

TOWNSHIP SPIRITUALITIES
AND
COUNSELING

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Spelling:

In this book, a choice has been made to use “counseling” and “behavior” as preferred ways of spelling.

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Foreword

This book is a reworked version of a doctoral thesis submitted in 2007 in the Department of Practical Theology at the University of South Africa. The title of the thesis was *Doing narrative counseling in the context of township spiritualities*. The study leaders were Prof Jacques Theron and Prof Hennie Pieterse, to whom I owe great appreciation for their insights into religious practice and healing.

As required by the university, I published an article based on the research findings of the thesis in *Practical Theology in South Africa* (22.3, 2008:201-218) entitled “The healing of intimate spaces through the deconstruction of religious discourses: Co-constructing alternative stories of faith in the context of township spiritualities.” However, parts of this thesis have not been published verbatimly in this article or anywhere else. The manuscript of this book has been submitted by the publisher for peer-reviewing to three reviewers. They are Proff Maake Masongo and Julian Müller from the Department of Practical Theology at the University of Pretoria, who are experts in narrative counseling, and Prof Jacques Theron from Unisa, who also had to confirm whether the changes as suggested in the original reports of the examiners had been satisfactorily made. The review process entailed the filling out of an evaluation form on the scientific contents and presentation of the manuscript, as well as a narrative report. Both the reviewers recommended the publication of the manuscript.

The manuscript, then, has now become a book. The book describes the counseling journey undertaken with 270 patients at the Family Medicine Clinic at Kalafong Hospital in Atteridgeville, Tshwane, between June 2000 and December 2003. Of these patients 75% were women, 74% were black and 97% Christian, with half of them belonging to born-again churches. A majority of the patients (52%) were unemployed and the others employed in minimum salary jobs. A third of the patients had attempted suicide at least once before, and a third had lost at least one close family member in the month before attending a counselling session.

With these patients a narrative pastoral counseling practice was established. Narrative counseling was practised as a MEET process in which the patients’ problem-saturated stories were mapped and their problems externalised; they were empowered through the deconstruction of religious problem discourses, and their alternative stories were thickened by means of religious practices. This was a pastoral practice with a focus on religious discourses as problem discourses, and on the deconstruction of these discourses towards alternatives stories of faith.

The first aim of the book is to describe the faces of religious problem discourses as found amongst township patients. They are *power discourses*

that hold patients captive in divinely sanctioned hierarchies of gender and class, *body discourses* that alienated patients from their bodies, *identity discourses* that placed the religious identities of patients in conflict with their other identities, and *otherness discourses* that created barriers between patients and God.

The second aim of the book is to describe the externalised faces of the problems ruining the patients' lives. Here Losses, Loneliness and Lack of money were described as problems causing amongst patients feelings of worthlessness, depression, paralysis, body aches and many more.

The third aim of the book is to describe the characteristics of the narrative pastoral counseling practice that has been established. This practice negotiates healing between binaries such as Western versus African, culture and dogma versus lived experience; patient passivity versus patient agency. It furthermore respects the indigenous knowledge of patients as it is embodied in township spiritualities. Finally it aims at introducing patients to a community of care as well as a new community of discourse where they can experience spiritual healing.

I want to thank several people for co-journeying with me and making the publication of this book possible. First of all, the personnel of the Family Medicine Clinic at Kalafong Hospital, especially Prof Helgard Meyer and Dr Sonia Hitchcock. Their support and accommodation made this study possible. Furthermore, I have to mention my colleagues at the Research Institute for Theology and Religion who supported my research and eventually ventured into publishing it. Here special mention should be made of Mrs Nonnie Fouché who is responsible for preparing the manuscript for publication. My mother and father, Rachel and Willem Landman, proofread the manuscript. My son Derek always reminded me of how fragile I am, the wounded wannabe healer. I want to thank him for making me strong. Final thanks go to the patients at the hospital who shared their stories with me and whom I have come to love dearly.

The struggle for happiness and healing continues. Hopefully this book bears testimony to one small step taken in this direction.

Christina Landman

August 2009

Chapter 1

The journey ahead

Journeying with religion

Religion belongs to everybody. Therefore, it is extremely simple. However, believers experience religion to be complicated. There are several reasons for this. Theologians and pastors try to make religion inaccessible to lay people. This is to keep their own professional status. Also, believers themselves may prefer religion to be mystical and secretive, and to be made complicated by taboos and initiations.

For me, religion is simple and rests on four discourses only, discourses that often make people ill – and are in need of therapeutic deconstruction. Much will be said about this later, but in short these discourses are as follows:

- Power is hierarchical.
- Bodies are controllable.
- Religious identity has priority over cultural and social identities.
- The otherness of religion leads to salvation and healing.

Having said that, I immediately have to explain what is meant by “discourse” and “deconstruction”. Later, these terms will be explained more fully. Here it is enough to say that a “discourse” is a grand narrative, a belief, that rules people’s lives. To “deconstruct” a discourse is to undermine its harmfulness, and to shift the discourse to a place where it can start to heal society.

But let me get back to what we have been discussing. The *faces* of religion are simple, then, although they have been hidden behind a variety of dogmas. The *effects* of religious discourses on people’s thinking and doing are, however, not simple, but varied, complicated and powerful. Often they are harmful. Also for professional reasons, religious leaders have emphasised the transcendent and saving side of religion, and ignored the harmful effects of religious discourses on believers’ thinking and doing.

Journeying with healing

This book presents a *counseling practice* which addresses both the harmfulness and the healing potential of religious discourses.

This is relevant in a country with a high incidence of religious affiliation. According to the most recent census, undertaken in 2001,¹ slightly less than 80% of South Africans are Christians. 1,5% belong to Islam, 1,3% to Hinduism; 0,2% are Jewish, and 0,1% Buddhist, with 0,4% belonging to African Traditional Religions. A small percentage, namely 1,5%, preferred not to indicate their religious affiliation. The remaining 15% listed themselves as “no religion”.

South Africa, then, is one of the most religious countries in the world. At the same time, it has one of the highest rape rates in the world, the highest incidence of domestic violence, and the fastest spread of HIV and AIDS. Statistically this means that the rapists, the domestic violators, and those who spread the HI virus, are religious people who are affiliated to a religious institution.

Indeed, South Africa is low in natural disasters, but high in (hu)man made ones. And often local religious discourses play a significant role in disastrous human relations.

A counseling practice which empowers believers to deconstruct the harmful effects of religious discourses on their lives, and rescope religion as a healing discourse, is needed in a country, then, where people commit relationship crimes under the influence of religious discourses.

Journeying in a township

South Africa accommodates another unique phenomenon, that of “townships”. These are peri-urban settlements which came into existence when the Group Areas Act (Act 41 of 1950) forced people to live in designated areas according to race. In the townships, religion has been reclaimed by people in search of the healing of their bodies and circumstances. This has given birth to religious discourses on healing which are unique to these areas, and largely foreign to the “outside world”.

A counseling practice is needed which respectfully reflects the healthy and unhealthy faces of the discourses that function within township spiritualities.

This immediately calls for a definition of township spiritualities. Here “township spiritualities” is seen as a combination of (Western) diaconal healing, (African) ritual healing, (Pentecostal) faith healing, and human rights. As such, township spiritualities – although they have internalised aspects of Western spiritual views on healing – are in constant dialogue with

¹ Numbers provided by Statssa, percentages presented and interpreted by myself.

Western medicine as practiced by state hospitals, and western counseling as practiced widely in South Africa.

It was the challenge of this study, then, to set up a counseling practice between township spiritualities on the one hand, and Western medicine on the other.

Journeying with an aim

This introduction enables me to describe the threefold aim of this study.

- 1 The first aim is to describe the faces of religious discourses in a township setting.
- 2 The second aim is to try to understand the effects of these discourses on believers' thinking and doing.
- 3 The third aim is to present a counseling practice, based on the insights of narrative counseling, within township concepts of illness and healing.

Ultimately, the aim of this study is to describe the healing that takes place when, in counseling, the harmfulness of religious discourses are deconstructed towards healthiness.

But with whom do I want to achieve these aims? The patients² whose stories of healing will be told here, will be profiled later in the chapter. Here it is enough to say that this is a study of the first 270 patients I have co-counseled at Kalafong State Hospital in Atteridgeville³ between June 2000 and December 2003. This journey was undertaken at the Family Medicine Clinic, also known as the "Out Patients". I use the word "co-counseled" to indicate that, in the counseling journey, I was but a co-traveller with the patient. I have travelled with patients at this hospital on Wednesday mornings for seven years, from 2000 till the completion of my doctoral thesis⁴ in 2007, and have co-counseled in total more than a thousand patients. In counseling

² This book is an exercise in narrative counseling which usually does not refer to counselees as "patients" or "clients" since these references may imply that the counselees are ill or on the receiving end of counseling only. Narrative counseling sees the counseling process as a journey on which counsellor and counsellee embark as co-travellers. However, here the term "patients" will be used to refer to counselees simply because this counseling journey was undertaken in a hospital.

³ Tshwane/Pretoria, in Gauteng, one of the northern provinces of South Africa

⁴ Christina Landman, *Doing narrative counseling in the context of township spiritualities* (DTh thesis, University of South Africa, 2007).

patients dealt in particular with the religious discourses that regulate their lives which, then, are the focus of this book.

Throughout the book there is a category “Journeying with stories” that seems to take on a structure of its own. Under these headings the stories of the therapeutic journeys with patients are told, at first to explain the theory, and later to illustrate the practice of the counseling done with patients. It is to the first of such a “Journey with stories” that I shall now proceed – in order to validate the aims of this book. In fact, this is only half a story, since the healing part of it is not known to me. I tell the story, however, to indicate the need for a therapeutic study on religious discourses within township spiritualities.

Journeying with stories: Susie⁵ and multiple religious discourses

It happened on a Wednesday, as usual. As mentioned before, Wednesdays are special days. They are days of learning at the hospital. Here I have seen the faces of religion, how they harm, and how they heal.

On a Wednesday in 2003 a mother of Brown descent brought her daughter Susie to the hospital. She was referred for counseling by the school where she has irregularly attended classes since February. Susie was not speaking, and she was shivering. According to the rules of the hospital, the patient was to be seen by a doctor first. The doctor prescribed medicine for depression and psychosis, according to what was available at the hospital. At this stage, Susie was considered “not counselable”.

The next Wednesday Susie and I entered into a session of narrative counseling. We externalised her problem as “Mister D” who told her not to go to school and to run away from home. Also, there was a “Missy” who made her feel good, because, as Missy, Susie was “beautiful and blond, and the boys liked her. The session succeeded in making the voices of Mister D and Missy softer, and Susie’s voice louder and more assertive.

Since there were at this stage no psychological or psychiatric services available at the hospital, I made an appointment with Dr C, a psychiatrist at a state psychiatric hospital, to see Susie. The next Wednesday we attended a joint session at

⁵ All names have been changed.

this hospital. Susie spoke little. Her mother related that Susie failed Grade IX the previous year, and that this was a huge shock to her. Since then, Susie was unwilling to attend school, even after her father had given her a hiding. Since February, Susie started “speaking in voices”. She spoke in Mister D’s angry voice, announcing that she was not going to school, and that she was leaving home. At times, she also took on Missy’s attitude to present herself sweetly and seductively.

The family tried to deal with this by taking her to the Baptist pastor who “drove the demons from her”. When this did not silence the voices, people from the neighbourhood diagnosed her as “bewitched” and suggested that she should go to a sangoma (traditional healer) for help. This would entail inner cleansing (through vomiting) and the slaughter of an animal to gain the goodwill of the forefathers. Since they were Christians, Susie’s mother said, they did not explore this option.

The psychiatrist made a preliminary diagnosis of dissociative identity disorder and major depression disorder. She referred her to the Adolescent Unit of the said psychiatric hospital. An appointment could only be secured within a month’s time. Because of a formal lack of cross-reference, this also meant the end of my contact with Susie.

Important to note here, is that at this stage, already, Susie’s “speaking in voices” had been given multiple explanations and a variety of cures were offered, most of which were of a religious nature:

- Demons caused the illness, and they were driven out by a pastor.*
- She was bewitched and needed the help of a traditional healer.*
- She was psychotic and needed anti-psychotic medicine.*
- She was socially constructed by discourses which left her powerless as a child and a girl, and needed narrative counseling to deconstruct these discourses in order to diminish the effects of the “voices” on her life.*
- She suffered from a disorder and needed psychiatric help.*

Although the unique outcomes of Susie's story cannot be related here because of loss of contact with Susie, her story validates the aims of this study in the following ways:

- The faces of religious discourses need to be described where western professional ignorance on the subject exists. Many of these faces may be unique to township settings and, as yet, not dealt with academically.
- The effects of religious healing discourses on the lives of people need to be understood. They need to be placed alongside other forms of healing available to people in township settings where there is restricted access to health care.
- A counseling practice is needed to explore religious healing within a multiplicity of psychological, psychiatric, medical and cultural healing discourses and practices. Formal professional cooperation between these forms of healing is needed even in the absence of state funding.

Journeying with questions

This study, like any other, started off with questions that needed to be answered by research. The research questions that initiated this study, and led to the formulation of the aims of the study, are as follows:

- Can the religious discourses which influence believers' thinking and doing be identified, classified and described? What are the roles religious context, race/culture, class, gender, age and money play in the identification, classification and description of religious discourses?
- What are the criteria for understanding the effects of these discourses as (un)healthy, (im)moral and (dis)functional? When do these effects lead to clients needing counseling, that is, when are these effects therapeutically significant?
- How can the harmful effects of religious discourses be diminished in counseling? Can religious discourses be successfully deconstructed towards healing by finding alternative spiritual sources for moral behavior? Can this be done in a township setting where people are not free to be moral because of financial restraints? Can a patient be empowered in counseling to reposition him/herself in social and ecclesiastical contexts dominated by class, race/culture, gender, age and money discourses? What will be the language of a healing religious discourse? What will a counseling practice in a township setting look like, and can it be practically implemented? What are the dis-

courses on illness and healing prevalent in the township, and how can they be invited into a counseling practice based on the deconstruction of harmful religious discourses? And eventually, can religion as a healing discourse become a reality within institutionalised religion?

To validate these research questions, again, a story has to be told.

Journeying with stories: Lerato and religious identity

Lerato (39) visited the Family Medicine Clinic of Kalafong Hospital in 2001, complaining of severe headaches. She was referred for counseling.

Lerato belongs to a new-born church in Mamelodi, Tshwane. She is employed and works at a chain store for R2 800,00 per month, which leaves her with R800,00 after deductions.

Lerato tells her story as follows. Her mother is a sangoma (a traditional healer) who wants to steal the Holy Spirit from Lerato to do magic. Also, her mother has put a spell on her sister by instilling a matrix (a virtual reality) in her. The matrix has kept the sister from obeying and respecting the pastor of the new-born church which Lerato is also attending. The matrix also caused Lerato's sister to dream incessantly about snakes coming out of her vagina and mouth. However, when the pastor baptised her, the matrix left her sister – and the dreams stopped.

Lerato's mother has a stepbrother who raped Lerato's daughter when she was five years old. Lerato's daughter is now an emerging teenager of 13 and wants to wear modern and close-fitting clothes. Her pastor advised Lerato to give the child a "good spanking", in accordance with Proverbs 22:15, lest she not invite being raped again. After Lerato had punished her daughter a second time with a sjambok (a kind of whip) for wearing revealing clothes, the school informed Lerato that, because of the severity of the punishment, they would make a case of assault against her if she hit the child like that again.

During counseling, Lerato moved towards an alternative story in which healthy Christian values played an important role. The focus was especially on rescoping "unconditional obedience" at the hand of questions such as "What is human

worthiness in the eyes of God?” Co-authoring Lerato’s story was a long and difficult road, which was made even more difficult by the fact that she could not get leave from her work for counseling. The therapeutic process will not be described here, since her story is told here simply to validate the research questions that initiated the research done for the study.

Lerato’s story explains the research questions which initiated and informed this research in the following ways:

- It validates the question whether religious discourses can be classified, and points to the possibility of a four-fold classification according to (1) power discourses, (2) body discourses, (3) identity discourses and (4) otherness discourses, as briefly referred to in the opening paragraph of this book: Lerato’s life, then, seems to be ruled by *religious discourses* that leaves her powerless and confused about *bodiness*, while her *identity* as member of a specific church brings her in conflict with other functional identities in her life; finally the “otherness” of religious laws brings confusion as to her human rights.
- The story furthermore validates questions related to criteria for understanding the effects of religious discourses on people’s health. It points to understanding patients’ behavior in terms of the harmfulness of religious discourses rather than in terms of them being sinful and immoral.
- Ultimately, the story validates the search for a counseling practice which would diminish the effects of harmful religious discourses on the lives of people who, like Lerato, lives within the restraints of a strong religious identity. This counseling practice, then, is to have the ability to deconstruct harmful religious discourses into discourses of healing.

Journeying with what is therapeutically significant

I am a religion historian by trade and training. During the past ten years, I have conducted oral history interviews in several South African townships, with a recent focus in Atteridgeville, Tshwane/Pretoria. The aim of these interviews was not primarily to establish dates for ecclesiastical events, but to write the history of the effects of religious discourses on the lives of believers. Interviewees were asked to describe history in terms of their personal journey with religion. Often the interviewees were (re)traumatized while telling their stories. Some were traumatized by the neglect displayed by reli-

gious office bearers during a time of personal crisis. Others were traumatised by domestic violence and other violent spin-offs of social roles prescribed by religion.

Many interviewees, however, were traumatised by political events – such as the forced removals of the 1960s and detention during apartheid. Although the causes of trauma may differ from person to person, traumatised people in the townships have this in common: they found support and strength in their religion. This ambivalent role of religion in believers' well-being was the focus of the mentioned research in oral history.

For the present study, the re-traumatisation of the interviewees was significant. It pointed towards the necessity of an oral historian obtaining counseling skills. It is for this reason that I undertook this study. Undergoing training through the Department of Practical Theology at the University of South Africa, I gained the prescribed therapeutic experience by working part time as a counselor in the Family Medicine Clinic at Kalafong Hospital in Atteridgeville (Tshwane), as mentioned before. This Clinic is a context rich in variety with regards to gender, race, culture, class, money, age and religious affiliation. Here, these factors will be regarded as significant in describing the effects of religious discourses on the well-being of believers. The clinic assisted in identifying and enriching these factors as therapeutically significant in the following ways:

- *Gender:* Referrals for counseling were made by the doctors working at this clinic. Both men and women were referred. Also, a majority of the referrals (if not all) included gender-related matters. This became especially apparent in male suicide attempts, male and female rape, and domestic violence against women. This enabled me to isolate “gender” as a therapeutically significant category in understanding the effects of religious discourses on the lives of believers.
- *Race and culture:* This clinic is visited by people both from the townships and from the surrounding suburbs. These constituencies consist of both black and white people. The townships and suburbs also house a variety of cultures. Race and culture, and the religious norms that keep them in place, were regularly mentioned in therapeutic discussions where problems experienced in both the work place and intimate spaces were concerned. This enabled me to isolate “race” and “culture” as therapeutically significant for understanding the experiences of believers.
- *Class and money:* The black and white people who visit the clinic, tragically, have one thing in common. They are poor and forced to make use of free primary health care. During the past five years I

have, simultaneously, entered into private counseling relationships with people from middle and upper-class suburbs in and around Tshwane (Pretoria). By comparing experiences between classes, and by becoming sensitive towards the enormous role played by money in people's well-being, I was enabled to isolate "class" (as it is related to "money") as a therapeutically significant category in understanding religious discourses and their effects on believers' lives.

- *Age*: "Age" increasingly became a therapeutically significant category in the context of this clinic. Many teenage suicide attempts, rapes and requests for abortion warrant this as a category of interpretation.
- *Religious context*: The people with whom I have co-journeyed in counseling for seven years, incidentally, have something else in common. They acknowledge religion as a potential support system and a source of healing. At the same time they belong to different religions, that is, Christianity, Hinduism, Islam and African Traditional Religions. Within Christianity, they belong to a variety of denominations, from the so-called mainline churches to those "born-again".⁶ This enabled me to isolate "religious context" as of grave therapeutic significance in understanding the effects of religious discourses on the lives of believers.

The following story points to these factors of therapeutic significance and the roles they play in patients' lives.

Journeying with stories: Fatima and her amazing context

Fatima (40) is a Muslim woman and wears the traditional attire covering her body in full except for the eyes.

On her 16th birthday, her mother woke her up, and told her to put on a specific dress. Fatima remarked that it was a wedding dress. She was married the same day to a person she had seen only once before. Also, she did not see him very clearly at the time, because she was recovering from an eye operation. However, her mother insisted that he had walked through the room where she was lying in bed alone, and that she had to marry him to save her honour.

