A Participatory Approach to Healing and Transformation in South Africa:

Ten Characteristics

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ICP 2012: Cape Town

Unequal society: Race, poverty and gender

Post-apartheid South African society is deeply divided. Past wounds are deep and still raw. Rated as the most unequal society in the world (Lefko-Everett, 2010), one sees destitution, hunger and over-crowding within minutes of being in extreme affluence. Of the estimated 50% of South Africans living in poverty the majority are black (Amoateng et al., 2004).

Patriarchal ideology dominates in all South Africa's various cultural and ethnic groups (Ramphele, 2008; Vetten, 2000). Despite progress since 1994, the domination of men in the socio-economic and public spheres continues in the post-apartheid era, perpetuating the image of women as inferior and dependent on men (Ramphele 2008). Sexism is expressed in its extreme form in violence against women with South Africa having one of the highest rates of reported rape in the world (Jewkes, Abrahams, Mathews, Seedat, Van Niekerk, Suffla, Ratele, 2009a).

The HIV/AIDS pandemic reflects the strong interrelatedness between race, poverty and gender. The vast majority dying of AIDS are black people in their prime. There is a strong link between vulnerability to HIV/AIDS and poverty (Nattrass, 2004). Ideas of masculinity based on gender hierarchy and the sexual entitlement of men add to the vulnerability of women who make up 58% of the adult population who are HIV positive in South Africa (Ramphele 2008).

Psychological services – Unequal and Inappropriate

The dominance of white middle-class males has significantly and systematically skewed psychological knowledge production and service provision in South Africa prior to and during the apartheid era (Magwaza 2001:38-39). As a profession it has mirrored discriminatory and oppressive practices associated with race, class and gender divides (Suffla, Stevens & Seedat 2001:30). Training has remained largely westernised and mainstream while mainstream intervention frameworks are often inappropriate in low-income settings where psychological distress is frequently related to structural issues such as poverty, unemployment etc. (Stevens 2001: 48 & 53). With the economic divide comes a large divide

between those who can afford psychological service and those who cannot (Ruane, 2010:221).

A participatory approach

I have been practicing as a psychologist in South Africa for almost thirty years. In the mid 90's, when political changes happened, I had a private practice that provided work for three full-time psychologists. During this time my social awareness was raised and I started questioning my practice that was serving only 10% of the community (mainly white) while the remaining 90% (predominantly black) could not afford my services but were clearly suffering extreme trauma (Kaminer & Eagle, 2010). When I volunteered one day per week to people from impoverished communities I was confronted by both the limitations of my training and by the privileged and sheltered life that I had been living. I had no way of making sense of the problems related to living in communities of extreme poverty: I felt I had nothing to offer.

Eventually I left my practice to retrain and reposition myself as a therapist within the wider South African context. I attended workshops presented by Michael White, David Epston and other narrative therapy practitioners. They introduced me to poststructuralist and social constructionist ideas embedded in a postmodernist worldview in which there are no essential truths and in which the therapist is no longer the expert who knows how clients should solve their problems. I shifted from those psychology models that view the "self" as consisting of innate personality characteristics, which often isolate individuals from their social contexts, to viewing the self as constructed in social interaction. Declining to return to my lucrative practice with its good infrastructure and high visibility in middle-class society was a radical step. In 1999 I opened a practice at my house which enables me to keep overheads low and to make time available for work (mostly voluntary) outside my practice. The ten characteristics of a participatory practice which I will discuss are informed by Narrative Therapy and feminist ideas. It has become central to my work as psychologist in my private practice and in communities as well as in my teaching of colleagues and participation within my own community (Morkel 2011b).

The personal is professional is political

In a participatory approach the key phrase within the feminist movement, personal is political (Harnisch 2009), combined with the feminist challenge to the academic discourse that separates the personal from the professional (Weingarten 1997: xii) are critical. As white woman I am both a part of the oppressors and of the oppressed within South African society. My personal awareness of my complicity with and the ways in which I benefitted from apartheid is expressed in a desire to use my professional skills to do restitution. My

awareness of the traumatic effects of our apartheid legacy is raised through my professional involvement with the wider community and this awareness motivates and supports my continued commitment to stay involved in acts of healing and transformation. I use my personal experiences of oppression as a woman in a patriarchal culture to support me in developing understanding of the effects of power abuse as well empathy for people who experience oppression in different areas of their lives.

