits of superficial freedom, power, wealth, or status everybody seems to believe so important. Maybe life really can be beautiful. For the first time in a long time, now, I am thankful to be alive. To be loved by a good man, one I can try to trust. To be able to make mistakes, and simply to be human. For the first time, my life seemed cracked open, full of emotions. Good emotions, such as I have never experienced before. I suppose it is part of the normal process of learning, but it seems to me a delightful revelation. Like tasting champagne for the first time.

Maybe I have found my “redemption” at last. In finding someone sympathetic, understanding, and offering support when I needed it the most. In being able to share my story with someone who cares, someone who was willing to listen without judgment. I am grateful for the opportunity to visit a pastoral therapist. What did she do to help me? It was the first time in my life that I'd opened up to a stranger like that. There was someone sitting across from me who would let me unburden myself without making me feel worse than I already felt. To me it felt as if our conversations were based on an equal dialogue or reciprocity. I was scared, I did not know what to expect. But she explained to me her way of working, what to expect, and she put me at ease. She never made me feel as if she was superieur. Most of all, she never made me feel as if “she was hearing God the right way” while I was not. That there was something wrong with me. She felt like a companion. I would say what I remember most of all was her humanity, her humility, and caring. The way she listened to what I was saying (not to what she expected I would say) and the warmth and support she projected. The way she was willing to discuss things I felt was

important to me, rather to discuss things she might have believed relevant. And maybe it was the way she cried with me, rather than hiding her emotions or trying to stay neutral or clinical.It makes a difference if you know the person you share your story with shares your pain. I believe the way a therapist is able to show the client's effect on their own emotions, can be healing too.

I do not know enough about pastoral therapy to judge whether it should receive professional status in South Africa. But based on my experience this far, I cannot see why not. I know enough about people to know that you cannot really generalise (although I still do so myself at times), so I would guess you would get good pastoral therapists as well as bad pastoral therapists. If I had connected to one who might have judged me, or tried to convert me, it would have hurt me more than it would have healed me. So I would say professionalising them will at least control the profession and establish codes for conduct. Protect the clients.

Sharing my story this way now maybe will lead to the redemption of others too, others who walk the same road I did. I feel at peace now, after revisiting my story again, realising that there are sparks of hope, courage, and perseverance in between which I have not noticed before. For such I have also come to see, is my spirituality – it might have slumbered for a while, but would not allow itself to be killed.

(iv) I CAN SEE NOW

Ilze Neethling & *Bakela (The Fist) Motlathegi

I am a 55-year-old black man. I do not believe in the white man's medicine so I have never visited their doctors before. If I am sick, I go to the sangoma. I do not trust white people, and I do not trust their laws. They lie and cheat and you always get the short end of the stick when working with them. My people suffered a lot because of the white man before Mandela became president. Now we have the vote and maybe things will start getting better for our people. Maybe now there will be more jobs, money, and food for us.

I work on a big farm where I live with the rest of my family. I have a wife and plenty children. Not all of them are mine. Some belong to my sister. After she died of Aids, I had to raise her children since I am the oldest of our brothers and we always take care of each other. It is our culture to take care of the family.

It is not easy to be a father. Children do not always listen to you, or respect you. Respect is very important to me. I am the head of the house so they have to listen to me. Otherwise, I give them beatings to show them I am the boss and to make them respect me. I have raised four children who now have good jobs in town. They look up to me and pay me the respect I deserve. Now it is more difficult to raise the other children especially the girls. I think the school they go to or the children they play with, put funny ideas in their head. They learn white man's things. But it is important to me that my children go to school and study hard. They must get good grades so they can get good jobs so they can take care of me when I get old. And at home, they must help their mother. But the one girl does not want to listen to me. She is now pregnant the second time and I do not know who the father of this baby is. She is 16 years old. She does not do good at school anymore. Last year she tried to kill herself. She drank all the perfume and pills in the house and the farmer had to take her to the hospital to clean her stomach. I had to give her a big beating to make sure she does not do it again. For a while, it was okay but then she tried to kill herself again. She ate a lot of the white chalk they write on the school black boards with. So I had to give her another beating to stop her from killing herself, and to make her listen to me. I used a cane and beat her all over her back with it until it bled so she can remember the beating.