⁶ In Atteridgeville alone there are 54 churches (and one mosque) which are built on sites acknowledged by the City Council. Another hundred plus churches worship in private homes, backyard constructions and in school classrooms.

Her husband assaulted her frequently. She had a miscarriage three times after he had beaten her. Fatima believes that the Koran allows a man to hit his wife three times, after which she may hit back. Therefore, during her fourth assault and losing her unborn baby again, Fatima stabbed her husband with a knife. She left him to die. His family found him in time and he survived. They were divorced. Fatima then married somebody else, who again was not the husband of her choice. A son was born. When Fatima found out that her husband was having an affair, she called the woman from a telephone booth and asked to meet her there. When the woman came, Fatima squeezed the woman's head in the door of the booth, and phoned her husband to come and pick her up. They were divorced, but she was forced to sign the child over to her husband.

As a young girl, Fatima was permitted to finish Standard 5 (Grade 7) only. Since her second divorce, Fatima has fraudulently obtained a job as a bookkeeper, teaching herself the job. She has done this self-study so well, that nobody has ever found out that she has no qualifications. However, her salary is very small. Fatima is now married for the third time. She has chosen a man who is a Pakistani, and has another wife in Pakistan. At first they were very happy. However, his son from his other marriage has come to visit, and is making things very uncomfortable for them.

Fatima feels very aggressive towards the child. She fears for his safety and her own sanity.

The unique outcome of Fatima's story was that she was able to identify instances in which she had shown care for other people and had, in fact, deeply influenced the lives of friends and neighbours by extending a warm and helping hand. Retelling her story as that of a caring and beloved person, assisted Fatima in standing up against her aggression and fears.

Here, Fatima's story is related because it points to the factors that play a therapeutically significant role in believers' lives. The story of Fatima validates **gender** (being a woman), **culture** (being culturally confined as a woman), **money** (being kept unqualified and impoverished as a woman), **age** (being a young girl who is not allowed choices), and **religious context** (being

assaulted with religion's approval) as categories of therapeutic significance in understanding the effects of religious discourses on the lives of believers.

Journeying with research populations

I now come to the stage where I have to profile the people who co-authored this study. This study has journeyed with the following research populations:

Patients counseled at Kalafong and at home

Kalafong Hospital is situated at the entrance to Atteridgeville. Atteridgeville was established as a township (then referred to as a *location*) for blacks in 1936 when Councillor Mrs MP Atteridge proposed on a City Council Meeting of 28 August 1936 that the township should be established on land belonging to the City Council. The piece of land awarded was a thousand acres in extent, and lay eight miles (13 km) west of Church Square in central Pretoria.⁷

During the three and a half years between July 2000 and December 2003, then, I was engaged in counseling as a doctoral student in Pastoral Therapy, with 270 patients either at Kalafong Hospital (Atteridgeville/Tshwane) or at my townhouse in Centurion, the latter as a spin-off of my engagement with Kalafong. This comprised 570 counseling sessions and as many hours. Slightly more than half of these patients (151, 56%⁸) attended one session only. Reasons for this are a lack of transport, the completion of therapy within one session, or pressure from the patient's spouse not to attend further sessions. A third of the patients (85, 31%) attended two to four sessions; and 34 patients (13%) attended five and more sessions. The record is held by a couple who attended 37 sessions. During this time only one of the 270 patients committed suicide.

In terms of the therapeutical significance of race/culture, class/money, gender, age and religious context, the research population presented itself as follows:

Age: More than a quarter of the patients were in their thirties

- 36 were teenagers (13%)
- 47 were in their twenties (17%)
- 74 were in their thirties (28%)
- 65 were in their forties (24%)

⁷ RD Coertze, *Atteridgeville, 'n stedelike Bantoewoonbuurt* (Pretoria, 1969), pp 9-10.

⁸ Percentages are rounded off.

- 34 were in their fifties (12%)
- 10 were in their sixties (4%)
- 4 were in their seventies (2%)

Gender: Three quarters of the patients were female

- 203 were women (75%)
- 60 were men (22%)
- 6 preferred to be called “gay” (2%)
- 1 was a transvestite (1%)

*Race:*⁹ Three quarters of the patients were black

- 201 were black (74%)
- 4 were white and English-speaking (1%)
- 48 were white and Afrikaans-speaking (18%)
- 12 were Indian (5%)
- 5 were Coloured (2%)

Country: Only 2% of the patients were not South Africans

- 264 were South African citizens (98%)
- 1 from Kharthoum, 2 from Pakistan, 1 from England, 1 from Mozambique, and 1 from Zimbabwe (2%)

Religion: More than half the patients belonged to an Apostolic, Zionist or Born-again Church where faith healing was practised

- 104 belonged to mainline churches and their African successions (39%)
- 148 belonged to Apostolic, Zionist and born-again churches (55%)
- 6 did not belong to a church (2%)
- 3 belonged to African Traditional Religions (1%)

- 8 were Muslims (3%)
- 1 was a Hindu

Money: Almost half the patients were unemployed; those employed received a salary technically regarded to be under the breadline

⁹ Patients mainly came from Atteridgeville - which accounted for the majority of black patients. However, patients were also drawn from neighbouring areas, such as Laudium (historically Indian) and Danville (historically white). Because of white people losing their financially privileged position after democracy in 1994, an increase was experienced in white patients who, without a medical aid, were referred to Kalafong. Kalafong is a state hospital offering free primary health care.

- 32 were learners and students (12%)
- 132 were unemployed (including 16 who have recently lost their jobs, 8 who worked for missions for lodging, and 2 who were unable to work after suffering assault) (49%)
- 96 were employed (receiving between R600 and R3600 per month) (36%)
- 9 were on pension (not more than R700 per month) (3%)

In summary

The profile of this component of the research population is as follows:

Patients mainly fall in the age group 25 to 45; three quarters of them are women, and three quarters are black. All the patients were born South African (except for 2% who come from other African countries). All the patients are poor, that is, either unemployed or working for a salary below the breadline. A majority of the patients do not belong to a mainline church but to an indigenous church where faith healing is practiced.

Patients attending counseling at Kalafong Hospital constitute the main component of the research population for this study. It is they who are to benefit from this study, which aims at establishing a counseling practice amongst this research population. However, as the next subsection indicates, their experiences were supplemented with those of church leaders in Atteridgeville, who constitute a second(ary) research population.

Interviews with church leaders

Interviews on healing practices

During 2002/2003 I was in a privileged research situation to interview church leaders of 102 churches in Atteridgeville on moral identity and healing practices.¹⁰ The results of these interviews are important for this study. They reveal the religious discourses on illness and healing prevalent in the churches attended by the primary research population profiled in the previous sub-section. The patients who came for counseling to Kalafong Hospital during the said period, with a few exceptions, were all devoutly attending churches in Atteridgeville. This establishes the church leaders who were interviewed on their churches' healing practices as part of the research population of this study.

¹⁰ Part of this research I have done for an Oral History Project sponsored by the Research Institute for Theology and Religion, where I work as the Director of Research.

The faces of structured religion in Atteridgeville

The inhabitants of Atteridgeville are overwhelmingly orientated towards Christianity. According to the 2001 census¹¹ 91% of the people in this township are Christians, 0,5% are Muslims, and another 2% of people belong to Judaism, Hinduism or an African Traditional Religion. Only 6,5% indicated during the census that they belonged to no religion, or prefer not to react to the question on their religious affiliation. The 91% Christians in Atteridgeville is way above the 80% for South Africa, and the 6,5% non-churchy people well below the 15% South African average. This establishes Atteridgeville as an above-average “Christian” township.

Numbers on religious affiliation in Atteridgeville provided by Statssa¹² on the 2001 census are helpful, but confusing for the following reasons:

- The table of religious affiliations given by Statssa amounts to 43 707 people living in Atteridgeville, while the Pretoria Central Statistic Services indicated that this township housed 194 420 people in 1993, with a projected population of 240 000 in the year 2000.¹³ Coertze indicated that, already in January 1960, the population of Atteridgeville was 45 196.¹⁴
- Also, the categories for classifying the churches/religions in Atteridgeville given by Statssa give an inconclusive view of structured religious life in this township. Categories such as “Other Reformed Churches” and “Other Independent Churches” testify to the census’ struggle to find an appropriate classification for all churches in Atteridgeville.

I shall therefore present my own classification of structured church life in Atteridgeville, based on the 102 churches interviewed during the above-mentioned project. There are an estimated 150 churches in Atteridgeville. This estimation was made by one of the patients at Kalafong, Ms Gabisile Mashigo, who assisted in identifying and making appointments with the different churches, and Mr Dingane Masilela, who both have an intimate

¹¹ Numbers provided by Statssa, percentages presented and interpreted by myself.

¹² Statistics South Africa which was responsible for executing and interpreting the 2001 national census.

¹³ Quoted by JS Krüger in his book *Sweeping Whirlwinds: A study of religious change: Reformed religion and civil religion in the city of Pretoria (- Tshwane) (1855-2000)*, (Pretoria: Unisa Press, 2003), p 96.

¹⁴ RD Coertze, *Atteridgeville, 'n stedelike Bantoewoonbuurt* (Pretoria, 1969), p 43.

knowledge of church life in this township. In my view, these churches spontaneously lend themselves to classification.¹⁵

An attempt at classification

The following is an attempt at classifying church affiliations in Atteridgeville, checked against the studies of Allan Anderson,¹⁶ and the experience of Mashigo and Masilela. Criteria for classification are, firstly, historical, that is, according to the time when they were established in the township. Secondly, classification is done in accordance with the illness and healing discourses offered by a specific cluster of churches.

(1) Classical mainline churches

- History

In the first category we find the mainline churches that became part of the township since its establishment in the 1940s and 1950s. These are:

- the Roman Catholic Church
- the Anglican Church
- the Baptist Church
- the Dutch Reformed (now Uniting Reformed) and other Reformed Churches
- the Methodist Church
- the Presbyterian Church, and
- the Lutheran Church.

Also belonging to this category are churches which came to South Africa as mission churches but which are not considered to be mainline. These are:

- the African Methodist Episcopal Church
- the Church of Christ of the Latter Day Saints
- the Kingdom Hall for Jehovah's Witnesses
- the Moravian Church in South Africa
- Lede in Mica Gemeentes van Suid-Afrika
- Church of the Nazarene, and
- the Congregational Church.

¹⁵ The classification is exclusively Christian, since the only mosque in Atteridgeville refused an interview.

¹⁶ Allan Anderson, *Bazalwane, African Pentecostals in South Africa* (Pretoria: University of South Africa, 1992); Tumelo, *the Faith of African Pentecostals in South Africa* (Pretoria: University of South Africa, 1993).

In Atteridgeville, 35 of these churches and their congregations fall within this category.

- Illness and healing discourses

According to these churches (generalised) illness is caused by

- personal sin (immoral behavior, not enough commitment, not enough prayer)
- original sin (illness as a natural part of life)
- structural sin (people oppressing one another, government not being Christian enough, poverty, unemployment, racism, cultural practices, secularisation), and/or
- Satan.

Healing is effected through

- praying (laying on of hands, holy water, exorcism)
- preaching and believing
- ministerial and congregational support
- pastoral (that is, Biblical) counseling
- hospitals, doctors and medicine, and/or
- moral (and cultural) regeneration.

(2) Classical African churches

- History

These are churches that broke away from the mission/mainline church under African leadership. They were well-established by the 1960s. They, too, have obtained a site from the City Council on which there is a church building. The name of such a church usually has the word “African” in its name. They are

- African Catholic Church
- Ethiopian Catholic Church in Zion
- Lutheran African Church
- Lutheran Bapedi Church
- St Mary’s African Church
- Tsonga Presbyterian Church*¹⁷
- (Bantu) Evangelical Church*
- African Orthodox Church

¹⁷ The churches marked with an asterisk have not been interviewed.

- New Church Mission in South Africa*, and
- Old Apostolic Church of Africa*.

There are 11 churches in Atteridgeville that are classified in this category.

- Illness and healing discourses

The illness and healing discourses offered by these churches are more or less in accordance with those of the mainline churches, except for some space given to traditional African practices, such as the acceptance of the influence of ancestors and the help of sangomas, and the calling of the pastor/priest through visions.

Illness, according to these churches, is caused by

- personal sin (unclean lives), and/or
- structural sin (poverty, too few Christians in parliament).

Healing is effected through

- laying on of hands and prayer, and anointing, as well as
- the pastor/priest being called as a healer through a vision.

(3) Classical Pentecostal churches

- History

The Classical Pentecostal Churches established themselves during the 1960s, and form our third category. These include

- the Apostolic Faith Mission
- Assemblies of God
- the Full Gospel Church of God, and
- the Pentecostal Holiness Church

In Atteridgeville, interviews were done with one or more of each of these churches and their congregations.

- Illness and healing discourses

Illness is caused by

- Satan/the devil
- original sin (“born in sin”)
- personal sin

Healing is effected through

- praying and speaking directly to God
- laying on of hands
- driving out demons/fighting powers, with doctors
- abstinence, moral life, educational programmes
- a pastor with the gift of healing
- the preaching of salvation, with repentance, as well as
- hospital ministry.

(4) Zionist/Apostolic churches

- History

These are Zion-type churches (according to Allan Anderson's definition) which have the words "Zion" or "Apostolic" in their names. The Zionist and Apostolic churches appeared in the 1970s.

- Illness and healing discourses

A distinction is made here between churches that heal through praying and the laying on of hands, and churches that heal through traditional African practices.

Zionist/Apostolic churches that heal through praying and laying on of hands

The churches interviewed in this category are:

- Apostolic Gospel Church International
- Bethal Apostolic Church of Christ
- Christian Apostolic Church in Zion
- Christian Catholic Apostolic Church
- Christian Catholic Apostolic Holy Spirit Church in Zion
- Holy Cross Apostolic Church of South Africa
- New Apostolic Church
- St Michael's Apostolic Faith
- True Zion Congregational Church
- Twelve Apostolic, the New Jerusalem, Holy Spirit Church in Zion, and
- Zion Apostolic Church

According to these churches (generalised) illness is caused by

- personal sin (lack of obedience to God, immorality especially drinking and pre-marital sex, and people leading double lives)

- punishment from God (eg Aids)
- original sin (natural causes), and
- demons.

Healing is effected through

- laying on of hands and prayer by pastor with a healing ministry (who was called through a vision)
- driving out of demons, but
- not through sacrifices or the worshipping of the ancestors

Zionist/Apostolic churches that heal through traditional African practices

The churches interviewed in this category are:

- Bantu Zion Christian Church
- Bethal Apostolic Church in South Africa
- Christian Catholic Apostolic, Holy Spirit Church in Zion
- St Johanna Apostolic Church in South Africa
- St John's Apostolic Faith Mission Church
- New Testament Apostolic Church
- St Petro Apostolic Church
- The Apostles and Christian Brethren Church of South Africa
- Zion Congregational Church, and the
- Zion Christian Church

According to these church (generalised), illness is caused by

- personal sin (alcohol, lack of holiness)
- unhealthy lifestyle (things you eat)
- not having peace with the ancestors
- punishment from God (e.g. Aids)
- witchcraft, as well as a
- lack of faith in prophecy and healing

Healing is effected through

- bird nests (balusi)
- mirror showing who has bewitched, bestolen you
- candles, Bible, cards, stick
- visions from ancestors and God
- bodily and spiritual cleansing (bathing, vomiting, sacrifices)
- ashes, and herbs, as well as
- prayer, and the laying on of hands.

(5) Born-again churches (“Bekeerkerke”)

- History

Finally, and in the fifth place, numerous born-again churches were established in Atteridgeville since the 1980s. This is a broad term for recently established churches of which the members claim that they are “born-again”.

Born-again churches that heal through praying and laying on of hands

Churches interviewed in this category are:

- Abundant Life Ministries
- Anthropol Christian Foundation
- Born-again Church of Christ
- Charisma Christian Centre
- Church of Christ Assemblies
- Church of Jesus Christ
- Christ Ministries Church
- Christian Revival Assemblies
- Fire Bible Church
- Forward in Faith Bible Church
- Good News Ministries
- International Assemblies of God
- Maranatha Ministries
- National Independent Congregational Church
- Nazarene Church
- One Way to Heaven Revival Ministry
- New Revival Church Ministries
- Revival Hour Ministries (1)
- Revival Hour Ministries (2)
- River of Life Temple
- Rock of Ages Ministries
- Shiloh Tabernacle Church
- Signs and Wonders Ministries
- Unchanging Christ Ministries
- United Pentecostal Church
- Universal Church, and
- Victory Fellowship Church

According to these churches (generalised), illness is caused by

- devil/demons
- witchcraft

- personal sin (lack of morals especially drinking, smoking, sex)
- lack of repentance, untruth, acting against God's principles, and
- not accepting Jesus as Saviour

Healing is effected through

- the pastor feeling your pain/illness physically, identifying it through a "word of wisdom"
- the pastor (who has been called to the healing ministry through a vision) prophesying
- the preaching of salvation, the teaching of morals, the confessing of sins, repentance, forgiveness
- the casting out of demons (deliverance)
- fasting
- praying and laying on of hands
- not through doctors or *sangomas* but through the blood of Christ through Holy Spirit and not *muti* (although there is a "yes" for herbs)
- social upliftment programmes, and
- Biblical counseling.

Born-again churches that heal through traditional African practices

Churches interviewed in this category are:

- Father, Son and Holy Spirit Church
- Umthunzi woku Phumula Church
- Hafila Ministries, and
- True Zion Congregational Church of South Africa

Again, generally, illness is caused by

- not listening to the ancestors
- evil spirits and demons, as well as
- personal sin (unclean lives)

Healing is effected by

- Bible, candles, water
- *muti*, robes, herbs, ashes
- vomiting
- fasting, praying
- sacrifice to the ancestors, and
- Biblical counseling.

In summary

The leaders and members of churches interviewed on their healing beliefs form an important, albeit secondary, research population to this study. Their descriptions of the causes of illness and healing provide the context within which proposals for a counseling practice will be made, which will be sensitive towards culture, age, gender, class and religious affiliation.

The following story is told here to profile to the research population and to attach human bodies to this profile:

Journeying with stories: Three women liberate themselves from their curse

On a particularly busy day at the hospital, Makhokoloso, Motle and Pula agreed to small group counseling in stead of attending individual counseling. It turned out that, although they were experiencing different problems, they offered the same explanation for their misfortunes: they were cursed by a sangoma. The women, incidentally, were devoted Christians, two of them belonging to a born-again church, the other to a mainline church. All three of them are educated and employed.

Makhokoloso's husband died in a motor car accident. Within his tradition, Makhokoloso's husband was of royal descent. This allowed him to marry four wives, but he had chosen to marry Makhokoloso only. Makhokoloso believes that this was the reason why other women had a curse placed on him and her. This, also, was the reason why he died. This, furthermore, is the reason why men are now not interested in her, they are afraid of her. Makhokoloso belongs to a born-again church, "Conquerors Ministry". She sleeps with her Bible to protect her against the curse.

Motle has lost her sexual desire. Because of that, her husband has left her. Motle believes that her husband's girlfriend has placed a spell on her through a sangoma. Proof of this, are the snakes she has found in her yard. She has also found animal excretion ("kak") in her yard. At night she wakes up with a wetness in her lap, and once with razor blades between her breasts. Motle belongs to the Universal Church. Here she was told that she could drive out the demon by praying and fasting for seven days.

Pula is divorced. She has a boyfriend who comes and goes. He comes, eats, sleeps over – and leaves for an undetermined

time. This causes great emotional stress in Pula. Pula believes that a sangoma has placed a spell on her. However, in order to break this spell, she needs the services of another sangoma but she does not have the money to pay for this service. Pula belongs to the Uniting Reformed Church, and bemoans the fact that this church does not want to deal with the spell.

During therapy, the patients' belief in the sangoma's curse was not undermined. Their histories were mapped and the instances highlighted when, in the past, they were able to sound a voice stronger than that of the sangoma's curse, a voice that was based on belief in God's power.

Again, the unique outcomes of this process will not be described now, since these stories are presented here to reflect on the validity of the above analysis of the research population.

The stories of Makhokoloso, Motle and Pula, then, reflect the research population as mainly

- female, middle-aged and black
- educated, but belonging to a low income group
- ardently Christian, but living within the fears and realities of township life
- people who believe that religious imbalances (curses, demons, spells) are causing their problems, but also that there are religious cures for their troubles (such as praying and casting anti-spells).

Journeying with books

Methodology is the steps taken to reach the philosophical aims of a study. The aims of this study, to repeat, are to describe the faces of religious discourses in a township setting, to understand their effects on believers, and to present a counseling practice that will deal therapeutically with the harmfulness of religious discourses. What follows, is a literary overview of the books with which I have journeyed and which have informed me on the philosophy and method needed to undertake this study. The overview is structured according to the three aims of the study.