Participating with the *other*

In South Africa the majority of psychologists are white and providing services to middle-class clients while the majority of society is black people living in poverty (Ruane 2010:215). In a context where trust has been broken and society is still organised along racial and social class structures, it requires conscious and continuous effort to bridge these divides to participate with the other (Morkel 2011b). Otherness is more than mere difference, but refers to a position where we could easily experience "the other" as so completely different that they become dehumanized and therefor invisible to us (Weingarten, 2003). Otherness invites us to ask whose voices are subjugated and silenced and to seek to reach out to the margins of society to those who are oppressed. In South Africa it also involves facilitating healing in relationships between stories of victim, victimizer and bystander (Gobodo-Madikezela 2006:74) like a Bridge Buidling function organized between the Strand Muslim community and members from the white community (Morkel 2011a).

Participating *with* people

Narrative therapists strive to enter into relationships of care in which we collaborate *with* people (Madson 2007). Therapists are alerted to the power difference that exists between clients and therapists as we work towards collaborative relationships where knowledge is produced together with clients (White 1997: 139). We maintain a stance of curiosity about and respect for the client's understandings and meanings. We draw on the expertise of clients as we believe that clients are the best experts on their experience. Working from a belief that lives are multi-storied it is our task to listen and search for the more hopeful and preferred story-lines of client's lives. Accountability about the effect of our actions is to the clients and communities that we work with (White 1993:57). Narrative therapists actively invite feedback and evaluate our work in terms of the degree to which our actions are experienced by clients as respectful, connecting, empowering and hopeful (White 1997: 138).

Participating with *awareness*

In therapy we often deal with problems that are symptoms of broader structural injustices like poverty, sexism and racism. If therapists are unaware of the effect of these injustices their actions might be misguided, ineffective and even harmful (Weingarten 2010: 11 & 12). When I work with people from cultures significantly different from my own I often collaborate with a cultural consultant, a person who is a trusted and informed member of that culture (Waldegrave 2003:22). In this way I attempt to raise my awareness about the experiences and meaning patterns of that particular culture (Morkel 2002:101). White (1990: 1995; 2004; 2007; 2002:36) refers to the operations of modern power that "incite" people to constitute their lives through truth discourses that reflect the dominant knowledge systems of a particular society. Narrative therapists invite people to gain a reflexive perspective on their lives and assist them to separate from truth discourses that are subjugating of them. These acts of refusal is linked to the idea that life and identity is constituted not given and that such refusals will be linked to possibilities that constitute life in other, more creative ways.

Participating in *voicing*

Herman (1992) points out that healing and justice begins within relationships of speaking and listening. She points out that victims of intense suffering and oppression are often deprived of the ability to speak about their experience and are silenced. Herman (1992:1) stresses that the process of remembering and telling the stories of trauma is an important part of the healing of individual victims and the restoration of the social order. Silence and fear are important political tools with powerful effect on perpetrators, bystanders and victims (Gobodo-Madikizela 2006: 74). The narrative therapist is very active in asking questions to encourage the telling of the clients' stories (Freedman & Combs 1996:57). The conversation is much more than just a cathartic expression, but is an active seeking of alternative ways of understanding and acting. Definitional ceremonies enable the recruiting of audiences and assist the joining of people around shared and significant themes in their lives, thus breaking the silence and isolation that so often surrounds experiences of trauma (Morkel 2011a).