**Author prefers pseudonym*

The school saw that I had beaten her and called the police. It was not the first time the school calls the police because I beat my children. I think it was the third time. So the police came and this time they took me to the court. I said of course I beat her. It is my job as father to beat her when she does stupid things. She must start listen to me. So the court says that I am guilty of violence or something like that and if I beat anybody again in the next five years, I will have to pay a lot of money and go to jail for a long time.

I was very confused. I do not understand this law. How will I make the children listen to me or respect me if I cannot beat them? The court now takes away my power as the man in the house. They make me a woman. Now the children can do what they want and I cannot stop them.

The woman who always comes talking with the people here asked me if I am okay and if I want to talk about it, I said no. You do not talk to strangers about the problems you have in your house. You make your own problems go away. And the man of the house never talks about his problems with a woman. So she said okay but if I feel like talk, I am welcome to come to her house or just to call her. I do not know why but then I started talking any way to her. I said to her I do not understand what to do with the children now. And that I am worried that I will loose my job because I think the people here are jealous and they always make trouble for me. I think they saw I beat my child and they told the school who told the police so they can take me away and then I will loose my job and they can put somebody else here they like more. And then my wife and children will have no home, no money, no food, and they will live on the street. So she talked to my boss and then told me the next day I do not have to worry because my job is still safe. I can still work here. I know she has helped many people so I thought maybe I could talk a bit more. Maybe because I can see, she wants to help and I thought maybe I should talk to her after she has helped me with the job thing.

So I said I was worried about the children, that they will not respect me anymore if I cannot beat them. She asked me then if I remember the old days when the farmers used to beat the black people to get them to work and to respect them. She asked me if I think the black people respected the white man for beating them. She asked that if the black man respected the white man for beating him and listened to him because of the beatings, why did the black man then start to hate the white man and then wanted to change the laws? Was it not the beatings also that hurt the black man?

I have not thought about this before. She asked me if I think that maybe the beatings can chase away the children from me. That they can also start to hate me and want to change my rules by not listening to them or run away. So I then think maybe the beatings makes the girl run to the boys to get pregnant so she can go and live with them because she does not like living in my house. This woman then asked me if I think the white and black people understand each other better now that they have stopped fighting and started to talk to each other. I said I think so but I still do not like white people very much. But if the rest of them are like her, I may have been wrong about them. Just a little bit. She laughed and said I may feel that way but she hopes we can talk about it. And she asks do I think I want people not to like me only because I am black or beat my children, or do I want people first to talk and understand me before they see if they like me or not. I think I want them first to talk to me. So maybe I will first talk to the white people and them see if I like them or not.

This woman made me think what would happen if we start talk and listen to each other. If we understand each other, it will be easier to respect each other and listen to other people. If I tell the children then why I have the rules and they understand them maybe they will listen to them and still respect me for making good rules. Then I will still be the man in the house and the girl will stop trying to kill herself because it will be more nice to live here.

I went back to the woman a couple of times but only at night because I was scared the people will think I am weak if they see me talk to a white woman about my problems. I started to enjoy going there because she was always respectful of me. She treated me like the head of the house and always listened to what I wanted to say. So I think I respect her because she respects me. This is different from going to the sangoma. The sangoma is always the one who gets the respect not the person who looks for help. It is also difficult to talk to the women at home still because I think maybe they do not expect me to talk to them. In my culture the women expect and want you to beat them or the children. It is the man's job. It has always been this way.

But this woman asked maybe if they want to talk together with us we can ask them what they want from me and I can tell them what I want from them and then we can make rules that will be good for me and for them. Because everything always change and the world never stays the same and maybe if something does not work for you or it causes bad things to happen in your house maybe you can find other rules that will work better.