Journeying with studies on “The faces of religious discourses”

In realisation of the **first aim** of this study, that is, to describe the faces of religious discourses in a township context (as will be done in chapter 2), both the insights of social construction theory and those of post-structural theory

are explored here. Social construction theory claims relevance for this study when religious discourse is regarded as socially constructed, and religious discourses are described as narratives of society. With social construction theory providing the philosophy for the construction of discourses, post-structural theory provides the method for describing the deconstruction of these discourses.

Social construction theory

Social construction theory postulates that people's thinking and doing are controlled by social discourses. Discourses are grand narratives constructed by the powerful in society as knowledge and truth. Social construction takes place through language which is rooted in perceptions on the relationships between people.¹⁸

The insights of social construction theory are important for this study, both in terms of research and of therapy. Social construction theory allows the researcher to describe the faces of religious discourses as mechanisms of control, constructed and perpetuated by those who hold power in faith communities. Michel Foucault and the insight that discourse is "a material condition which enables and constrains the socially productive 'imagination'"¹⁹ is of particular importance for this study. It empowers the researcher to describe "disempowerment" as a therapeutically significant component in the stories of victims of domestic violence, rape and HIV infection.

The significance of social (de)construction theory for therapy has been highlighted by Michael White. His article, "Deconstruction and therapy"²⁰, is a good example of the therapeutic significance of deconstructing discourses. In this article, White describes through women's stories how their identities of failure have been socially constructed, and how through externalising these constructs in therapy, practices of power are deconstructed. By asking "landscape of action" questions, the patient presents her history as possibilities for future preferred ways of being; and by asking "landscape of consciousness" questions, the counselor encourages in the patient "the articulation and the performance of these alternative preferences". The counselor thus co-journeys with the patient towards resisting the grand narratives which keep him/her the captive of problems, moving towards unique outcomes.

¹⁸ This working definition is dependent on Kenneth Gergen's four working hypotheses in *An invitation to social construction* (London: Sage, 1999).

¹⁹ Alec McHoul & Wendy Grace, *A Foucault Primer, discourse, power and the subject* (Washington Square, New York: New York University Press, 19), p 34.

²⁰ Michael White, "Deconstruction and therapy", in *Dulwich Centre Newsletter* 3 (1991), pp 21-40.

Social construction theory, then, not only allows the researcher to describe the faces of religious discourses and the grand narratives supporting them, it also opens up the possibility of the counselor co-authoring the patient's story of resistance against these grand narratives.²¹ It furthermore shows the way towards describing the deconstructed story, that is, the story in which a harmful religious discourse has been rescoped, as a healing discourse.

In terms of the description of research findings, this study takes note of three further insights of the social construction position. The first is that people's stories of resistance against grand narratives are not neutral in themselves.²² The second is that the counselor in co-journeying with these stories cannot claim objective validity.²³ Thirdly, and most important within the study's aim of describing the faces of religious discourses, is the insight that the researcher/therapist is not innocent when retelling these stories, but constitutes "knowledge" in the process, albeit within a postmodern consciousness.

Since the telling and retelling of stories are not ideologically innocent, the (postmodern) construction of knowledge should therefore be methodologically explained here. For this, I turn to post-structural theory.

Post-structural theory

Deeply moved by the fact that postmodernism has liberated us from the bondage of method, this study however remains in search of methodological insights for describing the faces of religious discourses. When our philosophical aim is social (de)constructionist, that is, to describe the faces of religious discourses in terms grand narratives, resistance and deconstruction, what method do we use to get there? And with "method" itself being post-modernly undermined, how are we going to describe the steps we are taking in our description of the faces of religious discourses within the consciousness that grand narrative, resistance story and academically retold story all are non-innocent constructions of knowledge?

The "answer" will henceforth be sought in post-structural theory as a method to deconstruct

²¹ Stephen Prickett in *Narrative, religion and science* (Cambridge: Cambridge University Press, 2002, p 17) quotes Lyotard who in his *The postmodern condition* (Manchester University Press, 1984) defined postmodernism "in terms of its resistance to any kind of grand narrative".

²² Prickett, p 14.

²³ Jay S Efran, Robert J Lukens, & Michael D Lukens, "Constructivism: What's in it for you?" in *Networker* 12.5 (1988), p 30.

- binary truths in the deep structures of grand narratives,
- the search for truthfulness in the stories of patients,
- as well as claims to expert knowledge on the side of the researcher.

What, then, is understood by post-structural theory? Post-structural theory exists as an extension of and in its resistance against structuralism. *Structuralism* offers the following in terms of the description of discourse.²⁴

- Discourse feeds on binary oppositions. In grand narratives ‘man’, for instance, exists as an opposition to ‘woman’, ‘sacred’ is defined in terms of ‘evil’ or ‘sinful’, and ‘moral’ is constructed as the opposite of ‘immoral’. Binary oppositions are intrinsic to human thought and are manifested in language. The elements of binary oppositions are, of course, seldom equal in power, and dualism implies that discourse empowers one element against its opposition.
- Binary oppositions display two further characteristics. In the first place, they are essentialist in nature. In the binary man/woman, ‘man’ implies essentialist manhood, and ‘woman’ displays the essentials of womanhood. In the second place, binary oppositions bestow epistemological privilege on one element of the binary only: in patriarchal discourses ‘man’ is wiser than ‘woman’; in Feminist Standpoint Theory²⁵ only ‘woman’ can understand the true nature of female experience.
- Binary oppositions point to the deep structures on which a (con)text is based, that is, to the dominant discourses (grand narratives) underlying the (con)text. The inequality suggested in the binary opposition ‘man’ and ‘woman’, for instance, reflects women’s inferiority as constructed in the grand narrative which controls women’s behavior in society.

Post-structural theory uses and moves beyond the insights of structuralism towards the deconstruction of binary oppositions in deep structures. Post-

²⁴ See Christina Landman, “Free to be moral, or moral free? Poststructuralism and the deconstruction of moral discourses”, in FA Swanepoel (ed.), *Religion, morality and transformation* (Pretoria: Research Institute for Theology and Religion, 2001), pp 44-48. She relies on insights from Chris Weedon, *Feminist practice and Poststructuralist theory* (Cambridge, Massachusetts: Blackwell, 1997).

²⁵ Feminist Standpoint Theory is a modernist version of feminism, and was prevalent in the developing stages of modern feminism. It rests mainly on two notions, that of “essentialism” and “epistemological privilege”, claiming that women are essentially superior to men, and that women are epistemologically privileged to such a degree that only women can understand women’s experiences.

structural theory feeds on the insight that grand narratives cannot be altered simply by rereading, renaming or reinterpreting the surface details of the narrative,²⁶ which need to be deconstructed.

Deconstruction consists of two related steps. The first step overturns and confuses the binary opposition. The second step displaces the full hierarchy present in the deep structure of the grand narrative.²⁷

Using post-structural theory in a method of description, the faces of religious discourses in a township setting will be described (in chapter 2) in the following steps:

- Religious discourses will find their description and faces in the binary oppositions which constitute the grand narrative. These binaries are found in the stories of patients as they are initially told as problem-saturated stories. Accordingly, religious discourses will be classified in four categories, as body discourses, power discourses, identity discourses and otherness discourses.²⁸ I will explore the dialogical spaces between binaries, especially the opposition of healing versus harmful religious discourses, in order to undermine a “true” distinction between them.
- In a second step, the faces of religious discourses will be described in terms of the patient’s ability to resist them. The researcher will describe elements of therapeutic significance in the patient’s story, elements which may empower the patient to resist the narrative. The researcher will constantly undermine the binary opposition between her innocence as an objective researcher on the one hand, and on the other her expert knowledge as a therapist on harm done by religious discourses on the other.
- In the third place, the deconstructed faces of religious discourses will be described. What do the healing faces of religious discourses look like? will be the question guiding the therapist/researcher here. Again, the researcher will undermine the binary opposition between her framework of what is to be considered as a healthy religious discourse

²⁶ See Pamela Milne, “The patriarchal stamp of Scripture: The implications of structuralist analyses for feminist hermeneutics”, in *Journal of Feminist Studies in Religion* 5.1 (1989), pp 21-23.

²⁷ See Leslie Rabine, “A feminist politics of non-identity”, in *Feminist Studies* 14.1 (1988), p 15.

²⁸ In the first paragraph of this chapter, the four faces of religious discourses are summarised and described as: power is hierarchical; bodies are controllable; religious identity has priority over cultural and social identities; and, the otherness of religion leads to salvation and healing.

on the one hand, and the patient's sacred story on the other. The researcher will also deconstruct the truth that change can be brought about, and a patient be guided towards an alternative story, by simply replacing a harmful socio-religious discourse with a healthy socio-religious discourse.²⁹ Again, the description will focus on the dialogical spaces between the binaries of harmful and healthy discoursing.

In summary

To describe the faces of religious discourses, and realise the first aim of this study, I have journeyed with studies by Kenneth Gergen, Michel Foucault, Michael White and feminist deconstructionists in order to make social construction theory accessible for this study.

Also, I was informed on post-structural theory through studies by Chris Weedon, Pamela Milne and other post-structural feminists. Feminist studies play an important role in establishing a method for describing the faces of religious discourses in a South Africa township, because of a preponderance of women in the research population under investigation.

Social construction theory was chosen as the philosophy underlying this study, and post-structural theory as the method to realise the philosophical aims of the study, in order to enable the research to define "spirituality" as a social discourse on the supernatural, and eventually to describe the pastoral practice designed here as "religion counseling", that is, counseling which deals with religious discourses as social discourses and not as confessional discourses with transcendental validity.

Researching the faces of religious discourses is not a simple process of identifying them either as healthy or as harmful, as the following story illustrates.

Journeying with stories: The Pastor and the medicine

*The Rev N is a pastor of a born-again church in Atteridgeville.
She was born in the Dutch Reformed Church, did not attend*

²⁹ See Mieke Bal, "Metaphors he lives by", in *Semeia* 61 (1993), p 185: "Feminism is caught in the predicament that the need to make an intervention in social structures enforces a constructivist position, while the change such interventions aim to bring about necessitates realism". Suzette Haden Elgin in her response (p 209) adds a relevant question to the debate "Do metaphors, however defined (as discourses? CL), have the power to change reality?" Finally Francis Landy ponders the playful but perilous aspect of metaphor (again, discourse? CL) in its role in the creation of alternative realities ("On metaphor, play and nonsense", p 219).

school, and practised as a sangoma for some time. In her twenties the Rev N converted to born-again spirituality. She dreamt that a feather from heaven fell unto her lips and into her mouth. This consecrated her as pastor of the church.

The Rev N defines herself in the three-fold function of healing, prophecy and deliverance. However, she emphasises that healing in her church is only done through prophecy and prayer. In other born-again churches the healing process is strengthened by cleansing procedures, including washing and vomiting. Also, in these processes ashes, powders and physical symbols play a visible and prominent role. The Rev N reacts strongly against such “superstitious behavior” which reminds her of her practices as a sangoma.

The Rev N describes the healing process in her church as follows. She identifies illness through prophecy. As a prophet she feels the same pain as the person seeking healing. She can tell that the person has, for instance, stomach pain because she experiences identical pain. Healing comes about only through prayer. If healing does not occur after praying, but goes elsewhere in the body, it is an indication that the pain is caused by a demon, and that exorcism is to take place.

The Rev N places on display several large black plastic bags full of medicine and medical apparatus, such as asthma pumps and a variety of pills. The people healed by God through her have been delivered from these medicines. She keeps the medicine as proof of their healing. She also has a bag full of church uniforms. In her church people do not wear uniforms. When somebody is converted from another church to hers, they hand over their uniforms to be kept as proof of their conversion to the real God.

The Rev N claims that there are no people in her church who suffer. Everybody has been delivered from suffering. All those unemployed have found employment. All those suffering from mental or physical discomfort, have been saved.

Is this a healing or a harmful religious discourse? The Rev N’s story points to the complexity of this question, and the inappropriateness of choosing for “healthy” and against “harmful” as if they are clearly in binary opposition. The story invites the researcher to deconstruct the compulsion itself to choose. It rather implores the researcher who wants to describe the faces of

religious discourses, to explore the dialogical spaces between the binary of healing versus harmful.

Journeying with studies on “The effects of religious discourses on people’s health”

To reach the second aim of this study, that is, to understand the effects of spirituality on people’s beliefs, relationships, behavior and mental/physical health (which will be discussed in chapter 3), I have informed myself,

- firstly, of studies on the incorporation of spirituality in counseling, and,
- secondly, of views on illness and healing in a variety of spiritualities.

In this section, then, “religious discourse” will be replaced with the concept “spirituality” or “religion”, since these are the concepts used in the books under discussion.

Views on religion and spirituality in counseling

This study defines “spirituality” (or religion and religious discourse) in terms of social construction theory as “a *social discourse* on supernatural healing”. The books chosen here were read within the following aims:

- *To explore definitions of “spirituality”*: To enable myself to validate my choice for a definition of spirituality as social discourse, I here wish to inform myself of studies which incorporate spirituality in counseling using a definition of “spirituality” both similar to and other than that of social discourse.
- *To see the opposing effects of “healing” and “harmful” on the believer*: In order to explore the dialogical spaces between the “harmful” and “healing” effects of spirituality on the minds of believers, I take special interest in the distinction made by the following books between what is considered to be “good” (healthy, healing) and “bad” (sick, harmful) for the health of believers.
- *To take note of therapeutic ways of dealing with spirituality*: To set up a counseling practice which will deal respectfully with religious discourses, I want to inform myself of ways in which spirituality have been incorporated into therapy as a healing religious discourse.

- Wayne Oates: “When religion gets sick”³⁰

In 1970 Wayne Oates published *When religion gets sick*, a book in which cooperation between the minister and the psychiatrist is explored. Not using the concept “spirituality”, he defines “religion” as a functional value system based on a belief in an Ultimate Being.³¹

Consequently, for Oates, a harmful religious discourse (he uses the term “sick religion”) is one which has become a disturbing factor in the total functioning of the person. “When religion is sick, it massively hinders the basic functions of life. Malfunction, then, is the criterion of sickness.”³²

A healthy religious discourse (he uses the term “healthy faith”), then, is one which encompasses a comprehensive philosophy of life, incorporating a consistency of moral sequence. Following the psychologist Gordon Allport (*The individual and his religion, a psychological interpretation*, 1950), Oates differentiates as follows between harmful (“sick”) and healthy (“mature”) religion:

- Mature religion houses a capacity of self-criticism. Sick religion is uncritical, self-contained, lacking humility and teachableness.
- Mature religion is dynamic, and controls motives without being controlled by self-interest. Immature religion is shot through with magical thinking, self-justification, and personal comfort.
- Mature religion is characterised by consistency of moral consequence which generates consistent standards of action. Sick religion becomes a *means* of immoral behavior.³³

When sick religion has made a person mentally ill, how then, can mature religion be incorporated to contribute to the healing of this person? Obviously, according to Oates, this can be done by enhancing the values of mature spirituality in the client, which is self-criticism and consistency of moral consequence.

However, Oates goes further to incorporate spirituality (“mature religion”) in the psychological treatment of mentally ill patients whose illness is

³⁰ Wayne E Oates, *When religion gets sick* (Philadelphia: The Westminster Press: 1970).

³¹ *Ibid*, p 26.

³² *Ibid*, p 20. See page 17: “When religion becomes deified – that is, made a thing of as separate and apart from the total expression of the whole life of a person - it becomes an external ‘it’, a thing apart. When this happens, the ‘it’ religion becomes either a segregated, autonomous system in an airtight compartment separated from the rest of life, or it becomes a disturbing factor in the total functioning of the person. In either instance, it is sick.”

³³ *Idem*, pp 30-31.

not necessarily related to the effects of “sick religion” on their lives. He does this on the following grounds:

- Religion can restore a sense of trust in the form of faith (cf Erik Erikson, *Identity and the life cycle*) to the paranoid schizophrenic or other mentally ill persons who have “major difficulties in establishing durable and trusting relationships with other persons.”³⁴
- Religion can restore hope to the manic-depressive client’s life situation, since “hope and hoping are the most important cross-cultural constants that characterize religion in all cultures” (cf Margaret Mead).³⁵
- Religion stands for the nutriment of love. Where the deprivation of love has led to mental illness, obviously, religion can play a healing role in the life situation of sufferers.³⁶

In summary

Using a functional definition of religion as all-incorporating, Oates distinguishes as follows between the opposing effects of religion: a mature religion leads the believer to self-criticism and consistent morality, while an immature religion makes a believer uncritical, unteachable, and ultimately immoral. Not only does a mature religion have a healthy effect on the health of believers, religion can also restore trust, hope and love to the life situations of the mentally ill.

- Geri Miller: “Incorporating spirituality in counseling and psychotherapy”³⁷

In his most recent book, *Incorporating spirituality in counseling and psychotherapy* (2003), a publication which was inspired by the counseling of September 11 survivors, Geri Miller defines spirituality in rather glowing terms as that tendency which “moves the individual toward knowledge, love, meaning, peace, hope, transcendence, connectedness, compassion, wellness, and wholeness. Spirituality includes one’s capacity for creativity, growth, and the development of a value system”.³⁸

³⁴ *Ibid*, pp 189-190.

³⁵ *Ibid*, pp 193-194.

³⁶ *Ibid*, pp 196-197.

³⁷ Geri Miller, *Incorporating spirituality in counseling and psychotherapy* (New Jersey: John Wiley and Sons: 2003).

³⁸ *Ibid*, p 6.

Miller forthwhile describes two distinctive psychological approaches to religion as either healing or harmful:

- Religion as having harmful effects on people (eg Freud): “In this approach, religion is seen as the result of external influences impacting the client. The environment determines the reactions of the client resulting in beliefs/behaviors that are not rational. Religion, then, was not seen as credible. This approach encouraged controversy and mistrust between the fields of religion and psychology.”
- Religion as having healing effects on people (eg Jung): “The focus on this approach is on the benefits that religion brings to the individual and the belief that what happens for the individual inside helps him or her change and develop. There is not a concern with what causes the person to believe in something. This approach lends itself to a more cooperative relationship between psychology and religion.”³⁹

Using Fromm (*Psychoanalysis and religion*, 1950), Miller distinguishes between two opposing ways of exploring the healing effects of spirituality on the health of clients:

- An authoritarian approach inhibits the potential of the person.
- A humanistic approach focuses on the development of the person’s potential.⁴⁰ It is this latter approach which Miller wishes to follow, as shall be seen shortly.

In counseling, then, Miller aims at helping a client to develop a spiritual identity which will enhance self-care as well as caring for others in a universal faith community. Miller does not give a description of what a healthy “spiritual identity” would entail, except for siding with Fowler that the most mature form of spirituality is where “the focus is on loving others at a universal level”.⁴¹ Rather than expanding on “spiritual identity”, Miller focuses on the therapist dealing respectfully with the religious world view of clients, and using techniques based on spiritual practices, such as prayer, liturgy and meditation, in treating clients.

³⁹ *Ibid*, p 22.

⁴⁰ *Ibid*, p 32.

⁴¹ *Ibid*, p 142.

In summary

Miller defines spirituality as a life skill, and aims at exploring it as a coping resource for clients. It is the healing effects of spirituality, which includes obtaining knowledge, connecting emotion to transcendence, and living wholly within a value system, which allow for this approach, according to Miller.

- Robert Lovinger: “Religion and counseling”

Robert Lovinger has written several books on the role of religion in counseling. In his *Religion and counseling: the psychological impact of religious belief* he defines religion (spirituality) simply as a meaning-system with a strong moral code.⁴²

According to Lovinger, religion has the following dysfunctional (that is, harmful) effects on the behavior of a believer:⁴³

- *Self-oriented display*: the believer boasts about his/her good deeds, piety, charity, etc.
- *Religion as reward*: the believer demands that God should treat him/her well because of his/her good behavior.
- *Scrupulosity*: the believer is preoccupied with his/her own sinfulness and not to do anything wrong.
- *Relinquishing responsibility*: the believer claims that the devil has made him/her do something in order to evade accountability.
- *Ecstasy or frenzy*: the believer expresses emotional deprivation and an effort to restore a sense of personal wholeness.
- *Recurrent church-changing*: the believer displays an inability to find a congregation to connect with, and in effect a difficulty in holding onto relationships.
- *Indiscriminate attitudes*: the believer is unable to identify spiritual abuse in a church, expressing a response more typical of childhood.
- *Double-sided “love”*: the believer acts on messages of love in the church, displaying simultaneously the other sides of love, which include anger, dependency, and immaturity.
- *The Bible as a guide to everything*: the believer uses the Bible as a moment-to-moment guide to all of his/her daily choices and problems as a way of relinquishing responsibility.
- *Possession*: the believer fears that the devil is possessing his/her soul.