Participating with our *bodies*

During apartheid our bodies defined whether we were stigmatized or advantaged. Our bodies were kept apart. When psychologists seek to participate with disadvantaged communities our embodied presence enables the breaking down of distrust, prejudices and cultural barriers. When we meet people in the streets, homes and gatherings of their communities our awareness of the implications of poverty is raised and we become familiar with the cultural practices of the communities. In my community-based work it has been this

embodied participation – e.g. my willingness to wait for hours in a cold community hall for clients who often did not turn up – that showed my commitment to care. Narrative Therapy joins feminist thinkers when they object to the body/mind dualism (White 1993: 55-56) and encourage ways of speaking and writing that are embodied by situating responses in the context of personal experiences, imagination and intentions. The practices of the written word like the writing of therapeutic letters all form part of embodied responses to client's words and actions.

Participating *together* with others

In scarce-resourced contexts of over-whelming trauma therapists can easily experience despair. Kaethe Weingarten (2000: 399) states that "matters of life and death are too hard, too onerous, too painful to 'do' alone". Narrative therapy offers various ways in which support from others can be invited into the therapeutic work. The practice of re-membering assists clients to view themselves through the loving and appreciative eyes of others (White 1997; 2007). Communities of concern can be recruited for support (Freeman, Epston & Lobovitz 1997: 132 & 135). When audiences of outsider witnesses participate in re-tellings of the stories that they have witnessed it allows them to join clients in their life struggles (White 2007: 165 – 218). Networking and teamwork is central to a participatory approach. Psychologists can support colleagues in marginalized communities through offering supervision, training and visits to witness their work. Through compassionate witnessing we can make contributions and progress visible and acknowledge the challenges that colleagues face in their work (Morkel 2007)

Participating in *social transformation*

If therapists are not involved in addressing and transforming social injustices we are in fact simply helping people to be better adjusted in a society whose fundamental values and assumptions remain unquestioned. This leaves people to identify themselves as the problem and does not change anything in terms of empowering them to take a stand and work with others to challenge the injustices. In a participatory approach we need to constantly think about ways to break the silence surrounding problems like sexual abuse, for example (Morkel & Matholeni 2012). This is the only way to encourage the community to take a stand, assist victims to speak out and seek help and to challenge the myths, stigmas and denials surrounding the problem. We need to use every opportunity in all the contexts of our participation to challenge cultural beliefs, practices and structures that inform and support social injustices. The 'cry for healing' within South Africa is inseparable from the need for justice (Ackermann 1998:83).

Participating in *interrelatedness*

A participatory approach challenges the individualistic understandings of Western culture. It moves us towards the African understanding of Ubuntu where people view their humanity to be bound up in the humanity of others (Tutu 1999:31). Michael White (1997:145) proposes the constructing of a two-way account of therapy in which the therapist acknowledges the extent to which therapeutic interaction is constitutive of the lives of therapists. This means that I listen to others while opening myself up to reflect on my own life and at the same time be challenged by what I am hearing. In this way my own life is touched and changed by my engagement with others. Heshusius' "participatory consciousness", a relationship construction which she calls the "self-other", was taken by Kotze (2002) into local narrative practice. This participatory consciousness where solidarity and care does not involve a patronizing, objective self-other relationship distinction (Kotze & Kotze 2001: 3) explains the type of interrelatedness between self and the other that is one of the planks of a participatory approach.

Participating in *restitution*

The participatory approach which I propose is borne in a deep desire to do restitution for my complicity with and the ways in which I am a beneficiary of apartheid. My people (the Afrikaner) and my church (the DRC) supported apartheid and my profession (Psychology) has mirrored the discriminatory practices of apartheid. Because of my complicity on so many levels I want to give back, participate in healing and transformation and redress imbalances. That comes at a cost. Engaging in acts of restitution involves giving up on ideas such as time equals money and money equals success. It also requires of us to give up on individualistic ideas of professional success. I have to hold my awareness of my own complicity and the ways in which I benefitted very close in order to keep my commitment alive.

Conclusion

In many ways a participatory approach is counter-cultural practice, which Jonathan Jansen insists, must be a feature of leadership for transformation and restitution in post-apartheid South Africa. To participate in this way requires courage, patience, and commitment, but it can make significant ripples and support hope (Morkel 2011a).

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