I can see that now. My wife said she wants to talk because she does not like the beatings. I am surprised. And now we talk much more and sometimes we ask the children what they think. I do not always listen to them but I give them the chance to talk first. My house is a much more happy place now and it is nice to come home from work in the night. And the children laugh more. I always want them to respect me but I think they now start to like me as well. That is a good thing. I did not think I want them to like me, but I like it. It feels good and makes me happy too and it is now easy to be a father.

I think if I have problems again I will go back to this woman. White people are not so bad anymore. I start to think that some of them you can trust. And if all the white doctors are like this woman then maybe the white man's medicine can be a good thing because it opens your eyes. If I go to the sangoma he would give me some other medicine for the problem, but my eyes will still be closed. And the sangoma asks a lot of money for his medicine. This woman did not ask me any money and she did good for me because I have become a man again in my house even if I do not beat the children anymore. What she did good was to respect me and to make me see that sometimes the old ways have to change because it hurts people. She also give me plenty time which I felt was good and strange too because the white people does not always understand that black people see time a different way. Most white people never have time and always run for time while the black people like me make time for what we want to do. White people never listen because they do not know how to make time. So it is good she gave me time because now I think she understands the black people and if she understands she must respect us. Respect is a good thing because then there is no fighting.

She ask me if I want to write my story for her so other people who have problems can read it and maybe it will help them too. My story will be put in a book. First I did not want to do it because then everybody will know that I went to see a woman for my problems but she says I can use another name. And now I also think it is not so bad to talk to a woman because sometimes they can make you see things you do not see before. My daughter help me to write the story and this woman also. And now I also feel proud of my story because I write it myself and maybe there is other people who also want to make new rules but they are too scared to do it. They also need help and maybe they must also speak to her. And if my story then helps other people it will make them see that one way is not always the right way. There are other ways that will not hurt people. It will also make them respect me. It makes me a man to tell them how I fight this thing and won it.

(v) STEP BY STEP

Ilze Neethling & *Ilze Schoeman

I am the youngest of three children. We grew up in a strict Christen household. Sundays were sacred and no homework, or anything else we normally do during the week, was allowed to be done on this day. Every morning and evening we went to church. We also, as far as possible, attended Sunday school until we were baptised.

We were good, God-fearing Christian people, committed to a life in the church.

Our parents were also setting good examples and high standards for us children. They never shouted at each other, or treated each other badly. There was no violence in our household. They really excelled in providing us with a good education.

I went to school the first time when I was five years old and struggled to adjust to the new environment. It was only at High School that I finally started to adjust, although, I still did less well than average. I passed matric with five subjects. Unfortunately, I had to be satisfied with some subjects I was not interested in. I was especially interested in music, and had plenty talent in this field, but unfortunately I also never had the opportunity to do Unisa exams. I am still disappointed about this. And I still wonder how my life might have turned out if I have attended a music or acting school.

After school I did study music for a year… The year there after my parents relocated to a different town and I tagged along to make a new beginning. During this time I struggled severely with depression. The move, and especially leaving all my friends, behind made it difficult for me to cope. This, however, was not the biggest reason for my depression! I was also involved in a relationship…. I was desperate for help and ended up visiting a clinical psychologist twice a week who simply fed me a variety of anti-depressants. From the word “go”, I told her that I was gay, but I think she was so overwhelmed that she did not know how to approach or handle me. So, we only focused on the depression. And the thing was, actually my depression was caused by being gay. Its implications, rather. I needed help to cope with it and to accept it. However, things did not work out this way and nothing was accomplished by my visits.

**Author prefers pseudonym*

Through all this, however, I continued part time studies in music as well as Bible studies. Three years later I did a service year for the Lord. He called upon me to work with younger people. For some reason this is a strong gift I have received. Then after finishing my studies, I applied for a job in a well-known city. I did not really think that I would get it, since it was a sought after job. But the Lord provided and I really believed that I have found my niche in life. The church community, though, eventually started to become suspicious since I was not married, did not date, and showed no inclination towards the societal requirements of settling down with a family and children of my own. So some of them then took it upon themselves to delve into my life, to find out what was "wrong" with me.