⁴² Robert J Lovinger, *Religion and counseling: the psychological impact of religious belief* (New York: Continuum, 1990), p 102.

⁴³ *Ibid.*, pp 171-172.

However, religion according to Lovinger also has the following healthy effects on the believer's thinking and doing:⁴⁴

- *Awareness of complexity*: the believer is aware that religious problems and writings are complex and multi-faceted, suggesting a maturity of intellectual and emotional development.
- *Willingness to try alternatives*: the believer is able to choose a church different to that of his/her parents, based on a mature choice.
- *"Conversion"*: the believer goes through a period of struggle before coming to a (mature) resolution.
- *Coherence*: the believer shows coherence in teaching and living.
- *Stability*: the believer sometimes falls short of the expectations of his/her religion but keeps on trying rather than making easy adjustments.
- *Respect for boundaries*: the believer shows limited enthusiasm at proselytising in a multi-religious society.

As was the case with the previous authors, Lovinger spends most of his book in describing how psychology can be used to detect mental illnesses caused by harmful religious discourses/spirituality. Lovinger's description of the healing influence of religion/spirituality on clients is underdeveloped, as were those of the previous authors. Lovinger's contribution to the incorporation of religion in counseling is a simple explanation of how the Bible can be used as intertext to shift harmful religious discourses on self-worth, anger, alcohol and sex to make clients feel worthy of themselves, allow them to express anger, enjoy alcohol in moderation and pursue sexual pleasure without injury.⁴⁵

In summary

Lovinger defines religion as a (social) meaning system which has more harmful than healing psychological effects on the believer. However, the harmful social effects of religion on the believer can be counteracted in counseling by using sacred texts, such as the Bible, to convince the client of healthy values such as forgiving perpetrators and enjoying a life of moderation.

⁴⁴ *Ibid*, pp 172-173.

⁴⁵ *Ibid*, pp 175-176.

- William Miller and John Martin: “Behavior therapy and religion”⁴⁶

In an anthology on “Behavior therapy and religion”, Allen Bergin’s essay (entitled “Three contributions of a spiritual perspective to psychotherapy and behavior change”)⁴⁷ points to the multi-faceted relationship between belief and behavior. Bergin, furthermore, does not approach “spirituality” in terms of “the supernatural”, but as something “natural” which proceeds according to laws, and stimulates measurable behavior. Spirituality forms part of a person’s mental apparatus, together with cognition and agency.⁴⁸

What are the spiritual values which are relevant to health and can be set as goals for therapeutic intervention? With this question in mind, and with the help of a questionnaire to mental health professionals, Bergin compiled the following priority list of healing religious discourses (“mentally healthy values”) *vis-a-vis* the effects they can have on behavior.⁴⁹

- Assume responsibility for one’s actions.
- Develop effective strategies for coping with stress.
- Develop the ability to give and receive affection.
- Increase one’s ability to be sensitive to others’ feelings.
- Increase one’s capacity for self-control.
- Have a sense of purpose for living.
- Be open, genuine and honest.
- Find fulfilment or satisfaction in work.
- Apply self-discipline in the use of alcohol, tobacco and drugs.
- Acquire an awareness of inner potential and capacity to grow.
- Be faithful to one’s marriage partner.
- Be committed to family needs and child rearing.
- Increase one’s respect for human value and worth.
- Be able to forgive parents and others who have inflicted disturbance in oneself.
- Be able to forgive oneself for mistakes that have hurt others.
- Understand that sexual impulses are a natural part of oneself.

⁴⁶ William R Miller & John E Martin, *Behavior therapy and religion: Integrating spiritual and behavioral approaches to change* (California: Sage, 1988).

⁴⁷ *Ibid*, pp 25-36.

⁴⁸ *Ibid*, p 28. “It is, of course, disturbing to try to embrace within the same frame of reference both mechanistic notions such as the existence of classically conditioned responses, and the idea that people have a mental apparatus with cognitive, agentive, and spiritual aspects. This is made much easier by assuming that the psychobehavioral aspects of organisms are multisystemic, just as the biological aspects are.”

⁴⁹ *Ibid*, pp31-32.

- Regard sexual relations as satisfying only when there is mutual consent of both partners.⁵⁰

In the same anthology, Ellie Sturgis' article on "The relationship between personal theology and chronic pain" distinguishes as follows between harmful and healing in terms of spirituality:⁵¹

Spiritual beliefs are harmful ("dysfunctional") when they

- interfere with growth
- hinder acceptance
- undermine physical and psychological adaptation, and
- restrict the ability to deal with stress or set goals.

Spiritual beliefs are healing ("functional") when they

- provide effective coping strategies
- bring comfort, and
- improve the ability to adapt.

In the same anthology, William Miller published an article on "Including clients' spiritual perspectives in cognitive-behavior therapy". The integration of spirituality with therapy is possible, according to Miller, because "(b)oth cognitive and religious perspectives are concerned with the implicit belief systems by which behavior is governed".⁵² This collaboration is healthy when spirituality does not take on an arrogant and dogmatic role, and the collaborated effort⁵³

- views therapy as an exploration of beliefs and their consequences
- evaluates consequences against client core values
- attempts to modify client beliefs better to pursue the client's purpose and higher-order values
- does not insist on client beliefs being overly verifiable, and
- accepts and respects the absolute core beliefs and values of the client.

These, according to Miller, are healthy therapeutic discourses based on non-arrogant spiritual insights.

⁵⁰ *Ibid*, p 32: There were also items on which the respondents were divided:

- Have preference for a heterosexual sex relationship
- Become self-sacrificing and unselfish
- Have a religious affiliation in which one actively participates
- Seek a spiritual understanding of the universe and one's place in it

⁵¹ *Ibid*, p 112.

⁵² *Ibid*, p 44.

⁵³ *Ibid*, p 46.

In summary

Working with a behavioristic definition of “spirituality” as a natural part of a person’s mental apparatus which has measurable effects on the person’s behavior, the behavior therapists under discussion are able to compile a priority list of behaviors which are based on mentally healthy spiritual values. Assuming responsibility, coping with stress and accepting failure seem to be preferable patterns of behavior and therapeutic goals.

- Vicky Genia, “Counseling and psychotherapy of religious clients”⁵⁴

In her book, *Counseling and psychotherapy of religious clients: a developmental approach*, Vicky Genia distinguishes between faith and religion: “Faith refers to the individual’s way of responding to a transcendent power ... While religion helps many people to nourish and express their faith, religious belief or practice is not synonymous with faith itself.”⁵⁵

Genia claims that, by developing a person’s psychospirituality, faith can be explored as a source of healing in counseling and psychotherapy. She thus views faith differently from

- psychoanalysts who regard religious practice as “a neurotic repetition of early childhood”,
- cognitively oriented psychotherapists who “presume that all religious beliefs are irrational and immature”, and
- humanistic and existential psychotherapists whose psychological orientation is compatible with spiritual belief only in that they regard the transcendent as a legitimate level of consciousness and honour human behavior’s self-determination in this regard.⁵⁶

Genia defines faith, from a developmental perspective, as a person’s spiritual journey from egocentricity and dogmatic fixation, to inclusivity and moral maturity.

According to Genia,⁵⁷ faith develops through five stages to maturity, the first two of which can still be called “harmful”. Through counseling and psychotherapy, however, a believer who got stuck in any of these two stages, can be guided towards a healthy and mature faith. These stages are as follows:

⁵⁴ Vicky Genia, *Counseling and psychotherapy of religious clients: a developmental approach* (Westport, Connecticut; London: Praeger, 1995).

⁵⁵ *Ibid*, p 5.

⁵⁶ *Ibid*, pp 9-10.

⁵⁷ *Ibid*, pp 17-18.

Stage 1: Egocentric faith ("harmful faith")

The faces of an egocentric faith are:

- magical identification with the omnipotent Other
- attempts to appease a sadistic and punishing God
- petitionary prayer and comfort seeking, and
- use of religious arena to reenact emotional traumas

The effects of an egocentric faith on a believer are as follows. The believer

- exhibits superstitious and magical thinking
- has erratic mood fluctuations
- fears abandonment
- feels shame or worthlessness
- seeks religion for comfort and emotional relief
- has low frustration tolerance and is impulse dominated
- relates to God as a need-satisfying object
- exhibits abrupt shifts in perceptions of self and others
- views the world as dangerous and threatening
- centers spiritual practice on appeasing a vengeful and intolerant God
- often fantasises about power, greatness and perfection, and
- selectively attends to morbid aspects of religious ideology.⁵⁸

Stage 2: Dogmatic faith ("harmful faith")

The faces of a dogmatic faith are:

- orientation towards earning God's love and approval
- compulsiveness in the conformance to religious codes
- guilt feelings about sex and anger
- rigidity and emotional restrictiveness, and
- self-denial, submission to authority, intolerance of diversity.

The effects of a dogmatic faith on a believer are as follows. The believer

- is overconscientious
- is perfectionistic
- engages in compulsive religious activity
- is extremely intolerant
- perceives God as judgmental and demanding
- is attached to religious authority
- is conformist

⁵⁸ *Ibid.*, p 27.

- has powerful feelings of guilt
- is religiously fanatic
- displays moral superiority
- is afraid of sexual and emotional intimacy, and
- is sin-focussed⁵⁹

Stage 3: Transitional faith (“healing faith”, with some “harmful” characteristics)

The faces of transitional faith, and its effects on the believer are:

- critical examination of previously held beliefs
- reformulation of spiritual values and ideals
- renouncement of the tyranny of dogma
- *however*, sporadic confusion of spiritual identity, switching of affiliation, experimentation with divergent faiths, inconsistent application of moral values.⁶⁰

Stage 4: Reconstructed faith (“healing faith”, with some “harmful” characteristics left)

The faces of a reconstructed faith, and its effects on the believer are:

- commitment to a self-chosen faith that provides meaning, purpose and spiritual fulfilment
- practising of constructive, internalised morals and ideals
- *however*, choice of a religious community that proposes definite answers to spiritual uncertainties

Stage 5: Transcendent faith (“healing faith”)

- selfless devotion to goodness and truth, and
- sense of community with people of all faiths and with God.

For Genia the first step in combining faith and psychotherapy would, of course, be to diagnose the client according to his/her stage of faith development. The path to healing, then, would be by strengthening the values of a “transcendent faith”. The aim of psychotherapy and counseling, then, would

⁵⁹ *Ibid*, p 65.

⁶⁰ *Ibid*, p 79.

be to guide the client towards transcendent faith, which is based on the following religious discourses:⁶¹

- Transcendent relationship to something greater than oneself is the cornerstone of mature faith.
- Life style, including moral behavior, is consistent with spiritual values.
- Commitment without absolute certainty is essential for spiritual health.
- The spiritually mature appreciates spiritual diversity.
- A mature faith is purged of egocentricity, magical thinking and anthropomorphisms.
- Reason and emotion are both essential to a mature spiritual outlook.
- A healthy spiritual life is characterised by mature concern for others.
- Mature faith supports tolerance, human growth and celebration of life.
- A mature spiritual outlook acknowledges the reality of evil and suffering.
- Mature faith provides an overarching meaning and purpose.
- Mature faith leaves ample room for both traditional beliefs and private interpretations.

In summary

Vicky Genia offers a developmental definition of spirituality as faith developing from egocentricity and dogmatism to tolerance, moral maturity and interpretations of the meaning of life which are both private and traditional. Through the combination of psychotherapy, counseling and faith practices, a client who has remained captive in childhood traumas and consequently in an immature faith, can be guided towards spiritual maturity and mental health.

- Eugene Kelly: “Spirituality and religion in counseling and psychotherapy”⁶²

In his book *Spirituality and religion in counseling and psychotherapy: Diversity in theory and practice*, Eugene Kelly uses the following working definitions of spirituality and religion. “Spirituality” is the active, spiritual search for the meaning and betterment of life, and “religion” is the codified,

⁶¹ *Ibid*, pp 105-119.

⁶² Eugene W Kelly, *Spirituality and religion in counseling and psychotherapy: Diversity in theory and practice* (Alexandria, VA: American Counseling Association, 1995).

institutionalised and ritualised expression of people's connection with the Ultimate.⁶³

Kelly acknowledges the choice of at least a third of his patients not to link their spirituality with institutionalised religion. This is Kelly's first step towards accommodating spirituality/religion in religion counseling, as an alternative to religious counseling which aims at dogmatic righteousness and conversion.

A harmful religious discourse, according to Kelly, would be one that hinders life development and makes the patient dysfunctional in other areas of his/her life. Kelly consequently spends a significant part of his book in describing healthy religious discourses as those enhancing a believer's life development, promoting personal and social well-being by assisting a believer in overcoming emotional distress, and allowing a believer to be functional in all areas of life.

The *development*, *well-being* and *functionality* of the whole person in context and relationship, then, are the keywords in dealing significantly with spirituality/religion in therapy, according to Kelly.

Kelly aptly summarises the therapeutic significance of incorporating spirituality/religion into counseling as follows:⁶⁴

To understand the therapeutically relevant impact of the spiritual/religious dimension in peoples' lives, counselors can be prepared to explore (a) the personal meaning(s) that a client gives to the spiritual/religious dimension; (b) the cultural, traditional, and/or institutional context with which this meaning is associated; (c) the particular formulations and symbolizations in which spiritual/religious meaning is clothed; (d) the developmental process in which this meaning has evolved; and (e) the connections of the spiritual/religious elements to other areas of the client's development and functioning.

In summary

By exploring the therapeutic significance of spirituality/religion within therapy as a process to develop the patient as a relational being, and restore his/her functionality within the broader context of life, Kelly successfully makes the shift from *religious counseling* (healing through prayer and Scripture

⁶³ *Ibid*, pp 4-5.

⁶⁴ *Ibid*, p 85.

reading) to *religion counseling* (healing through alternative discoursing on belief and spirituality).

- James and Melissa Elliott Griffith: “Encountering the sacred in psychotherapy”⁶⁵

For Griffith and Elliott-Griffith⁶⁶ spirituality is a discourse on relatedness, expressed through language and relationship. Spirituality is “a commitment to choose, as the primary context for understanding and acting, one’s relatedness with all that is.” These include “relationships between oneself and other people, the physical environment, one’s heritage and traditions, one’s body, one’s ancestors, saints, Higher Power, or God.” This distinguishes spirituality from psychology and physiology:

- In the spiritual domain the context for understanding and acting is choosing relatedness (interpersonal relationships with the world and other people, intrapersonal relationships with God or other non-material beings)
- In the psychological domain the context for understanding and acting is choosing personhood (a whole self with intentions, choices, plans, desires, and behaviors), and
- In the physiological domain the context for understanding and acting is choosing relationships among elements of the body: muscles, bones, hormones, neurons, and neurotransmitters).

Griffith and Elliott-Griffith add four perspectives to their definition of spirituality as a choice for relatedness which explore spirituality as a healing discourse. Griffith and Elliott-Griffith consider the following as healing discourses within the spiritual domain:⁶⁷

- A person committed to spirituality fills his/her life with *I-Thou relationships*, which are relationships of quality (see Martin Buber).
- People committed to spirituality engage in the social process of *communitas* which binds people together in love and acceptance (see V Turner).

⁶⁵ James L. Griffith & Melissa Elliott Griffith, *Encountering the sacred in psychotherapy: How to talk with people about their spiritual lives* (New York, London: The Guildford Press, 2002).

⁶⁶ *Ibid.*, p 16.

⁶⁷ *Ibid.*, pp 23-26.

- The sacred is a form of *liminal experience* where the transitional space between the subjective and objective is explored in a creative and fluid way (see DW Winnicott).
- Spiritual experience as an *emotional posture* makes the body's physiological systems ready for a particular path of action (see Humberto Mataranka).

Griffith and Elliott-Griffith work from a narrative counseling point of view. Therefore, the way in which they will invite spirituality/religion into therapy, would be

- to ask landscape of action questions, as well as landscape of consciousness questions,⁶⁸ and focus these questions on spiritual experiences. Thus the door is opened for spirituality to become part of the client's story.⁶⁹ Examples of such questions are⁷⁰
 - What has sustained you?
 - From what sources do you draw strength in order to cope?
 - Where do you find peace?
 - Who truly understands your situation?
 - When you are afraid or in pain, how do you find comfort?
 - For what are you deeply grateful?
 - What is your clearest sense of the meaning of your life at this time?
 - Why is it important that you are alive?
 - To what or whom are you most devoted?
 - To whom, or what, do you most freely express love?
- to deconstruct discourses which are harmful to relationships, and reconstruct them as healing ones

The book of Griffith and Elliott-Griffith is committed to describing the therapeutic movement from religious certainty to spiritual wonder. Instead of trying to summarise the book in this regard, I wish to refer to an earlier essay by Elliott-Griffith, "Opening therapy to conversations with a personal God",⁷¹

⁶⁸ As was explained in 1.5.1.1, landscape of action questions encourage the client to present his/her history as possibilities for future preferred ways of being, while landscape of consciousness questions invite the client to articulate and perform these alternative preferences.

⁶⁹ *Ibid*, chapter 2, pp 28ff.

⁷⁰ *Ibid*, p 46.

⁷¹ Melissa Elliott-Griffith, "Opening therapy to conversations with a personal God", in Kathy

in which she identifies four discourses of certainty about God and describes their deconstruction in therapy:

Certainty 1: I know what God is like for you because I know your religious denomination

Elliott-Griffith describes how a “fallen” Reformed Presbyterian shifted the discourse that God only minds those who are morally clean, to a discourse that the Lord would come through filth to pick him up without disgust. “With this new knowledge, he could reconnect with members of his faith community. He started by forming one new friendship there, that was neither dominated by a need to confess nor to hide”,⁷² Elliott-Griffith reports.

Certainty 2: I know what God is like for you because I know what your language about God means

Elliott-Griffith relates that patients shift the discourse “God is like a kind father” to metaphors such as “God is like our housekeeper, who taught me about love that lasted through hard situations.” She also relates how, when the word “God” comes with oppressive connotations and touches the patient with a hard, cold thing, shifting to words such as “Spirit” or “Light” envelops the patient with goodness.⁷³

Certainty 3: I know what God is like for you because your image of God is a reflection of your early attachment figures

What interests Elliott-Griffith and her patients in this regard, “are not explanations for the stability, but the transformations, differences, unique outcomes that could never be predicted by these theories”,⁷⁴ that is, theories that God may be seen as stern and stone-faced because one’s grandfather had, for instance, been that way. Elliott-Griffith and her patients deconstruct these theories with questions such as “Is that all there is to God?”, or “Has there ever been a time when you experienced God being with you in a different kind of way?”, or “Has there ever been a time when God surprised you?”

Weingarten (ed.), *Cultural resistance: challenging beliefs about men, women and therapy* (New York, London: Harrington Park Press, 1995), pp 123-142.

⁷² *Ibid.*, p 129.

⁷³ *Ibid.*, pp 130-131.

⁷⁴ *Ibid.*, p 133.

Certainty 4: I know what God is like and you need to know God as I do

Elliott-Griffith explains how, instead of imposing one's own views of God on the patient, co-creating alternative images of God is the open-ended aim of therapy.⁷⁵

In summary

Social construction theory "invites one to challenge the objective basis of conventional knowledge."⁷⁶ Conventionally, religion has been incorporated in psychotherapy as a system of moral values based on neighbourly love, as can be seen from the works of Oates, Miller, Lovinger, Miller/Martin and Genia discussed above. Religion/spirituality is tolerated in the therapeutic process in as far as it provides a universally accepted system of values which can be objectively judged by psychotherapists as "mature".

However, the books by Kelly and Griffith/Elliott-Griffith take another direction in the relationship between religion/spirituality and psychotherapy. These works describe how to respectfully deal with patients' spiritual identities in religion counseling as part of their development and enhanced functionality in broader contexts.

This study sides with the insights of Kelly and Griffith/Elliott-Griffith. I work with the premise that spirituality/religion too is socially constructed, and that the deconstruction of harmful religious discourses can therefore be part of a therapeutic process of healing. This study will not try to incorporate religion/spirituality into psychological systems and theories, but to look with believing patients for the unique outcomes afforded by the deconstruction of religious discourses.

Journeying with stories: Dikeledi looks happy after her rape

Dikeledi was gang raped on a Sunday, and counseled on the next Wednesday at the hospital.

Dikeledi told her story as follows: On Sunday she was on her way from Atteridgeville to the Holiday Inn in Sunnyside where she was employed. It was 05h40. A man approached her. He smelled of liquor. He demanded money and she gave him R25,00. As soon as she had opened her purse, two other

⁷⁵ *Ibid*, p 135.

⁷⁶ Kenneth, J Gergen, "The social constructionist movement in modern psychology", in *American Psychologist*, March 1985, p 267.

men approached. They grabbed her purse and cellphone. They grabbed her as well, and took her to a furrow. They threw her on the stones, and raped her one by one, several times. The sharp stones cut her back; the weight of the men damaged her back irrevocably. Also, she was menstruating. This angered one of the men. "You have been with another man," he said and with force pushed his finger up her anus to punish her for this. He then forced her to write her pin number on his arm.

Dikeledi offered religious explanations for her misfortune. God was testing her, she said. God was punishing her for being on her way to work and not to church on a Sunday morning.

However, during counseling, Dikeledi was able to deconstruct the discourse of the testing, punishing God, and to invite God-talk into the therapeutic process which was friendly, and on her side. Also, she managed to rescope her role in rape as that of moral agency, that is, she reviewed herself as a moral agent amidst an act of utmost immorality.

Eventually, Dikeledi retold her story as follows:

On her way to work, Dikeledi was grabbed by men and raped. She did not accept this act, but resisted, telling the men that this was against God's will. There was blood during the rape, and she was accused of having been with another man that morning, but she resisted, and said that she was menstruating, and that the blood was from God, as God sent it every month.

They took all her valuables, and again she protested, telling them that God wants us to work honestly for our belongings. However, one of the men gave her some of her money back. He took her in a taxi to buy some fruit. They talked together for a while. She said to him: "Do not do this to anybody else, because God loves you too." She assured him that God would not punish him, because something was driving him, and he himself did not like what he was doing. She explained to him that men like him rape women because they did not have a steady girlfriend, were still young and not thinking what they were doing. She recommended to him to go to church. Dikeledi felt that she dealt respectfully with her rapist, and that she was able to connect him with God.

Dikeledi's rapist then took her to hospital, where she received treatment. When she was discharged, she went to her church, which is the "Hope for Africa" Church in Mamelodi.

Here Pastor Maluleke prayed for her and urged her to forgive her rapists, and herself.

Dikeledi's church forbids pre-marital sex. Dikeledi had not had sex with her boyfriend before. He was very angry about the rape, but she discouraged him from going to look for the rapists.

As her counselor, I would have felt more comfortable with Dikeledi reporting her rapists and seeing them being punished. However, Dikeledi let herself be healed by forgiving.

Two weeks later Dikeledi came for follow-up counseling. Her concern now was three-fold. In the first place, people at church were telling her that she was looking too happy for somebody who was raped, and that she was lying about the whole incident. During this session we deconstructed the discourse of "A raped woman must look sad" to "I am happy because I could use this as an opportunity to be a moral agent to these men". And "I am proud of myself that I did not panic but handled the situation well". And "I am not only a survivor, I am also protective towards other people, even people who hurt me."

In the second place, people outside the church told her that, if she indeed had been raped, this meant that her God has forsaken her. They recommended that she should see a "witch-doctor" who could give her muti to protect her against further rapes. During counseling, Dikeledi shifted the discourse of "Your God has failed you" to "God let them not touch my soul".

In the third place, Dikeledi was concerned because her boyfriend was visiting her less and less frequently. He told her that God must have something against her to allow her to be raped. During counseling, the discourse "God punishes a woman through rape" was shifted to "God is on the side of a woman who suffers through rape". When my boyfriend does not come, I remind myself that God still is on my side, Dikeledi said without guidance from the counselor.

Dikeledi's story testifies to the commitment of this study to invite spirituality and religious experience into the therapeutic process in a two-fold way. On the one hand the patient's belief system is respected; on the other hand the patient's ability to deconstruct this system towards unique healing outcomes is encouraged.

Religious views on illness and healing

This study is concerned with the deconstruction of religious discourses as (part of) a process of healing. It will be argued that, through deconstruction, the patient could move towards being “healed” from the harmful effects of sexist, classist, racist and other religious discourses which promote hierarchical power, discourses to which the patient has fallen prey. Eventually the aim of a therapy of deconstruction is not only to minimise the harmful effects of religious discourses on the health of the patient, but to maximise the healing effects of the deconstructed discourse.

However, I here wish to inform myself also on other views on healing which presuppose a spiritual point of departure involving religious practices, such as praying and exorcism. Other works have given overviews of religious healing practices, of which the thesis of Stuart Bate, “Inculturation and healing ...”,⁷⁷ is of special significance. Here, I have made a choice of books which will help me to understand the discourses on illness and healing that may inform township spiritualities, which are a unique combination of charismatic, indigenous, traditionalis and missionary Christianity. For this, books have been chosen to represent the following views:

- a “western”, charismatic view (MacNutt),
- an integrated view on medical and African Christian practices (Long),
- a culturo-Christian view on healing practices in a township setting (Anderson), and
- views from African traditional healers (Motsei and Cumes).

These views are supplemented by

- a charismatic view on God’s healing activity in social constructionism (Thiessen), thereby exploring the possibility of narrative counseling as an inroad of healing into township spiritualities.

The questions asked to these books are questions that are of therapeutic significance to the patient population under discussion. These questions simply are (1) What is illness? (2) What causes illness?, and (3) What effects healing?

⁷⁷ Stuart C Bate, *Inculturation and healing: A missiological investigation into the coping-healing ministry in South African Christianity*. DTh thesis. University of South Africa, 1993.

- Francis MacNutt: “Healing”⁷⁸

Francis MacNutt, a Catholic charismatic, distinguishes between three types of illnesses,⁷⁹ which roughly reflects the traditionally Western division of a human being into spirit, soul and body:

- Sickness of the spirit
- Sickness of the emotions, and
- Sickness of the body.

These three illnesses have diverse causes; however, they also have one cause in common, that of demonic possession:

- A person’s own personal sin causes sickness of the spirit
- The sins of others cause sickness of the emotions, and
- Disease, accidents, and psychological stress cause psychosomatic illness.
- Demonic possession can cause any of the above.

Healing, according to MacNutt, is quite simply effected by prayer:

- Prayer for repentance heals a person from sickness of the spirit, which is caused by personal sin;
- Prayer for inner healing heals a person from emotional sickness, which is caused by the fallen human condition;
- Prayer for physical healing heals a person from sickness of the body, which is caused by natural illnesses and human made disasters; and
- Prayer for deliverance (exorcism) heals a person from demonic possession.

In short

MacNutt rejects human endeavours, such as *willpower*, as means to healing.⁸⁰ He focusses on **prayer** as the only divinely designated pathway to healing,⁸¹

⁷⁸ Francis MacNutt, *Healing* (London, Sydney, Auckland: Hodder & Stoughton, 1989/1996) and Francis MacNutt, *Deliverance from evil spirits: a practical manual* (Grand Rapids, Michigan: Chosen Books, 1995). Also arguing for a place for religious healing in the modern world is Morton T Kelsey, *Psychology, medicine & Christian healing* (San Francisco: Harper & Row).

⁷⁹ *Ibid*, p 166.

⁸⁰ *Ibid*, p 161.

⁸¹ In later works, MacNutt explores the concept of **soaking prayer** as the ultimate way to healing.

while acknowledging medicine and counseling as subsidiary human remedies only.

This view helps to understand the charismatic-indigenous-pietistic combo of township spiritualities. A majority of patients, then, indicated that they experience prayer as their only access to healing. This study, however, wants to indicate that the shifting of harmful discourses is as powerful a way of healing as prayer may be.

- Meredith Long: “Health, healing and God’s kingdom”⁸²

Meredith Long had worked for seven years as a Christian health worker in Africa when she published *Health, healing and God’s kingdom: New pathways to Christian health ministry in Africa* in 2000. This book is prescribed reading for students at a variety of seminaries and theological faculties in Africa. The book tries to combine the benefits of Western medicine with the wisdom of African beliefs on healing in a neo-charismatic way.

When Western medicine and African healing combine, three classes of diseases emerge, according to Long:⁸³

- natural diseases or injuries that have no spiritual significance
- natural diseases or injuries that have spiritual causes, and
- diseases that have only a spiritual cause.

While Western medicine only acknowledges disease in the first sense, African healing brings insight and wisdom on the second and third, according to Long’s description.

Long describes the healing process as a drama in two acts. In the first act of the healing drama the cause of the illness or misfortune is revealed, and in the second the treatment for the illness or misfortune is prescribed.⁸⁴ Long does not make a distinction between healing in the African Independent Churches and the healing executed by traditional healers.

Act 1: The cause of the disease/misfortune is revealed by

- the prophet/diviner being possessed by spirits
- the prophet/diviner receiving and interpreting dreams, and
- the prophet/diviner throwing and interpreting bones.

⁸² W Meredith Long, *Health, healing and God’s kingdom: new pathways to Christian health ministry in Africa* (Carlisle, United Kingdom: Regnum Books International, 2000).

⁸³ *Ibid.*, p 119.

⁸⁴ *Ibid.*, pp 157-175.

Act 2: The prophet/diviner intervenes with treatment, which includes

- the giving of medicines/muti
- the performance of rituals (such as the slaughtering of an animal)
- the uttering of powerful words (blessings, preaching, prayer), and
- the performance of exorcism.

Going into prescriptive mood, Long decides that Western medicine and African healing may blend under the following conditions. For healing ministries in Africa to be biblically holistic, they

- must be Christocentric (Jesus Christ must fulfill the role of the ancestors in healing; Jesus is the one who commands the power to heal; Jesus is the one who forgives our sins and bears our curse)
- must recognise the reality of the spirit world but not use it (God/the Bible forbid communication with spirits), and
- must make reconciliation a central part of the healing practice (a person must restore peace with God, their family, their neighbour, different ethnic groups, and the enemy).

In summary

Long's proposal for a biblically holistic Christian health ministry in Africa presupposes a take-over for western charismatic piety; it subdues western medicine to charismatic faith practices, and patronises African healing under the pretext of tolerance and respect. Furthermore Long, like MacNutt, gives a central place to prayer in the healing process, and a minor place to counseling.

Again, Long's analysis is relevant to township spiritualities too, and helps me to understand the quest of the research population to find healing through a combination of western-charismatic-indigenous prayer. On the other hand Long, like McNutt, convinces me that there is a need for what this study wants to do: do give patients/believers access to healing not only through prayer, but also through the shifting of discourses, as is done in narrative counseling.

- Allan Anderson & Samuel Otwang: “Tumelo: The faith of African Pentecostals in South Africa”⁸⁵

Allan Anderson finished his D Th Dissertation on the Pentecostal churches in Soshanguve with the assistance of Samuel Otwang in the early 1990s. In 1993 he published his dissertation as *Tumelo: The faith of African Pentecostals in South Africa* through the Institute for Theological Research at the University of South Africa. This book reflects Pentecostal township views on healing.

Misfortune, according to township Pentecostalism, is caused by⁸⁶

- Satan
- believers who do not keep the rules of the church, thus bringing misfortune on themselves
- God who punishes believers for their wrongdoings
- ancestors who are neglected, and
- witches.

Believers are healed through prayer, finding a word of discernment from the Bible and the laying on of hands. However, prayer can only be effective when the believer believes and confesses his/her sin.

Healing is a process and is assisted in some of the neo-Pentecostal churches in the townships by (some of) symbols,⁸⁷ such as water (for cleansing), ropes and strings tied to various places on the body, staffs, and church badges.

In the neo-Pentecostal churches too prayer, the laying on of hands, confessing sin and belief, and reading the Bible are accompanied by the following healing methods:⁸⁸

- the sprinkling with blessed water (for protection and cleansing)
- the use of symbols such as walking sticks, string, strips of cloth, copper wire across gates and houses, church badges, salt, wood, etc
- the pricking of a finger to get rid of impure blood, and
- exorcism.

⁸⁵ Allan Anderson, *Tumelo: The faith of African Pentecostals in South Africa* (Unisa, Pretoria: Research Institute for Theology and Religion, 1993).

⁸⁶ *Ibid*, p 83.

⁸⁷ *Ibid*, pp 75-78.

⁸⁸ *Ibid*, pp 78-80.

In short

Anderson observes that healing is the reason why people join Pentecostal churches in the townships (or any church which offers healing for that matter). He sympathetically and informatively describes the healing processes in these churches, thereby contributing significantly to the body of knowledge on township churches reclaiming Christianity from its western forms. He does not deal with counseling as part of healing, probably because the churches themselves regard “counseling” as a Western concept.

This study, then, aims at filling this gap. It wants to present narrative counseling as sensitive to the spiritual needs of believers in townships. While respecting the charismatic-indigenous ways in which they find healing, the shifting of problem stories to healing ones is done according to the believers preferred ways of being religious.

- David Cumes: “Africa in my bones: a surgeon’s odyssey into the spirit world of African healing”⁸⁹

Born in the 1940s, David Cumes grew up in one of Johannesburg’s white suburbs and trained as an urologist. He emigrated to the USA in 1975, to return to South Africa in the 1990s. He started training as a sangoma in December 1999. The name of his book, *Africa in my bones: a surgeon’s odyssey into the spirit world of African healing*, published in 2004, reflects his preference for African healing as an alternative to western medicine, and probably, to Christianity.

Cumes explains that illnesses, from an African perspective, are caused by

- the ancestors who take possession of a person as a form of calling. When you are called by the ancestors to perform a specific task, you suffer from psychosis, headaches, stomach or other pains.⁹⁰
- Illnesses and misfortunes are caused through witchcraft. When a person has evoked the envy of another, this person is exposed to being cursed by a witch.⁹¹
- Illness is furthermore caused by pollution. When a person pollutes his or her body through an unhealthy lifestyle, or unbalanced relation-

⁸⁹ David M Cumes, *Africa in my bones: A surgeon’s odyssey into the spirit world of African healing* (Claremont, South Africa: Spearhead, 2004). See also Mmatshilo Motsei, *Hearing visions, seeing voices* (Bellevue: Jacana Books, 2004).

⁹⁰ Cumes, p 11.

⁹¹ *Ibid*, p 15.

ships, that person is haunted by illness and misfortune, which have both spiritual and natural causes.

Healing, Cumes explains, is effected through⁹²

- communication between the *sangoma* and the ancestral spirits. This is done by means of the throwing of divine bones, spirit mediumship (the spirit takes possession of the sangoma), and dreams;
- the *sangoma* interceding between the living and the dead through animal sacrifice or other forms of sacrifice, such as foam or beer;
- the *sangoma* administering *muti* through bathing, steaming or inhaling;
- the *sangoma* performing rituals of a wide variety which differ from clan to clan.

In summary

Cumes' description of traditional African healing practices is important to this study for several reasons. The research population for this study consists mainly of Christians, with a small minority of traditionalists. However, the research population is hugely affected by discourses from Christian healers in the townships who have incorporated the methods and philosophies described by Cumes into healing. Christian healing practices in the townships internalising traditional healing practices are a way of reclaiming Christianity for Africans.

The narrative counseling presented in this study, will honour Africa taking Christianity back from the West.

- Walter Thiessen: "Praying in a new reality: A social constructionist perspective on Inner Healing Prayer"⁹³

Walter Thiessen is a Canadian who obtained his D Th degree in 2003 from the University of South Africa (Department of Practical Theology) with a dissertation entitled *Praying in a new reality: A social constructionist perspective on Inner Healing Prayer*. In this dissertation he interprets Inner Healing Prayer from a social constructionist perspective, and argues "that a personal Creator God, who has a privileged perspective on reality, actively

⁹² *Ibid*, pp 7-13.

⁹³ Walter James Thiessen, *Praying in a new reality: A social constructionist perspective on Inner Healing Prayer* (Unisa: Unpublished D Th dissertation, 2003).

joins in the social processes by which we construct our understandings of reality.”⁹⁴

Thiessen explores constructionist explanations of illness within narrative counseling. Rejecting diagnosis and assessment as ways of determining the faces and causes of illness, Thiessen looks for the cause of illness in narratives which do not sufficiently represent the lived experience of people. People are socially constructed by dominant narratives which prescribe the way in which they are to story their experience. “Illness” occurs when a person’s lived experience contradicts these dominant narratives.⁹⁵

Healing, according to narrative counseling, initially lies in externalising the patient’s problem. Through mapping the influence of the problem on the patient’s life, as well as mapping the influence of the patient’s life on the life of the problem, outcomes unique to the patient’s lived experience are achieved.⁹⁶ The patient is thus empowered to deconstruct the dominant discourses which hold him/her captive in a world without choices and outcomes.

Thiessen, like MacNutt and Long, sees prayer – in this case Inner Healing Prayer – as the pathway to healing. However, in his dissertation he takes a post-modern look at Inner Healing Prayer, tries to reconcile Inner Healing Prayer with social constructionism, and assigns a significant role to God in the social construction of reality. Inner Healing Prayer, then, is a conversation with the God who plays a significant role in constructing reality from a (spiritually) privileged perspective. Encouraged by the believer’s prayer for inner healing, God actively participates in the healing process.⁹⁷

This study’s position on illness and healing

After having studied the above books, I confirm my position on illness and healing:

- 1 This study does not see prayer and an irrational belief in the benevolence of God as the believer’s only access to healing. This study acknowledges counseling as an important component in the healing process (as opposed to what is reported by MacNutt, Long and Anderson). At Kalafong hospital, the challenge before the counselor is to position counseling between African traditional healing practices and its Christian-township renderings on the one hand, and the

⁹⁴ *Ibid*, p vi.

⁹⁵ *Ibid*, p 28, quoting White & Epston.

⁹⁶ *Ibid*, pp 35ff.

⁹⁷ *Ibid*, pp 101-102.

western medicine practised at the hospital on the other. African healing practices, in both its traditional and Christian forms, do not allow for counseling, especially not as a co-journey of the counselor with the patient. Western medicine, again, tolerates counseling only as a diagnosis and assessment of mental illnesses. Narrative counseling, as practised by this researcher, neither diagnoses nor assesses, but externalises. The narrative concept that illness is not internal to a patient, but is externally caused by “harmful” social discourses, resonates with the African concept that illness is externally caused by evil forces. This is the point of departure for counseling as a healing process as presented by this study.

- 2 This study supports the findings of Long, Anderson and Cumes on the traditional views on illness and healing. In my study on township spiritualities, I have found that the following are considered to be causes of illness:

physical illness is caused by

- God as punishment for a sinful life
- original sin
- the person him- or herself leading a sinful life
- ignorance about a healthy lifestyle

mental illness/ and troubles are caused by

- the ancestors
- bewitchment, or
- demons.

However, I view both traditional healing and western healing as socially constructed discourses to be deconstructed in therapy (as opposed to Cumes who views both types of healing as objectively truthful, albeit in opposing camps). Respecting the gains and insights of both traditional and western healing (as opposed to Long who views both forms of healing as unbiblical, albeit for opposing reasons), this study describes the deconstruction of these discourses in the case of them having harmful effects on the health of the patient.⁹⁸

- 3 This study furthermore supports Thiessen in finding God in the social *construction* of reality, and in exploring healing in the *deconstruction* of harmful religio-social discourses on God, as well as in the *co-construction* of a healthy God-talk.

⁹⁸ In an article “Of formulae, fear and faith: Current issues of concern for pastoral care in Africa”, Emmanuel Lartey expresses his concern about “deliverance ministers” who demonise African culture in their deliverance ministry, thereby causing “much pain and suffering... by wrongful diagnosis or faulty discernment of the presence of demons”.

- 4 “Illness” in this study, then, will be defined in terms of harmful discourses, while “healing” will focus on the deconstruction and (healthy) co-construction of these discourses. This will be done with respect towards the spirituality of the patient in all its nuances.

Journeying with stories: Kutloano with the burp of a witch

Kutloano, a 30 year old woman of mixed Ndebele descent who is now living in the township, was referred by the doctor at the hospital for counseling because of a constant burp.

Throughout the first counseling session Kutloano was unceasingly making burping noises which were socially repulsive. In between burps she was repeating one sentence only: “My boyfriend speaks roughly with me.” The doctor demanded a diagnosis, but in terms of narrative therapy none was or could have been given.

At this first session, the problem was externalised as “A boyfriend thinks he may beat his girlfriend.” This externalisation was risky, since Kutloano did not participate in the conversation and simply repeated the sentence “My boyfriend speaks roughly with me”. The counselor reacted on the doctor’s suspicion that Kutloano was severely beaten at home, and since Kutloano was lying on her hands on the table all the time, the counselor presupposed that she was hiding her wounds. However, since the doctor does not accept externalisation as diagnosis, she noted in the patient’s file that, in the light of an absence of diagnosis, counseling was unsuccessful.

However, Kutloano was not untouched by the externalisation of her problem. She returned for counseling on 6 March 2002. During this session she was more talkative and relaxed, although the burp was constantly with us. During this session she participated in suggestions on how to take control over the problem. She was empowered by the idea of working on her self-esteem and personal happiness. She was engaged by the idea of shifting her self-esteem from that of a victim to that of a woman with the right not to be beaten.