At this stage, I have already developed strong relationships with the younger people I worked with. I consider myself as an extravert and as somebody with a strong personality. I have the ability to "draw" people to me, maybe because I also always try to understand others' point of views. Being "different" myself has taught me that people differ, and that we have the right to of respect for those differences. I believe young people were attracted to me because of those qualities. I so enjoyed my work! Working with these young people on a personal level especially was fulfilling. This was my calling. Unfortunately, parents started to become extremely nervous because of our relationships, even though it was on a professional and part friendship level only. The rumour started to develop that I was trying to alter the teenagers' sexual orientation, probably to my own advantage. General hysteria broke out in the community. I would guess that some of the young people were questioning or exploring their own sexuality, which is a normal part of puberty after all, is it not, and some of them started to show a deeper kinship towards me than was considered normal or acceptable.

It was definitely not my intention to change anybody's sexual preferences or to elicit "unnatural" responses. At that stage, I was barely able to confront and accept my own sexual identity, and I definitely would not wish the same confusion and pain upon anyone else. Yet, I was considered the origin of all sin and responsible for the awakening of "unnatural feelings" under the teenagers. I am using the term "unnatural" since anything that deviated from the societal norm, was considered unnatural. Sometimes still, unfortunately. Even colleagues started to shun me. I was told on several occasions that I am not allowed to come close to their children. Some started to warn their children against people like me, claiming they needed protection against me. What did I do that was so bad? Why could people not see passed their prejudice to accept me for the person I am? And why, would nobody offer help rather than judgment? Why was I being judged in terms of my presumed sexuality only?

Everything snowballed. I had to appear in front of a church commission who decided that, if it is not possible for me to follow certain “rules” as decided upon by them, and if they decided in my favour, I would have to resign and leave the community. Through this all, they never had the decency to refer to the rumours or perceptions by name… they so gently camouflaged their language… using language which cannot discriminate or be held against them later.

I was desolated. Crushed. My life was over. I was not even given the opportunity to defend myself properly. I had to wait outside while they made decisions about my life. Nobody seemed interested in hearing what I had to say. And nobody seemed to care about the pain I was going through, the utter confusion and alienation. I could see no other way out but to resign (giving them enough time to find a replacement for me). The next couple of months I worked under tremendous stress and ostracism, in an atmosphere absolutely loaded with negative emotional electricity. I was not allowed any contact with any of the younger people, nor was I given any support at work. I had to do everything by myself, alone.

So this part of my life ended on a very unappetising note, to put it mildly. When going to church, people openly stared and discussed me behind cupped hands. Whispering and pointing. It was quite plain that anybody who did not conform to the normal acceptable heterosexual standards had no part, no breathing rights, in this community. The worst of all was that so-called Christian people, people you would expect to stand by you and support you, did not do so. The church and its “true” followers had to be protected, and that was that. There was no place for people like me. I became an outcast from the community as well as my church. Nobody was worried that my world was collapsing around me. Never in my whole life have I come so close to committing suicide… I guess the only reason I did not follow through with this, was not to give them the satisfaction! They were wishing me off the face of the earth with every breath they took. Nobody even tried to find out my side of the story. Nobody bothered about me. And as long as the word “gay” was not used openly, it was okay… So I ran away, going overseas.

When I returned to South Africa after a couple of months, I assisted my dad in starting his business. I did not really want to do Youth Work again, but I also felt that I did not have much option since my dad could not afford to pay me a full salary. So I asked the Lord if he thinks it a good idea for me to do Youth Work again. Since he approved I applied for yet another job, which I got, and still am at.

Unfortunately, I have been hurt much by my church. Therefore, I distrust ministers/priests who do not know anything about other peoples' circumstances and then want to pretend themselves that their own lives are spotless, above suspicion. As if! Worse, if they as spiritual leaders really make it difficult for you to walk "the path"… being a child of God.