Kutloano returned two weeks later for further counseling with two booklets from the Human Rights Commission entitled “My rights; your rights”. She pointed out one sentence in particular to the counselor: “You have the right to be free from all forms of violence, even in your own home” (p 11). Kutloano

suggested that the counselor take one of the booklets for her own enlightenment. During the time when Kutloano was talking about her rights, she felt strong and the burps subsided. However, the counselor was still under the impression that the violence against Kutloano was of a physical nature. A letter was written to her boyfriend Karabo, inviting him to join the counseling process as a significant other.

Kutloano attended counseling faithfully every Wednesday. However, it was a month later that her boyfriend joined us.

It turned out that the violence between Kutloano and Karabo was verbal. Kutloano was unhappy because she already had three children with Karabo and he had not yet paid lebola. Also, he was working out of town and only visited during week-ends. Karabo, fed up with Kutloano's bad moods, called her a witch.

This was, according to Karabo, when Kutloano started burping like a witch. During this session, Kutloano was back to one-sentence utterings. This time it was "I am not a witch, I am a Christian" which was repeated constantly. Karabo explained that he only called her a witch in anger. He did not consider her to be a real witch which, in their context, was worthy of death.

At this stage, "Calling each other hurtful names" was externalised as the couple's problem and avenues were explored to lessen the influence of the problem on the couple's life. With the verbal abuse lessened, and Kutloano's fear of being driven out as a witch removed, the burping stopped. The doctor, too, was happy.

The story of Kutloano illustrates the influence of religious discourses on the physical health of patients. It also points to the role a counseling process that deconstructs harmful religious discourses towards healthy ones can play in the healing of the patient. This is an area where neither western nor traditional medicine can adequately reach.

Journeying with studies on a pastoral counseling practice

In realisation of the third aim of this study, that is, to present a counseling practice based on a therapy of deconstructing harmful religious discourses and co-constructing them in a way unique to the patient's view of healing, the following fields of study were explored:

- the interface between social construction theory and pastoral counseling
- the narrative structure of pastoral counseling,
- the interface between women's theologies and pastoral counseling, and
- the challenges of intercultural pastoral counseling.

The books chosen in these fields to inform the researcher bear directly on the aim of this study, which is to set up a counseling service based on social constructionism as theory and narrative counseling as practice, with a sensitivity towards women's pastoral needs, within the challenges of intercultural counseling.

The interface between social construction theory and pastoral counseling

The counseling done by myself at Kalafong and elsewhere, can best be described as "religion counseling" since it deals religious discourses as problem stories. The counseling is not done from a specific stance on denominational belief. In this section "religion counseling" shall be equalled to the better known term "pastoral counseling" as a search point in a literary review. However, when "pastoral counseling" is used here, it is still under the presupposition that the counselor is not a spokesperson for his or her own belief, but one who co-journeys with the believer's preferred ways of believing.

For this study then, the researcher has to face the question: What are the benefits of social construction theory for a pastoral practice based on a therapy of deconstruction? The researcher was alerted to this question, and informed about the gains of social construction theory for pastoral counseling, by an anthology of essays edited by CAM Hermans *et aliter*, entitled *Social constructionism and theology*.⁹⁹ At least one of the essays in the Hermans-anthology is of special significance to the pastoral counselor who regards social construction and narrative deconstruction as therapeutically significant. This is an essay by Kenneth Gergen.

⁹⁹ CAM Hermans, G Immink, A de Jong, J van der Lans (eds), *Social constructionism and theology* (Leiden, Boston, Köln: Brill, 2002). Volume 7 in the series *Empirical Studies in Theology*, edited by JA van der Ven.

- Kenneth J Gergen, “Social construction and theology: The dance begins”¹⁰⁰

Gergen describes¹⁰¹ five premises to construction theory, all of which I think can be made available for the pastoral practice of co-construction. These premises are as follows:

- 1 “The terms by which we account for the world and ourselves are not dictated by the stipulated objects of such accounts,” says Gergen. As counselor I understand this to mean that the relationship between religious language and belief is arbitrary, and that, when a fixed relationship is claimed by religious dogma, its deconstruction is of therapeutical significance.
- 2 “The terms and forms by which we achieve understanding of the world and ourselves are socially derived products of historically and culturally situated interchanges among people,” says Gergen. I take this to implicate that religious language as a means through which understanding of the world is achieved, is socially constructed, and that a therapeutical shift of religious language can lead to the healing of human relationships.
- 3 “The degree to which a given account of world or self is sustained across time is not principally dependent on the objective validity of the account, but relies on the vicissitudes of social process,” says Gergen. I understand that the door is thus opened to explore alternative religious voices in counseling, voices which have previously lacked religious authority.
- 4 “Language derives its major significance from the way in which it is embedded within patterns of relationship,” says Gergen. I understand the significance of this for pastoral narrative counseling to be that religious propositions are not driven by reality (truth) but by dogmatic culture, and therefore invite deconstruction.
- 5 “None of the propositions making up the social constructionist web are candidates for truth,” says Gergen. This undermines the truth claims of both constructed religious language and its deconstruction.

Gergen, in short, rejects the notion of individual knowledge and finds knowledge constructed in *communities of understanding*. I see pastoral

¹⁰⁰ Kenneth J Gergen, “Social construction and theology: The dance begins”, in CAM Hermans et al, *Social constructionism and theology* (Leiden, Boston, Köln: Brill, 2002), pp 3-22.

¹⁰¹ *Ibid.*, pp 6-11.

narrative counseling as the patient's deconstruction of religious knowledge towards unique outcomes in order to, eventually, establish alternative communities of understanding. In the establishment of alternative communities of understanding, then, based on the insight that religious understandings of reality are socially constructed, lies the interface between social construction theory and pastoral counseling.

Journeying with stories: Likeleli, constructed into subordination

On a Wednesday in 2001, one of the sisters at Kalafong Hospital indicated that Likeleli needed counseling. We found her sitting in front of the office crying. She had been bitten by her mother, the sister said. Likeleli was indeed very upset when she spoke to me. She briefly told me the story leading to the numerous bite and other marks on her arms and head.

Likeleli had recently joined an independent church in Atteridgeville, where she found love and consolation after having lost her job on a charge of "gross insubordination". However, her family belonged to another independent church, and her mother saw her joining another church as an act of insubordination. Moreover, her mother was suspicious of the rituals performed in Likeleli's new church and called it "satanistic". Salt and oil were used in these rituals and when Likeleli's mother found these ritually displayed in her house, she forbade Likeleli to cook. She also accused Likeleli of throwing hot water on her sister's baby, trying to kill her, and of forcing her, the mother, to eat her "number two". Her mother then bit her, and while her sister's boyfriend held her, hit her with utensils over the head. While Likeleli felt herself the victim of her mother's behavior, it was the mother who then called the police, who took her to Weskoppies. There Likeleli insisted on coming to Casualty at Kalafong to have her wounds attended to.

During the next four months Likeleli attended several counseling sessions, walking the ten kilometers from the shelter where she was now staying to the hospital. I once dropped her at the shelter. Her living conditions are miserable, where she lived cramped in a temporary shed, almost like a chicken. For this she had to look after the children in the shelter.

Even here, Likeleli said, there are people threatened by her energy and enthusiasm, and she was pushed back on an un-

spoken charge of insubordination. And, Likeleli said, the same was happening at the church. Although she was happy there, the people found her outreach too much and her right to preach had been taken away from her. Also, the pastor at the church had visited her mother and had ordered her to obey her mother (even though her mother is against her new church) because the Ten Commandments tell us to honour our parents.

At home, at work, at her new home, at her new church – everywhere Likeleli was sidelined and “removed” for being “insubordinate”. During therapy, the discourse of insubordination was externalised as the problem devastating Likeleli’s life. Likeleli named the covered fears of the people around her which fed this discourse: Her mother was afraid of a possible friendship between Likeleli and her stepfather; her supervisor at work was afraid of Likeleli doing her job well; so were the people at the shelter, and at church.

At this stage, Likeleli invited me to attend church with her. During a service that lasted five hours (08:30-13:30), several demons were driven from the more than a thousand believers present. Noticeable was the demon of insubordination which was driven from several women. Likeleli herself was almost unrecognisable with a grey suit and a grey cap pulled over her eyes. She has become, or rather, she has made herself, invisible.

Likeleli has tried to resist the discourse of insubordination which ruled her life. But the battle was hard. She made a case of assault against her family, but she withdrew it to win her mother’s favour. She made a case at the CCMA against her employer, won the case, but did not have money to go and collect the out payment which was constantly postponed by the employer. In therapy she has renamed herself and identified her significant others. We have invited her mother, a nurse at Kalafong, to join in one of the sessions, but little was achieved through this bitter conversation. The conversation did not move beyond fiery accusations, and there was an unwillingness from the mother to accept the daughter back “who pays the pastor to pray for her for employment, but does not pay for her food at home.”

One day Likeleli did not turn up for her appointment. This was rare. I phoned her shelter, but they were unwilling to say where she had gone. I went to her church, but was showed

away. Has Likeleli lost the battle against the Discourse of Insubordination?

The story of Likeleli illustrates the captivating influence of discourses on the believer's life. It also shows how agendas of power are hidden behind religious discourses which claim to truthfully separate right from wrong. Finally, Likeleli's story alerts us of how difficult it is to deconstruct a powerful and dominant discourse, such as the Discourse on Insubordination, when an alternative community of understanding is not available. Therapeutical deconstruction is especially difficult when women are using power discourses against one another, as in Likeleli's case.

The narrative structure of pastoral counseling

Daniël Louw teaches pastoral counseling at the University of Stellenbosch. In a recent talk at the South African Society for Practical Theology (2004)¹⁰² he mentioned two exciting developments, or rather "revolutions", in pastoral counseling. The one is a narrative approach to pastoral counseling, which represents a movement "from salvation (*kerygma*) to metaphor and story". The other is hope therapy, which is a movement "from the focus within...to the focus onwards". Louw discussed Charles Gerkin as a representative of the first revolution, and Donald Capps as representing the second. Laying the foundation of these "revolutions" is the work of Howard Clinebell.

I have informed myself of these approaches, which include:

- growth-towards-wholeness therapy (Clinebell)¹⁰³
- hope therapy (Capps)¹⁰⁴, and
- a narrative approach to therapy (Gerkin).¹⁰⁵

Here the insights of Charles Gerkin in his *Widening the horizons* and Donald Capps in his *Living stories*¹⁰⁶ shall be explored to remain within the aim of this subsection explained above.¹⁰⁷

¹⁰² Daniël J Louw, "What about 'human soul' in *cura animarum*? The paradigmatic revolution in care, counseling and practical theology". Unpublished paper given at the South African Society for Practical Theology, 2004.

¹⁰³ Howard Clinebell, *Basic types of pastoral care and counseling: Resources for the ministry of healing and growth* (London: SCM Press, 1984).

¹⁰⁴ Donald Capps, *Agents of hope. A pastoral psychology* (Minneapolis: Fortress Press, 1995).

¹⁰⁵ Charles V Gerkin, *Widening the horizons: Pastoral responses to a fragmented society* (Philadelphia: The Westminster Press, 1986).

¹⁰⁶ Donald Capps, *Living stories: Pastoral counseling in congregational context* (Minneapolis: Fortress Press, 1998).

- Charles Gerkin: “Widening the horizons”

Elaine Graham explains Gerkin’s “narrative hermeneutical practical theology” as one “in which narrative serves as the primary bearer and interpreter of meaning.”¹⁰⁸

Gerkin indeed offers three valuable insights into the narrative structure of pastoral theology:

- 1 Human experience has a narrative structure. People find meaning in the narrative structure in which they are grounded. Believers find meaning in the narrative of their belief.¹⁰⁹
- 2 The recovery of poetic, storylike language for pastoral care takes seriously the common language of the people for whom the pastor cares. This narrative language speaks simultaneously about human and divine events.¹¹⁰
- 3 When the pastor recognises that narrative articulates reality, meaning can be transformed through narrative. It is not the story which is structured, but the story of the believer which structures reality. Thus the narrative structures the believer’s experience of life and time. The aim of pastoral narrative theology, then, is to transform the human story in ways that open the future of that story to creating possibilities by blending human with divine stories. Pastoral theology involves a process of interpretive fusion of horizons of meaning.¹¹¹

Honouring the insights of Gerkin on the narrative structure of pastoral care, I find the hermeneutical role given to the pastor to interpret the believer’s story problematic. I see the role of the pastoral counselor not as interpreter, but as that of co-traveler on the journey of storying, and restorying.

¹⁰⁷ This aim is to keep the literary overview within the direct scopus of an envisaged pastoral practice which is “based on social construction theory and narrative counseling, with a sensitivity towards women’s pastoral needs, and the challenges of intercultural counseling.”

¹⁰⁸ Elaine L. Graham, *Transforming practice: Pastoral theology in an age of uncertainty* (Eugene Oregon: Wipf and Stock Publishers, 1996), p 118.

¹⁰⁹ Gerkin, *Widening the horizons*, pp 22, 26, 46.

¹¹⁰ *Op cit*, pp 29, 46.

¹¹¹ *Op cit*, pp 46, 51, 54, 61.

- Donald Capps: “Living stories”

Capps, more than Gerkin, emphasises the pastor as interpreter. Eventually, Capps goes beyond the pastor interpreting the believer’s story. The pastor is to guide the believer’s story by¹¹²

- incorporating suggestions into the counseling process
- pointing out paradoxes in the believer’s story to help him/her untie the apparent knots in the story by bringing in the unexpected, and
- bringing out the miraculous in the story. In the language of narrative counseling this would be called co-authoring the unique outcomes with the believer.

The latter remark brings out an interesting feature of Capps’ work in *Living stories*. Capps subscribes to narrative counseling, but obviously in another form than that proposed by White and Epston. The latter’s names and works are not mentioned in Capps’ book. On the contrary, Capps refers to Charles Gerkin,¹¹³ Edward P Wimberly,¹¹⁴ Andrew D Lester¹¹⁵ and Carrie Doehring¹¹⁶ as narrative pastoral counselors. He discusses the work of Janine Roberts,¹¹⁷ Patricia O’Hanlon and William Hudson O’Hanlon,¹¹⁸ Alan Parry and Robert E Doan¹¹⁹ as (family) therapists who use a narrative-oriented therapy. As the prime story-sensitive therapists of the past century, Capps hooks onto the work of Milton H Erickson¹²⁰ for his use of the inspirational story, that of Paul Watzlawick¹²¹ for the art of untying knots through the

¹¹² Capps, *Living stories*, pp 53, 92, 125.

¹¹³ Apart from *Widening the horizons*, Capps also mentions Gerkin’s *The living human document* (Nashville, Abingdon Press, 1984). See Capps, *Living stories*, p 215, n 1.

¹¹⁴ Edward P Wimberly, *African American pastoral care* (Nashville: Abingdon Press, 1991).

¹¹⁵ Andrew D Lester, *Hope in pastoral care and counseling* (Louisville: Westminster John Knox Press, 1995).

¹¹⁶ Carrie Doehring, *Taking care: Monitoring power dynamics and relational boundaries in pastoral care and counseling* (Nashville: Abingdon Press, 1995). Doehring is misspelt in Capps (*Living stories*, p 215, n1) as Doerring.

¹¹⁷ Janine Roberts, *Tales and transformation: Stories in families and family therapy* (New York: WW Norton, 1994). See Capps, *Living stories*, p 216, n 1.

¹¹⁸ Patricia O’Hanlon & William Hudson O’Hanlon, *Rewriting love stories: Brief marital therapy* (New York; WW Norton, 1991).

¹¹⁹ Alan Parry & Robert E Doan, *Story re-visions: Narrative therapy in the postmodern world* (New York: Guilford Press, 1994).

¹²⁰ See Jay Haley, *Uncommon therapy: The psychiatric techniques of Milton H. Erickson* (New York: WW Norton, 1973).

¹²¹ *Inter alia* Paul Watzlawick, *The situation is hopeless, but not serious* (New York: WW Norton, 1983).

paradoxical story, and that of Steve de Shazer¹²² for the art of identifying exceptions through the miracle story.

Taking note of the fact that there are other forms of narrative counseling apart from the one proposed by White and Epston, I also take note of what distinguishes Capps' narrative counseling from that of White and Epston. The distinction, as far as Capps is concerned, lies in the power given to the counselor in interpreting the patient's story, in inviting the patient's story to be told as an inspirational, paradoxical and/or miracle story, and in guiding the patient's story through the inspirational, paradoxical and miracles stories of others.

Narrative counseling as proposed by White and Epston, on the other hand, places the power of storytelling, meaning giving and healing in the hands of the patient.

This researcher's position

In an article entitled "Journeying a life-giving ethical spirituality", Trevor Hudson¹²³ describes narrative counseling in a pastoral setting as "co-constructing new meanings in and for spiritual lives". I feel removed from Gerkin and Capps in as much as they view narrative counseling as an hermeneutical exercise. Narrative counseling, for me, is not to interpret a person's story, but to become part of it by co-constructing meaning and by engaging in a co-journey towards unique outcomes.

To illustrate how the story of the believer structures reality, the following story is presented.

Journeying with stories: A boy was raped at church

It took a long time to co-author Lehlohonolo's story, simply because Lehlohonolo did not talk. Lehlohonolo (12) was brought by his mother to the hospital. She is Sepedi-speaking, a dressmaker who earns R260 per week. Her husband left nine years ago. Lehlohonolo remained quiet while his mother narrated his story as follows:

One Sunday she and Lehlohonolo went to church. This was the Zion Christian Church. The service lasted throughout Saturday night. At some stage the children went to play at the

¹²² Steve de Shazer, *Difference to work* (New York: W W Norton, 1991).

¹²³ Trevor Hudson & Dirk Kotzé, "Journeying a life-giving, ethical spirituality", in Dirk Kotzé, ea (eds), *Ethical ways of being* (Pretoria: Ethics Alive, 2002), p 285.

shops. A man approached Lehlohonolo and promised him a bicycle which was allegedly hidden in the bushes. Here the man raped Lehlohonolo. Afterwards Lehlohonolo ran out into the road, where he was picked up by somebody and taken to church. The pastor called the police, who took Lehlohonolo to hospital where it was confirmed that Lehlohonolo was raped. Lehlohonolo eventually pointed out the man to the police. The man was taken into custody, but released later.

Lehlohonolo spoke very little during the counseling session, except to deny that he was raped. However, he indicated that playing soccer was very significant to him, and that his friends were of great importance to him.

During the next few months, Lehlohonolo turned up for his counseling appointments every week. Since his mother was working, he walked the five kilometers from their house to the hospital on his own. He enjoyed the sandwiches I brought him from home, and soon started to communicate through drawings. The first time he drew himself, he presented himself as a goalkeeper with a very sad face. A feeling of being unsafe (especially in and near the church) was externalised as the problem which made Lehlohonolo sad. Lehlohonolo then started to identify the people and places which did make him feel safe, which included the pastor who called the police after the rape, and God.

Later, Lehlohonolo drew a picture of himself as a striker, with a happy face. The striker became the narrative of Lehlohonolo's healing. One Wednesday the doctors at the Polyclinic who were involved with Lehlohonolo, gathered for a short certificate ceremony, when a certificate was given to Lehlohonolo, the Striker, who scored a goal against a previous sadness in his life – with the help of God.

The story of Lehlohonolo points to the variety of narratives in pastoral counseling, which here included drawings, words, sandwiches and a certificate ceremony. It also illustrates the blending of secular and sacred horizons, in this case with main characters Lehlohonolo the Goalkeeper and God the Protector. Finally it points to the limited role of the counselor as interpreter.

The interface between women's theologies and pastoral counseling

Relanguaging religious discourses as part of socially reconstructing women of faith, is a central theme in the work of southern (eg Lisa Isherwood¹²⁴), western (eg Mary Grey¹²⁵) and African (eg Musimbi Kanyoro¹²⁶) women theologians.

In South Africa this process has received impetus with the work of Yolanda Dreyer. Teaching at the University of Pretoria, she finished her DD dissertation at this university in 1998 on *Pastorale interaksie met vroue: 'n Prakties-Teologiese begronding* (Pastoral interaction with women: a practical theological foundation).¹²⁷ In a follow-up article, "Pastorale interaksie met vroue – gesien vanuit die beelde wat vir God gebruik word" (Pastoral care and counseling with women: God-images and the identity of women),¹²⁸ Dreyer explains the influence of harmful religious language on both the identity and health of women. She suggests the renaming of God as a starting point for healing women believers.

Since this process is still underdeveloped in South Africa in spite of Dreyer's brave attempts, I now turn to the work of Christie Cozad Neuger, a narrative pastoral theologian from the north who specialises in counseling women. Neuger is also quoted by Dreyer as her point of departure for re-languaging God-talk.¹²⁹

Women pastoral theologians and their insights are important to the field of pastoral counseling in general, but of special importance to this study because of its research population being overwhelmingly female.

¹²⁴ Liza Isherwood & Dorothea McEwan, *Introducing feminist theology* (Sheffield: Sheffield Academic Press, 2001, second edition). See especially chapter 5, "What's in a word?", pp 107-122.

¹²⁵ Mary Grey, *Introducing feminist images of God* (Sheffield: Sheffield Academic Press, 2001).

¹²⁶ Musimbi RA Kanyoro, *Introducing feminist cultural hermeneutics: An African perspective* (Sheffield: Sheffield Academic Press, 2002).

¹²⁷ Yolanda Dreyer, *Pastorale interaksie met vroue: 'n Prakties-Teologiese begronding* (Unpublished DD Dissertation, University of Pretoria, 1998).

¹²⁸ Yolanda Dreyer, "Pastorale interaksie met vroue - gesien vanuit die beelde wat vir God gebruik word", in *Hervormde Teologiese Studies* 54.3,4(1998), pp 544-572.

¹²⁹ Dreyer, *op cit*, p 544.

- Christie Cozad Neuger: “Counseling women: A narrative, pastoral approach”¹³⁰

Neuger stands in the narrative counseling tradition of Michael White and David Epston. There are at least four reasons why I find Neuger’s work helpful vis-a-vis the counseling of women:

- 1 Neuger explains discourses as instruments of power that “privilege certain groups and disempower others.”¹³¹ Deconstructing victimhood due to religio-cultural discourses, and empowering women to re-language their selfhood, are important aspects of the pastoral counseling practice in which this researcher engages.
- 2 Neuger bemoans the fact that women’s stories have for centuries been left out of cultural and ecclesiastical stories, and “that men’s experiences and interpretations, the dominant culture, have been used as normative in creating theories (and theologies).”¹³² This resulted in women encountering experience that contradicts the stories by which they live.¹³³ The pastoral counseling practice proposed here follows the process described by Neuger, that of retrieving women’s stories of lived experience, transforming their interpretation, and creating new personal, familial, and cultural realities for women through the re-shaping of stories.
- 3 Neuger describes the counselor’s role in counseling in (at least) three ways which are attractive to me for a pastoral counseling practice in which disempowered women feature prominently:
 - The counselor helps the patient to find her own strengths instead of focusing on her “pathology”.¹³⁴ The woman is not the problem, the discourse disempowering her is the problem.
 - The counselor’s role is collaborative and co-creative, placing the woman patient in the driver’s seat.¹³⁵ Women’s agency is an important focus in the pastoral counseling process supports by this researcher. The counselor helps the woman to “come to voice” through collaboratively shifting the discourse which

¹³⁰ Christie Cozad Neuger, *Counseling women: A narrative, pastoral approach* (Minneapolis: Fortress Press, 2001).

¹³¹ *Ibid*, p 8.

¹³² *Ibid*, p 35.

¹³³ *Ibid*, p 43.

¹³⁴ *Ibid*, p 45.

¹³⁵ *Ibid*, p 55.

steals the woman's selfhood, and through creatively re-languaging the words which undermine her personhood.¹³⁶

- The counselor engages in a process of deconstructive listening and feminist reconstruction. Neuger aptly describes "deconstructive listening" as follows:¹³⁷ "These three elements of deconstructive listening – externalising, naming the problem, and looking for unique outcomes or deconstructive possibilities within the story – work together to plant the seeds for gaining voice, agency, and authority in the naming of one's own life and in the meaning making of life experiences." "Feminist listening", or "feminist reconstruction" as I hope to call it, "is based on the belief that the counselee has the resources she needs within her own narrative. She has survived and struggled against the problems she is facing and the resources she has used in those struggles are still available to her."¹³⁸
- In doing pastoral counseling with women, Neuger aims at finding a balance between "individual experience, family system dynamics, and cultural location."¹³⁹ This is one of the most important challenges of the multicultural pastoral counseling practice within which this research functions, and brings us to a subsequent subsection.

But first, a story that carries testimony to the concepts introduced by Neuger:

Journeying with stories: The blind woman who sees God

Susie (53) is a white woman who became blind at the age of 41. Before that, she worked as a social worker. Now she handles the switchboard. Also, when she became blind, her husband of 24 years left her. Since then, Susie has developed fibromyalgia, a fatal disease which attacks the nervous system. There is no cure for this illness; constant medication offers no more than 30% relief.

Susie lives alone in an apartment in suburban Centurion (Tshwane). She is blind. She is bored with her job, which she may lose since she already has no feeling in her hands. She is

¹³⁶ *Ibid*, p 73.

¹³⁷ *Ibid*, p 91.

¹³⁸ *Ibid*, p 89.

¹³⁹ *Ibid*, p 46.

angry because of the desertion of her husband, who now lives with his girlfriend. Because of the fibromyalgia she chronically suffers from acute pain, migraine, nausea and insomnia. Her two daughters, both in professional careers overseas, often suggest that she is fabricating new illnesses for herself, a suggestion which Susie experiences as particularly abusive.

Most of all, Susie is angry with God – for creating and allowing illness.

The counseling session originally took place in 2003. On Saturday in January 2005, that is, a year and two months later, Susie met with this researcher/counselor to reflect on the deconstruction of the religious discourses which, at the time, had a harmful effect on both Susie's mental and physical health.¹⁴⁰ Susie related that two things during the counseling session convinced her to be healed from her anger towards God. The first was the process of relanguaging God-talk during the session. After she had told her story, the counselor said: "Voel jy God het sy gat aan jou afgegee?" (Do you feel God has shown you his arse?) Although this counselor cannot remember using such highly alternative language, Susie related that she experienced this as extremely healing. She immediately felt that the counseling was "on her level", and that she was taken seriously ("Dit het my katswink geslaan"). She felt that the counselor understood how serious her anger was: ("As ek kon, sou ek God iets aangedoen het"). During counseling she felt that it was okay to be angry and to feel that way.

In Neuger's language, I suppose, this would be called "deconstructive listening".

The second thing which invited her to become healed, Susie said, was the process of repositioning herself with respect to God. Now, when I get angry or depressed, she said, I remind myself that I do not stand over and against God, but next to him. Traditionally pastors told her that she was ill and blind because she was sinful. She was already down and they bashed her even further. They told her that God had a goal with her suffering. But she asked herself whether God could not have done the same without the pain. Pastors used to say: "God will

¹⁴⁰ On this occasion, also, Susie gave permission for her story to be used in this study under her real name. However, the name has been changed here.

not give you a burden which is too heavy for you to carry". Now she knows that God will not give you a burden which is too heavy for you and God to carry together. She has repositioned herself to stand next to God, her friend. God is God in a special way to women who have been emotionally and verbally abused, and deserted, she said.

That would be, a la Neuger, "feminist reconstruction", I suppose.

The challenges of intercultural pastoral counseling

"Religion is the substance of culture, culture is the form of religion", writes David Augsburger in *Pastoral counseling across cultures*,¹⁴¹ quoting from Paul Tillich's *Theology of culture*.¹⁴² The insight that religion stands in some kind of obvious relationship to culture, and that culture has a significant spiritual face, is an important one for pastoral therapy practiced in multicultural settings such as those prevailing in townships. In their book, *Counseling and psychotherapy: A multicultural perspective*,¹⁴³ Allen and Mary Bradford Ivey (and others) confirm the culture-religion relationship and state that "(a)s individuals get in touch with multicultural experience, they often find that spirituality is closely related". The Iveys regard spirituality as the intersectional core among the individual, family and community (that is, cultural) spheres in which the patient functions.

In the works quoted above the link between spirituality/religion and culture is considered to be of therapeutic significance. First, it poses a challenge to the skills of both the pastor and the patient in multicultural communication as they journey together from and to a variety of cultural worlds. Second, being sensitive to the lived narratives of the cultural and religious traditions in which the research participants are involved, seems to be a necessary prerequisite for the pastoral counselor who works within a therapy of deconstruction.¹⁴⁴

Narrative counseling is philosophically closely bound to words, language, discourse and relanguaging. The multicultural context in which

¹⁴¹ David Augsburger, *Pastoral counseling across cultures* (Philadelphia: The Westminster Press, 1986).

¹⁴² Paul Tillich, *Theology of culture* (New York: Oxford University Press, 1959), p 42.

¹⁴³ Allen E Ivey, Mary Bradford Ivey & Lynn Simek-Morgan, *Counseling and psychotherapy: a multicultural perspective* (Boston etc: Allyn and Bacon, 1997). Fourth edition, p 8.

¹⁴⁴ Jan M van der Lans, "Implications of social constructionism for the psychological study of religion", in CAM Hermans et al, *Social constructionism and theology* (Leiden, Boston, Köln: Brill, 2002), pp 23-40.

counseling is done at Kalafong Hospital presents specific challenges to the counseling situation where neither counselor nor patient communicate in their mother language, and communication has to be done between cultures foreignised by a history of apartheid.

In Paul Petersen's anthology on *Counseling across cultures*,¹⁴⁵ the terms *multicultural*, *cross-cultural*, and *intercultural* are used with no apparent distinction. John McFadden¹⁴⁶ uses the term "transcultural counseling" as an umbrella term for all types of counseling where more than one culture is at stake, and offers a taxonomy of terms related to counseling where cultural sensitivity is needed (international, intercultural, multicultural, pluralistic, bicultural, cross-cultural, bilateral, mono-cultural counseling). I prefer the term "intercultural counseling"¹⁴⁷ to refer to the pastoral counseling practice proposed in this study. This acknowledges that both the counselor and the research population live in contexts where many cultures are functioning, and that this is of therapeutic significance. In a township such as Atteridgeville, no person lives within one culture only. They live within a mixture of African and Western cultures, township culture itself being a force with which to reckon.

Here only the work of David Augsburger on *Pastoral counseling across cultures* will be studied to remain within the scope of this section on pastoral counseling practice.

- David Augsburger: "Pastoral counseling across cultures"

For Augsburger, the interculturality of the pastoral counselor implies that the counselor stands between many cultures. (S)he is not culture-free, but culturally aware. Augsburger does not work from a narrative counseling point of view. Here, I want to summarise Augsburger's insights in a few simple "discourses", using the language of narrative counseling to further the aims of this study.¹⁴⁸

¹⁴⁵ Paul Petersen ea (eds), *Counseling across cultures* (Thousand Oaks, London, New Delhi: Sage Publications, 1996). Fourth edition.

¹⁴⁶ John McFadden (ed), *Transcultural counseling: bilateral and international perspectives* (Alexandria, VA: American Counseling Association, 1993).

¹⁴⁷ See also Parry's usage of "intercultural communication" in Adele Tjale & Louise de Villiers (eds), *Cultural issues in health and health care* (Cape Town: Juta Academic, 2004), pp 106-113.

¹⁴⁸ David Augsburger, *Pastoral counseling across cultures*, pp 372-373.

- The intercultural pastoral counselor, on his/her journey with the patient, is aware of the cultural faces of religious discourses and the effects thereof on the health of the patient.¹⁴⁹
- The intercultural pastoral counselor is sensitive to cultures which accept supernatural explanations for human pain, tragedy, and disorder, and empower themselves to fight evil and the demonic with religious concepts.¹⁵⁰
- The intercultural pastoral counselor co-journeys in deconstructive counseling with his/her patient towards renaming cultural realities and identities to enhance the health of the patient.¹⁵¹
- The intercultural pastoral counselor respects the integrity of each language world. (S)he enters another's language world with respect, and allows the patient to enter his/her world too.¹⁵² The patient is the expert in solving cultural dilemmas, that is, in deconstructing cultural discourses.
- The intercultural pastoral counselor does not see the patient as an individual in need, but as a person in pain-producing relationships, that is, relationships which are defined by culturo-religious discourses.¹⁵³ The counselor respects the core values of cultures, but is sensitive to the wide variation of human controls embedded in cultural discourses, and is committed to work for justice and the liberation of all who suffer oppression because of gender, racial and other iniquities.¹⁵⁴
- Intercultural pastoral counseling entails a movement from the counselor and patient being created by discourses, to being co-creators and co-authors of healing culturo-religious discourses.¹⁵⁵
- The intercultural pastoral counselor recognises that many discourses on healing exist in various cultures, seeing each as an expression of grace, inviting integrity and wholeness.¹⁵⁶
- The intercultural pastoral counselor is aware of the cultural shaping and labelling of mental illness, recognises the wide variation in what

¹⁴⁹ *Ibid*, p 27.

¹⁵⁰ *Ibid*, p 373 (no 9).

¹⁵¹ *Ibid*, p 29.

¹⁵² *Ibid*, pp 41, 72.

¹⁵³ *Ibid*, p 102.

¹⁵⁴ *Ibid*, pp 372 (nos 4,5,7)

¹⁵⁵ *Ibid*, p 107.

¹⁵⁶ *Ibid*, p 373 (no 11).

is normative and normal in each culture, and looks at human frailty and suffering with insight and compassion.¹⁵⁷

The following story both supports and problemises these theses:

Journeying with stories: Hlompho kicks sadness out of his life

Hlompho (who said that he was 15) was referred for counseling by the doctor who could not find any physical problem with Hlompho. Hlompho had been visiting Kalafong Hospital frequently for unidentifiable illnesses. He was referred for counseling because he was obviously depressed, and extremely angry. Hlompho did not speak English, and did not want to see the counselor.

With the help of another patient who translated, Hlompho eventually disclosed that he was living in a back room of his aunt's house, and that his mother had died of "sebabo". Hlompho was an orphan.

Through landscape of identity questions, Hlompho started speaking about his love for karate. He wanted to be Bruce Lee. He had a green belt in karate, he said, and he was going to fight for the blue belt on 16 November. Although it was clear that Hlompho did not have the financial means to pursue his karate dream, the presumed benefits of karate were explored. Hlompho identified them as self-control, discipline and rules.

For the next year, Hlompho religiously turned up for his appointments. He did not want to talk about his mother, and said that she had appeared to him in a dream and told him not to discuss her with anybody. We eventually externalised "Sadness" as the enemy which stole his happiness. The counselor then posed as "Sadness", and Hlompho tried his skills as karate kid on "Sadness", giving the counselor a few dangerous kicks!. "Sadness", then, was kicked out of the door and Hlompho was hailed as conqueror. One of the counseling sessions was converted into a ceremony when the doctor who had referred him, handed over a certificate to Hlompho for qualifying as the "One who has kicked Sadness out of his life". Also, he was presented with karate gloves.

¹⁵⁷ *Ibid*, p 373 (no 10).

Hlompho's frequent visits to the hospital continued. He complained of stomach pain. And that he could not see properly. The counselor took him to a private optometrist, where his eye sight was tested as adequate. The counselor visited his aunt, who disclosed that his mother and his baby brother died of Aids. Hlompho agreed to an Aids test, but it was refused by the hospital because he was not yet 18 and there was no adult to sign for him.

One day Hlompho was admitted to the hospital after he was assaulted on his way home by some youngsters. Tattered and bleeding through his bandages, he sat in front of the office. The counselor was very busy, and when she looked for him, he was gone.

After that, Hlompho did not attend counseling for more than a year. On a Wednesday in 2004 a concerned friend (the person who previously translated for him during counseling) brought Hlompho for counseling. Hlompho has joined the Muslim faith. He is now 18 years old (a year ago he said that he was 15) and still in primary school.

Hlompho says that he is leaving school to be trained in Tunisia for the jihad, that is, the holy war. He is going to fight the Americans who do not believe in Allah. Also, he is going to fight South Africans who do not want Zimbabweans to work here. He will fight people who hurt him or his brothers. He will fight till the war is over.

The counselor asked him what his mother would say about his plans. He said that his mother was not visiting him any more. The counselor then asked whether he wanted his mother to visit him. He said that Allah was against the ancestors. He would see his mother again on the day of kijam (paradise). Hlompho concluded with a warning that if the counselor should do anything to harm the imams at the mosque, "we'll send you a jihad". He said, "You cannot stop us when we want to do something."

The counselor assured Hlompho that all she wanted for him was to be happy, that is, to kick "Sadness" out of his life. Hlompho never returned for counseling.

The story of Hlompho shows the counselor and the patient interlinked between demanding social, cultural and religious discourses. It also points to

the healing power of narrative counseling, and simultaneously to its failure in the face of the social needs of an Aids orphan.

Journeying into the new

The literary overview has now been done, and I have to identify spaces where I hope to make my own contribution to the body of knowledge under discussion, that is, pastoral counseling practice.

This study sees pastoral counseling not as religious counseling, but as religion counseling, that is, dealing with religious discourses in a therapy of deconstruction.

This study hopes to contribute new knowledge to pastoral counseling thus defined in the following ways:

- This study regards religion/spirituality as a social discourse on healing. Normally, faith communities see praying and believing as the believer's only access to healing. This study proposes a pastoral counseling practice which regards the deconstruction of harmful discourses as part of a therapeutic process of healing.
- This study explores the dialogical spaces between harmful and healing religious discourses, reaching unique outcomes with believing patients through a therapy of deconstruction. Normally, psychological studies evaluate religion's worth only insofar as it encourages morality; from a psychological point of view, then, healthy religion is regarded as consistent ("mature") moral behavior. Normally, also, religious counseling works towards the realisation of dogmatically defined moral behaviors as the aim of pastoral counseling. To repeat, 'this study sees pastoral counseling not as religious counseling, but as religion counseling, that is, dealing with religious discourses in a therapy of deconstruction.' This enables the researcher to explore the healing effects of religion/spirituality over an infinite spectrum of unique outcomes which are not trapped within the binaries of dogmatic morality.
- This study describes the establishment of a pastoral counseling practice in spaces between the healing practices of a hospital, on the one hand, and township spiritualities, on the other. In the hospital, on the one hand, illnesses are diagnostically determined and western medicine is applied. On the other hand, the research population is exposed to township spiritualities where the pastor offers no counseling or diagnosis, only a prophecy from above prescribing the believer's illness and his/her treatment. Respecting both practices but situating itself in between, this study describes how a pastoral counseling

practice is established where the narratives of the patient take central stand, and where the patient is not diagnosed with a problem, but where the problem is externalised according to the patient's own expert insight.

- In a context where the doctor and the pastor are considered to be either western or cultural experts, this study describes the pastoral counselor as intercultural, unfriendly towards oppression, and co-author of the patient's alternative story of hope.

The following story supports this working definition of pastoral counseling:

Journeying with stories: Thabo belongs to the future

Thabo (45) went into exile for political reasons in 1976. He stayed in Tanzania for 18 years, most of the time in the bushes outside Dar-es-Salaam where, with 5000 other men, he was treated not as an exile but like a refugee. The group was kept apart from society. "I wish I could hear a child crying", Thabo said. Sometimes they were tortured.

Eventually Thabo was allowed to study at the University of Dar-es-Salaam, where he finished his second year training as a medical laboratory assistant. However, in 1994, with the coming of democracy, he was returned to South Africa to be integrated into the South African Defence Force. It was promised that he would go to Medunsa (Medical University of South Africa) to further his studies, but "the politicians did not meet their promises". Instead, he was appointed as a captain in the SADF, and was promoted to major in 1996.

At first, things were going well for him. He married, had two children, lived in Kempton Park in a very nice house, and drove a Honda Ballade. Then his problems started. He had some "unfinished business", as well as new problems. New problems included his work load and his subordinates – of which there were 37 – whom he could not control. In 1997 he spent time in the Psychiatric Ward of 1 Military Hospital, and three weeks in Weskoppies where he was under the care of clinical psychologists. When he went back to work, his subordinates treated him "like a mad guy" and complained to the superintendent that they could not be led by a crazy man. In 1999 he went to a sangoma for treatment and stayed away

from work for three months. Because of this, he was dismissed in February 2000.

Thabo now lives in Jeffsville, the oldest squatter camp in Atteridgeville. He has lost his house, his furniture, and his income of R7 000,00 per month. His wife is not working, and his children are three and five years old.

Thabo has tried several paths to healing. In the psychiatric ward he was told that he was not a psychiatric case and sent home. The psychologist diagnosed him with depression, stress and burn-out, but movement beyond the diagnosis was not possible. The sangoma told him that he was not bewitched, but needed power, power which would not return to him. He is a member of the Roman Catholic Church, but “they are not into healing”, as he put it. Also, Thabo has turned to the Union and to the Minister of Defence for help, but to no avail. He has applied for a grant since he had been in exile for 18 years, but has received no answer to his application.