I learnt to distrust. Today I still do not trust people easily. Once, though, I did find enough courage to trust one person, and shared my story with her. She, in turn, shared my story with one of the ministers at the church, in the hope that somebody would be willing to listen to my side. I was referred to a Psychologist. Again. The only thing that happened this time was that I received the opportunity to tell my side of the story, in order to "feel better about myself". Nothing was solved, and nothing was put into perspective. We barely discussed my sexual orientation. Again! Nor could this person assist me in dealing with my destructive emotions.

The road I was travelling was long and bitter. I experienced hate and wrath against my colleagues … and still do. Forgiving takes time, and I pray that God will grant me the strength to forgive completely one day.

Through all this, I have almost lost my trust in God completely. I blamed him for everything. My intensions were honourable – so I believed – but the price was too high. How can I do my calling if I am continuously forbidden to have contact with any young people or with children? The perception still existed that a person "like me" will be a bad influence on them; that a person "like me" should not be allowed to work with children. So, I really tried very hard to get back control of my life. I needed to figure out whether I am acceptable to the Lord, or not. At this stage I went to see a pastoral therapist (something like that anyway) in the hope that he would be able to help me.

This time I was subjected to an exorcism. For two hours he attempted to exorcise the demons responsible for my problems. It was a terrible experience…one I do not want to repeat or relive.

The situation reached a turning point when I read an article in the paper about the wife of a minister who "came out of the closet". I tried to contact this woman. It was hard since at first I struggled to get hold of her, and she also needed time to work through her own healing process. After a couple of months, we finally did manage to meet each other. Through her, I was put into contact with a narrative pastoral therapist. (I had absolutely no intention of seeing a psychologist again, for the reasons I have already mentioned).

This therapist listened to my story. She was interested in hearing about me and in what I had to say. I also found no difference in the power position between myself and her; meaning I never experienced an attitude of "I am the therapist and you the patient" (... "therefore you have to listen to me" – such as when with a psychologist, in my experience). Her policy was that she had no patients, only clients. Therefore, you do not feel inferior when you knock on her door for help. This helps you to build esteem and respect for yourself. She was a person who worked quite often with gay people, and she seemed to understand us. She never judged – she also believes that some of us are born this way. Like the colour of your eyes or colour of your skin – part of you since the day you are born.

Since, who will actually choose to be an outcast the rest of your life?

She helped me to open up, to share my story, which was so painful to share with others. It was a struggle on its own, but I realised that this was the only way I could heal and to emerge as a healthy person on the other side. A healthy person; one who could accept herself unconditionally. I so badly want to be "healthy", but the negative perceptions in society and especially circumstances at my work, still sometimes make it difficult for me to believe that my life is believable and worthwhile. My work situation is still the same: negative towards gay people. I also seek a happy, fulfilling relationship. At the moment I am in a relationship, but I would really like to be able to have this relationship openly even in church, without the shame and fear of what others might think. My youth is passing me by without the second most important person in my life: a companion: a soul mate. So, I intend to make some changes towards the end of the year. I simply cannot continue going through life alone any more. I will have to find a Christian community who would be able to accept my gay identity as well as my relationship. This will be difficult, because people still have many issues with people such as me. The church's point of view is still too exposing, too destructive. However, I can hope, can I not?

I still have to work very hard at not letting societal discourses rule my life. I was so scared that people would not accept me, that I later (almost) conformed to societal standard just not to be rejected. I often feel torn between two worlds: the one I live in right now, which is considered "normal" in society, and "abnormal" according to society – but the one I want to live. True to the person I really am. However, now I have come to realise also there are more people on my side than I knew. For, sometimes it does feel as if you are the only gay person in South Africa: in the world. But I have realised there are really many others like me.

I will never be able to thank this therapist enough for what she has done for me! She gave me back my self-esteem and my self-worth. Since I have seen her, I could work at loving myself again. I thought so little of myself. I really felt that the Lord would obliterate me with lightning at any time. Thanks to her and especially her narrative approach, I could find healing in a story, which tells of a courageous person who had to overcome set backs and pain. I was so scared she would reject me, as everybody else always does, but she proved to me the opposite! Telling my story, without worrying whether it would be acceptable or not, meant so much to me. We shared ideas around religion as well. My religion is my spirituality. And, the more I thought the Lord did not love me anymore, the more I started to realise that he loves me unconditionally; endlessly! I so badly wanted to feel his love, but people always made me understand that he would not be able to love me especially since I am gay. So, step by step, I dared to approach his feet again with my imperfect little face full of tears. Since I have discovered that he accepts me, things are going much better! He gave me such unbelievable talents and gifts, but the problems I experienced also blocked out all positive experiences and thoughts in my life. These gifts are so amazing... and God touches me even in the most difficult times of my life… this is an indescribable experience.

I will definitely see a narrative pastoral therapist again if the need arises. I feel there is more accomplished with "story telling" than with the distributing of anti-depressants (although this probably also has its function in some cases). I definitely believe that pastoral therapists can contribute to the health sector, but then the person has to know what he/she is doing. Not everybody who believes themselves good therapists, are good therapists. Sometimes they are more destructive than anything else, such as the therapist who wanted to exorcise me. I would say deep knowledge as well as a natural talent to work with people on this level is necessary so as not to hurt or damage people. I also think it would be fantastic if pastoral therapists could receive professional status, especially if they could work through medical funds. That way they can reach more people. It is because of the affordability especially of the narrative pastoral therapist, that I was able to visit her. Some Psychologists are simply too expensive.

This is my story. It was difficult to present everything linear. Chronologically it is not always "correct". But, it is amazing after all the cutting and pasting, and translating, to see how this plot which is my life, unfolds. At one stage I could barely believe that all this had happened to me! It felt as if I was reading somebody else's story. Participating in this study really was wonderful. Sharing my story, I think, is also part of the healing process. This is what I find so amazing of

narrative therapy especially. By telling your story and hearing someone else's story, you are healing. To make a stand, though, is not always easy. What more can I say? The story writing made me look again at my life from a different perspective. As if I want to change my life and live it differently the next couple for years. I still do not have the courage to come out of the closet yet, although somewhere this year I intend sharing my story with my parents. All I know is that, step by step, I am working at it to one day live a happy life as a gay-christen. I do not want to live a lie anymore. I want to live my life fully as a gay. As myself. Step by step.

(vi) HOPE IN MY HEART

Ilze Neethling and *Sarah Motlhabi

I took my children to see a pastoral counsellor at the Kalefong Hospital after we had an armed robbery at the house. I was very worried about how this might have affected them. Just before Christmas, four men forced their way into our house and held us at gunpoint. We were forced into the bedroom where we had to lie down on the floor while they were looking for money and other valuables they could find.

The whole time I was worrying because, I knew it was not about money only. I kept thinking about what would happen afterwards, once they had the money. Would they kill us? Would they rape me, or my little girls? I knew that sometimes during car hijacks, they take the car and everything they want and afterwards they kill you anyway even if you give them want they want. So I was very scared. I just wanted them to take whatever they want and then go away. I was thinking about so many things… because those things, we see them on the television; those things, they do happen. We only had a thousand rand in the house and they wanted more. One of them even threatened to shoot one of my children if we do not give them more money. But then they took the TV and the radio, and other things, and left.

I was praying the whole time. My religion is important to me and it really helped me during this robbery. But this thing… you pray, and you cannot even say amen afterwards! You are so scared...

I had another problem I could not speak about before, especially with the children there. So I arranged for extra time at the counsellor without the children present. My husband does not know about this. I had a serious problem at home with him (my husband). I do not know how to say it, or how to describe him, but he does not want me to go to school, he does not want me to work… In fact, he does not want me to do anything. And I really want to study and to work. Once I enrolled for a BsC Degree at Unisa, but he refused to give me any money or to support me. So I had to cancel and even lost the original money I already paid. My husband does not even want to give me pocket money in the house. Everything he does himself, even buying the groceries. I do not do anything.

**Author prefers pseudonym*

He is also very negative towards my family, which causes many problems. Then he started coming home late at night, only claiming to have worked late. But I see the messages from his girlfriend on his phone. Once I even asked the police for a protection order because he started to beat me. His family does not understand my complaints because he has enough money, and they say he takes good care of me and the children. If his mother, for instance, asks for money, he always deposits the money the same or next day. When someone would say: "I want R10 000 because I want to buy the new car but I am short of money", he would simply say: "Okay I will give it to you." But for me it is a different situation. And they do not see my problem.

The situation was very disempowering. It broke me down and I do not know how I survived it. I started to consider filing for a divorce because I could not deal with the situation anymore. The situation was too hard for me because it also extended to other people, especially the children.

I had my first baby in 1991. After that, things changed and my husband started to bring his girlfriends to our house. This was wrong, because in our religion you may only have one wife. Things have not been easy. And love, when you talk about love, what is it really? Other people go out together and share things. I do not get anything. If you do not get love, you feel like you are not loved, and you think why is it? What is wrong with you? And I wondered why he got married to me. Maybe the family just wanted him to get married, or something. So, I went to the court to apply for a divorce. I do not know what happened, because up to now they have not been responding. I just do not know.

Since I started to visit the pastoral counsellor, things became better with me personally as well as at home. What did he do to help me? I think it was the talking. Before I did not have anyone to talk to, sometimes my mother, but then I realised the situation are affecting her as well and I decided not to tell her anything anymore. So, then I had no-one. You must have someone to talk to who will understand but for me there was no-one. When I went to the pastoral counsellor I noticed that he made time for me. And the fact that he listened… he asked questions I never thought about before. He gave me a safe place to talk. Maybe I started to trust him because of that. I felt I could talk about anything to him. So, the way he handled me was special.

I have not even told him this yet, but I have been to a clinical psychologist before. Here I was given homework every week, something like making lists of what I would do after I have divorced my husband. Future things. I was not very happy with the treatment I received. I wanted to

explore my relationship, maybe discuss the possibility of a divorce or the possibility of saving my marriage, but instead the psychologist took it as a given that I would divorce. We did not really discuss the options, nor my relationship self. It did not help me with the situation itself, or with how I felt. Maybe I did not want to talk about these things at the time. I did not want to go back to the psychologist/s because they have a different way of doing things and I did not feel comfortable there. I rather feel comfortable with this one.

The pastoral counsellor talked with me about the things I want, how I want things to change, and what it is that I am not comfortable with. Not like "Ok you want a divorce so I will help you through it and then let us see how you will cope." Throwing everything back at me again. As if I already made the decision. I needed help to see what decisions I wanted to make. With the pastoral counsellor I did not even discuss the divorce or consequences. He also spoke to me differently, respectfully. The psychologist spoke to me like a teacher and me the student, telling me what to do how to sort out my life. But the pastoral counsellor worked together with me and gave me time. It was nothing like "ok, next!" He could communicate and listen and he cared. I could talk to him. I did not feel this from the previous people. All the questions he asked, gave me the options or opportunity to decide what I wanted to do. It was nothing like, giving "reasons" for wanting to divorce, and then giving reasons not to divorce, like at the psychologist.

Instead, at the pastoral counsellor, he never made assumptions. He never thought he knew better. He asked many questions and I had the chance to discover for myself what I wanted to do. He was such a lovely man. He had time. This is something that bothered me with the psychologist. I had the feeling that it was just another job to him. That counselling was only business [money wise] to him, nothing else. Here, at the pastoral counsellor, I was never rushed. I had the feeling I was important and no matter how long a session took, he never made me feel that this was a business transaction. He cared.

We also talked about my religion. How it helps me, and the hope it gives me. Sometimes when someone dies, you cry and cry, but then you think about this man [God] who loves us. It gives you hope. The counsellor asked me about hope - it was difficult to describe what hope is! It is someone to trust, to like, to keep you going, but then I do not know how to put it. Hope is there and in your heart and it is doing something for you. Hope just makes you go on with your life because you have hope. It is that at the end of the tunnel, there can be light. It is hope you cannot see, but you can feel it. The discussion itself gave me hope again. It made my hope stronger again. It enabled me to think about things I was not able to think about before. To think about

what it is I am looking for and what I want. What I want hope to do for me. And how to get to the things I am hoping for. If you do not have hope, I do not think you can be successful in life.

My religion is my spirituality, because it is part of my life always not only when going to church. I believe in that way we should all have the same spirituality. To me it is wrong to ask the Lord things only because you need it while you do nothing for the Lord. Then you are only sitting there doing nothing. When you have a problem,you ask him to help you but other times you forget him. Then you do not understand when nothing happens and things do not get better. That is when people say there is no God. That is wrong. We have to do things for him too. I think then, we need to have the same spirituality, which is living your whole life everyday with him and not only when we need Him. So when people go for counselling, I think they should talk about religion as well. It can help because you base everything on religion. Religion is part of your life and then it should be part of counselling as well. They go together: religion and counselling. The problems you encounter every day are of the spirit also. Because of my experience I think there is a place for pastoral counsellors in South Africa. It can make a difference because it can give people Hope. Sometimes it can be dangerous, it depends. It should not be in the form of a sermon. People are sensitive about religion. As long as it does not become an occasion where people preach to you and try to convert you to their specific way of believing it will be good to speak about spirituality in counselling too.

The situation at home has changed now. Everything has changed. I do not know how, I do not know why. I do not know what I did. So much has happened over the last five months since I started going to the pastoral counsellor. The other day, there was one dress I liked. I really loved it. But, it is not like I can ask my husband for money, or anything. But then he asked if I liked it and when I said yes, he said I can have it. Just like that. I am not sure, if it is the "real thing" or if it is a "bribe", because something else has happened. Maybe he has changed because something bad is going on. However, I just hope it is the beginning of a real change. We now also started to talk about problems. We never used to talk before. No communication. Sometimes he would come home and greet the kids, and never even talk to me before going to bed. This would continue for a whole month. But now, even when he is cross, we can talk about it. I do not know how I did that. But there must be something. I do not even worry so much anymore about his girlfriends. He will see at the end of the day if they help him in any way, or if they are worth while having while he has a good family at home. But I am worried about sexual diseases. I am scared, also for HIV. But what can I do? My husband does not believe in condoms. I have to protect myself but I do not know how. That is the only problem there is now. He comes home earlier,

sometimes, or spends the whole day at home. Girlfriends do not call here at the house anymore but that does not mean he does not have any. It is not easy. The answer is how to cope with it. HIV is not selective. Good things sometimes happen to bad people and bad things sometimes happen to good people. And for different reasons, even good things can happen for bad reasons. Maybe something happens and he gets HIV. That might make him a better person, which is good, but then I will also get HIV, which is bad. But what can I do?

The hope is there. If you pray, he hears you and you become light. Others may say you are clever or something but it is not that. He just makes the problems easier. When you have a problem you pray before going to bed and read something from the Bible. In the morning the problem is lighter. He makes it easier to carry the problem. He does not make the problem disappear but he gives you the strength to carry the problem and to deal with it. Problems cannot disappear because we live in this world and Satan is always there. Satan is trying to make problems so the Lord helps you to fight against it. Then you can face the problem and win it. The Lord is your friend, and someone or something you know you can tell anything. It is between you and him only. And he gives you hope in your heart to face the problem.

I enjoyed sharing my story because I am a very social person. I enjoy talking. Talking to a white person about my story was not so difficult maybe because of my background. I went to boarding school and there were white people too. Talking to them now is not like they see anything different about you or you about them. But it is a long way still for black and white people to understand each other. We have a lot of work in this country still. Maybe if we share our stories, it will help people to understand each other better.