I met Thabo in 2003 in Ward 2B of Kalafong Hospital after he had attempted to commit suicide. After he had told his story of problems, we decided that we were going to journey towards what was right with him, and not what was wrong. By retracing his history, we found Thabo to be a sensitive, proud, loyal, wise and adaptable person. We also looked at the contribution made by doctors, psychologists and sangomas to this positive view of Thabo. They were regarded as part of Thabo’s history. Their diagnoses were made to speak in an encouraging voice. Thereby their influence on Thabo’s life was shifted to a place of healing. This journey was not a quick and easy one. It took hours of sifting through his history to assist Thabo in reestablishing himself as a person of worth.

The influence of Thabo’s alternative story on his state of mind was remarkable. By looking differently at himself, Thabo was empowered and energised to take on life again. He started making plans and putting them into action. Eventually he declared: “I belong to the future!”

Thabo’s story reflects the aims of a pastoral counseling practice as envisaged in the above. This entails

- healing through the deconstruction of harmful discourses

- counseling respectfully between western medicine, Christian township spiritualities, and traditional healing¹⁵⁸
- establishing unique outcomes through religion counseling
- casting the pastoral counselor as co-author of the patient's story of hope through the deconstruction of health discourses

Journeying with narrative counseling

It was pointed out in the above that several forms of narrative counseling are being practiced internationally. Here, narrative counseling will refer to the counseling practice developed by David Epston and Michael White.¹⁵⁹ This, also, is the counseling practice supporting the work done for this study.

Narrative counseling journeys from a story of problems to a story of hope. Narrative counseling is philosophically and methodologically enabled to do so¹⁶⁰ through

- social construction theory, which maintains that realities are socially constructed through language;
- post-structural method, which explores the dialogical spaces between the binaries which organise and maintain narratives; and
- deconstruction, which overturns and confuses the binaries in the grand narrative, and displaces them in the deep structure of the narrative, thus constructing new realities.

Situated within postmodernism, narrative counseling escapes definition. However, narrative counseling manifests itself through a distinct process. I have in her work come to call this the MEET process. The acronym MEET represents the main phases of the process, namely

¹⁵⁸ For further reading on indigenous healing, see Gideon Byamugisha, *Journeys of faith: Church-based responses to HIV and AIDS in three southern African countries* (Pietermaritzburg: Cluster, 2002), William Clark, *The new healers* (New York: Oxford UP, 1997), J le Fanu, *The rise and fall of modern medicine* (London: Abacus, 1999), and F Staugard, *Traditional medicine in a transitional society: Botswana moving towards the year 2000* (Gaborone: Ipeleng, 1989).

¹⁵⁹ The most well-known of their earlier, foundational works are Michael White, *Re-authoring lives: Interviews and essays* (Adelaide: Dulwich Centre Publications, 1995); Michael White & David Epston, *Narrative means to therapeutic ends* (New York: WW Norton, 1990).

¹⁶⁰ The book which is still regarded as authoritative in explaining the philosophy behind narrative therapy, is by Jill Freedman and Gene Combs, *Narrative therapy: The social construction of preferred realities* (New York, London: WW Norton, 1996). See pages 22-23.

- 1 *Mapping*: the counselor and patient map the latter's problem-saturated story
- 2 *Externalising*: the counselor follows the patient in externalising the problem
- 3 *Empowering*: the counselor and patient empower each other to deconstruct the problem
- 4 *Thickening an alternative story*: the counselor and patient become co-authors in recreating the patient's story of hope and thickening this story with inside and outside witnesses

Doing therapy narratively will now be described as a creative – albeit slightly controlled – process. The works of Cheryl White & David Denborough (*Introducing narrative therapy*, 1998),¹⁶¹ Alice Morgan (*What is narrative counseling?*, 2000),¹⁶² and Martin Payne (*Narrative therapy*, 2000)¹⁶³ will be used in this regard.

Mapping

The first stage of the MEET process, namely “Mapping”, entails the following:

- 1 The patient is invited to tell his/her story. The story starts with a description of the problem, or with the events which, according to the patient, led to the problem. Thus the history of the problem is traced. The problematic discourse(s), which holds the patient captive, shows its face.
- 2 Counselor and patient work together to put the events of the problematic history into a story-line, and situate it within its cultural and social context.
- 3 Simultaneously the counselor listens in the patient's seemingly problem-saturated story for signs of hope, that is, seeds which can grow into unique outcomes. Thus spaces are opened up for the patient to venture into alternative life stories.

¹⁶¹ Cheryl White & David Denborough (eds), *Introducing narrative therapy: A collection of practice-based writings* (Adelaide: Dulwich Centre Publications, 1998), pp 1-15.

¹⁶² Alice Morgan, *What is narrative therapy: An easy-to-read introduction* (Adelaide: Dulwich Centre Publications, 2000).

¹⁶³ Martin Payne, *Narrative therapy: An introduction for counsellors* (London, Thousand Oaks, New Delhi: Sage Publications), pp 6-17.

Journeying with stories: From First Avenue to 1 Potgieter Street (Mapping)

1 Potgieter Street is the address of the Pretoria Female Correctional Centre. "From First Avenue to 1 Potgieter Street" is the heading Andrea herself has given to her story. This is the story of a woman who was taken out of suburbia to spend seven years in prison.

Placed within a story-line and within context, Andrea's problem-saturated story evolves as follows.

Andrea has sensed rejection from her mother since she was a foetus. She was born an hysterical baby and experienced harsh words from her mother right through her childhood. In matric she suffered from anorexia nervosa and refused to eat. Andrea's feelings of rejection were strengthened when she was date raped in her first year at college. Again she stopped eating. In 1991, when she was 22 years old, she married the neighbour's son, Adrio, who was 19. Two months into the marriage, she became pregnant, and another two months later her husband started abusing her physically.

In 1989 their first son was born. He was two years, two months and four days old when he died in December 1991. During his short life she took him to the doctor 30 times. It was because I cared for him and was worried about his health that I took him to the doctor so often, Andrea said, and not because I wanted to hide something. A month after his death, in January 1992, Andrea's only daughter was born. She was born prematurely and was constantly ill. Andrea who was still dealing with her son's death, found it difficult to cope with the situation. The child was removed from her care for some time. A year later, in 1993, a second son was born. When he was six months old, the baby suffered a fit and Andrea took him to a specialist. The doctor alleged that the child's ribs were broken, and reported Andrea and her husband to the police. Two years after the death of their first child, they went on trial for murder and child abuse.

The court case took more than four years. Andrea and her husband were not detained during this period and continued with their lives. Their third son (and fourth child) was born during the course of the court case. On 29 May 1997 Andrea's husband was found guilty of the death of their child, and for abusing their daughter, and their second son. Andrea was

found co-responsible. Sentence was to be given on 18 June. At this stage Andrea was pregnant with her fifth child. Since the beginning of May her husband had been detained in prison on a charge of fraud. Three days before sentencing could be given on the murder conviction, Andrea's husband committed suicide in prison by drinking an overdose of anti-depressants. Her husband's father, who was against their marriage, had the body removed and buried without Andrea's participation.

Sentencing was postponed till 3 December. Andrea was now very pregnant and living with her uncle. She had her youngest son with her. The two older children were placed in a house of safety. On 10 October she gave birth to her fifth child, also a boy. On 3 December 1997 Andrea was sentenced to 17 years imprisonment. The baby and Alfred were taken away from her and she commenced with her prison sentence.

While she was in prison, her three sons were given up for adoption, to three different sets of parents. That was when Andrea stopped eating again.

In July 2004, after serving almost 7 years of her sentence, Andrea was released on parole from Pretoria Female Correctional Centre. Not owning anything, deserted by friends and family, and kept from seeing her children, Andrea now has to start a new life. She asked me to assist her in counseling as a non-paying patient.

Externalising

The second stage of the MEET process, namely "Externalising", entails the following:

- 1 The counselor and patient work together to name the discourse which is influencing the patient's health. Thus the problem is externalised. Through externalising conversations, the patient is discouraged from internalising the problem and seeing him- or herself as the problem.¹⁶⁴
- 2 The counselor now asks questions which invite the patient to state his or her position in relation to the problematic discourse.

¹⁶⁴ See also Stephen Madigan, "The politics of identity: Considering community discourse in the externalizing of internalized problem conversations", in *Journal of Systemic Therapies* 15.1 (Spring 1996), pp 47-61.

- 3 The counselor and patient explore the effects of the discourse on the patient. Through relative influence questioning¹⁶⁵ both the influence the discourse has on the patient, and the influence the patient has on the problem are explored.
- 4 The patient is invited to evaluate these effects on his or her life. The patient indicates which of these effects are not acceptable to him/her.
- 5 The patient is invited to justify his or her evaluation. The patient indicates why these effects are not acceptable.

Journeying with stories: From First Avenue to 1 Potgieter Street (Externalising)

Andrea externalised the problem which was making her life miserable, as "Rejection". During the interviews, relative influence questions were asked to Andrea, such as "What were Rejection's other friends?" Its friends were Suicidal Thoughts, Doing Anything for Acceptance, and Anorexia, Andrea said. This, then, was Rejection's influence on her life: it convinced her to think of killing herself, starving herself to death, and/or doing anything to please other people. When asked what her influence on the problem was, Andrea was caught off guard. She had to enter into a new frame of mind to consider herself as somebody who could resist "Rejection". Andrea insisted that she was a good mother. Not her mother, nor her rapist, nor her husband, and not even the sentencing judge could steal that away from her – not even her children being taken away from her.

Empowering (Deconstruction)

The third stage of the MEET process, namely "Empowering", entails the following:

- 1 After harmful discourses have been identified and externalised, a deconstructing conversation¹⁶⁶ is opened up. Grand narratives and taken-

¹⁶⁵ On relative influence questioning, see also Michael White, "The process of questioning: A therapy of literary merit?" in *Dulwich Centre Newsletter* (Winter 1988), pp 37-45.

¹⁶⁶ For deconstructive practices, see Michael White, "Deconstruction and therapy", in Michael White and David Epston, *Experience, contradiction, narrative and imagination* (Adelaide: Dulwich Centre Publications, 1992), pp 109-151. Also, Jeffrey L Zimmerman and Victoria C Dickerson, *If problems talked: Narrative therapy in action* (New York, London: Guilford

- for-granted truths are taken apart, that is, deconstructed. Deconstruction, then, means taking apart, overturning, confusing and displacing discourses which are generally accepted by society but only serve the interests of the powerful.
- 2 Other discourses which feed the problem discourse, are identified and deconstructed. This often means that injustices have to be named, and power relationships explored, such as the power exercised in gender relations. It also means that culture needs to be questioned, and cultural discourses deconstructed.
 - 3 The counselor assists the patient to separate him- or herself from that discourse(s) which has a negative effect on his/her life. They encourage each other to discover times in the history of the problem/discourse, when the discourse had less of an effect on the life of the patient. Everyday actions of resistance against the problem discourse executed by the patient, even if they were few and far between, are observed and applauded by the counselor.
 - 4 Together, the counselor and patient look for unique outcomes. During the therapeutic conversation the counselor observes things which stand outside the problem stories. These things lead to the discovery of unique outcomes.
 - 5 By tracing the history and meaning of the unique outcomes, an alternative story is named.
 - Through landscape of action questions, actions are discovered that can be linked to the unique outcomes to the alternative story. An example of a landscape of action question is: What did you do immediately before and after the rape to survive?
 - Through landscape of meaning questions, the meaning of the actions for the patient is traced. An example of a landscape of meaning question is: How did it make you feel to have acted in such a way that you survived the rape?

Journeying with stories: From First Avenue to 1 Potgieter Street (Empowering through deconstruction)

A final form of rejection is holding Andrea captive now. That is rejection by society after she had been imprisoned for seven years. She served a sentence for being co-responsible for the death of her son, assault on another, and abusing her daughter. Andrea is separating herself from the societal

discourse on ex-convicts in a number of ways. She accepted a job in the Regional Office of the Inspecting Judge of Prisons to do administrative work. After her contract expired, she was re-contracted. Also, she is auditioning at a variety of places in order to claim back her public role as a vocal performer, a role she filled before she got married.

Thickening an alternative story

The fourth stage of the MEET process, that of Thickening the Alternative Story, entails the following:

- 1 The alternative story is named to separate the patient even further from the dominant discourses which affected his/her life. Space is thus opened up for the patient to express his/her preferred way of being.
- 2 The alternative, preferred story is now thickened. Ways of thickening an alternative story may include the following.¹⁶⁷
 - The patient's significant others are called in to witness to his or her ability to live the alternative story.
 - The patient is incorporated into support groups or networks.
 - The patient, counselor and significant others participate in ceremonies and rituals.
 - A group of outsiders act as members of a reflecting team.
 - The patient engages in producing therapeutic documentation, such as declarations, certificates, or pictures.
 - The counselor writes a therapeutic letter to the patient summarising the contents and gains of the therapeutic sessions.

“Therapy ends when the person decides that her self-story is rich enough to sustain her future. The final session may be organized as a joyful occasion. People significant to the person may be invited for re-tellings and there may be a ceremony to mark the occasion, such as the presentation of a therapeutic certificate.”¹⁶⁸

¹⁶⁷ See Morgan, *op cit*, p 75.

¹⁶⁸ Payne, *op cit*, p 17.

Journeying with stories: From First Avenue to 1 Potgieter Street (Thickening an alternative story)

In therapy, Andrea has thickened her alternative story in a variety of ways, of which two will be described here:

- (1) Andrea has relanguaged her story. The old story is filled with language dictated by problems: rejection, emotional abuse, rape, loss of identity, humiliation, deprivation of parental rights, excruciating fear and panic, hopelessness, loss of privacy, and fear of the future. However, the new story is renamed in the language of hope: forgiveness, learning to trust again, coping, learning new skills, tolerance, acceptance, patience, new ways of communicating and socialising, being considerate, respecting oneself and others, sharing and giving, love, assertiveness, self-knowledge, getting priorities straight, desire to be successful, willingness to change, closure, feeling alive, incredible religious growth.*
- (2) Andrea has pointed to her religious belief as an important aspect of thickening her alternative story. She has indicated this to be the challenge of the counseling lying ahead: to take the harm out of the religious beliefs which made her feel bad about herself, and shift them to healing places.*

It is to the ability of spirituality to thicken the alternative story that we turn next.

Thickening alternative stories by means of spirituality

How can spirituality thicken the alternative story? is an important question to ask within the parameters of this study. Three books which are helpful, within narrative counseling and with regard to this question, are:

- Trevor Hudson: “Co-authoring spiritual ways of being: A narrative group approach to Christian spirituality”¹⁶⁹

Within a narrative group, connected through their quest for spiritual meaning, Hudson observes several ways in which participants of the group thickened their own and each other’s stories:

- Spirituality thickens our stories when we develop a deeper appreciation of God’s presence in all things.
- Spirituality thickens our stories when we learn fresh ways of discerning God’s will, and revise our “pictures” of God.
- Spirituality thickens our stories when we revisit the place of spiritual discipline in our lives, and commit ourselves to a life of compassionate caring.
- Spirituality thickens our transformed stories when we feel connected to each other.
- Spirituality thickens our transformed stories when we deconstruct our traditional beliefs, thereby generating possibilities for new meanings to emerge.
- Spirituality thickens our transformed stories when we open up spaces for alternative religious voices to be heard.
- Spirituality thickens our transformed stories when we enter the Scriptures in a personally meaningful and life-related journey.¹⁷⁰
- Jean Andrews and Elmarie Kotzé: “New metaphors for old: Healing spiritual talk”¹⁷¹

Re-storying Jane’s life narrative, Andrews and Kotzé detect the healing role of an enabling spirituality in Jane’s alternative story:

- Spirituality thickens the believer’s life story when (s)he rejects punitive biblical interpretations of a severe and authoritarian God.¹⁷²

¹⁶⁹ Trevor A Hudson, *Co-authoring spiritual ways of being: A narrative group approach to Christian spirituality* (M Th, Pastoral Therapy, University of South Africa, 2000).

¹⁷⁰ Snippets for these points taken almost verbatim from Hudson, *op cit*, pp 84-89.

¹⁷¹ Jean Andrews and Elmarie Kotzé, “New metaphors for old: Healing spiritual talk”, in Elmarie Kotzé, *A chorus of voices: Weaving life’s narratives in therapy and training* (Pretoria: Ethics Alive, 2000), pp 322-339.

¹⁷² *Ibid*, p 324.

- Spirituality thickens the believer's life story when (s)he engages in "inner talk" about and with God, thereby accepting and respecting his/her inner struggle with spirituality.¹⁷³
- Spirituality thickens the believer's life story when (s)he shares with other believers freeing metaphors of God, such as God the mother, homemaker, mother eagle, hen, midwife, woman giving birth, and friend.¹⁷⁴
- Spirituality thickens the believer's life story when (s)he invites other voices into his/her God-talk, thereby contending that his/her ideas of God are influenced by a plurality of perspectives, including religious language, class, race, gender, nationality and family background.¹⁷⁵
- Spirituality thickens the believer's life story when (s)he opens up different ways of viewing the divine relationship, thereby providing a grid through which relationships in humanity can be seen.¹⁷⁶
- Spirituality thickens the believer's life story when (s)he believes in the healing power of spiritual talk in his/her life.¹⁷⁷
- Spirituality thickens the believer's life story when (s)he enters into dialogue with her spirituality, and finds ways in which spirituality can lead him/her to meaningful and hopeful experiences.¹⁷⁸
- Spirituality thickens the believer's life story when it is no longer restricted to his/her private and secret life, but is invited into counseling.¹⁷⁹
- Spirituality thickens the believer's life story when (s)he enters into a significant conversation with God as a significant other, thereby connecting with God through "participatory consciousness". God and the self are not separated through otherness and selfness, but participate in consciousness.¹⁸⁰
- Spirituality thickens the believer's life story when space is opened up for personal agency, freeing the believer from fundamentalism, essentialism and the colonisation of inner personal experiences of God through dogmas.¹⁸¹

¹⁷³ *Ibid*, pp 324-325.

¹⁷⁴ *Ibid*, p 325.

¹⁷⁵ *Ibid*, pp 325-326.

¹⁷⁶ *Ibid*, p 326.

¹⁷⁷ *Ibid*, p 327.

¹⁷⁸ *Ibid*, p 327.

¹⁷⁹ *Ibid*, p 330.

¹⁸⁰ *Ibid*, p 331.

¹⁸¹ *Ibid*, p 333.

- Wyda Naudé: “Dekonstruksie van die invloed van die sosiale diskoers ‘godsdiens’: ‘n individuele narratief”¹⁸²

Naudé seeks to thicken her own life story by means of spirituality. She comes to a number of academic conclusions on this process:

- Spirituality thickens your life story when you are able to identify a priority narrative (*voorkeurnarratief*) which has a healthy effect on your health. Naudé’s priority narrative is “God of love”.¹⁸³
- Spirituality thickens your life story when you retell and remember your spiritual history with significant others.¹⁸⁴
- Spirituality thickens your life story when you actively practice to strengthen your spiritual experiences.¹⁸⁵

These studies views spirituality’s thickening effect in

- renaming God
- discovering personal agency in opening up new meanings in our lives
- sharing consciousness with God, and
- remembering our spiritual history

Thickening alternative stories with black people

In the above we have identified four factors which are of therapeutic significance to the research population. These are race/culture, gender, age and class. Our research population proves to be overwhelmingly black (74%), female (75%) and unemployed (65%). A significant percentage of the research population is younger than 30 (33%). In the following four subsections, then, we shall consider studies done within the field of narrative counseling in co-authorship with black people, women, young people and poor people.

Due honour is to be given to post-graduate studies in narrative counseling within historically black societies in South Africa, such as the Master’s dissertation of Christine McLachlan, *‘Doing hope’: Mentoring with people doing care, working and dealing with trauma in a township in South Africa*.¹⁸⁶ Here caretakers’ stories as thickened by the alternative discourse

¹⁸² Susanna S Naudé, *Dekonstruksie van die invloed van die sosiale diskoers ‘godsdiens’: ‘n individuele narratief* (M Th, Pastoral Therapy, University of South Africa, 2001).

¹⁸³ *Ibid*, p 77.

¹⁸⁴ *Ibid*, p 78.

¹⁸⁵ *Ibid*, p 78.

¹⁸⁶ Christine McLachlan, *‘Doing hope’: Mentoring with people doing care, working and*

that hope is always possible and that it can be “done”, that is, made visible and even institutionalised even in the worst of circumstances.

Also, locally, Julian C Müller, professor in Practical Theology at the University of Pretoria, and his post-graduate students are co-authoring the stories of black people in disadvantaged communities toward stories of survival and victory.¹⁸⁷ In this regard Sunette Pienaar¹⁸⁸ thickens the alternative stories of black women by creating communities of care in vulnerable communities. Co-travellers on this journey to form a community of care, is the counselor-researcher herself, the women afflicted by gender-driven calamities such as HIV and AIDs, and their sisters as the caretakers of society.

I was furthermore informed on racially and culturally focused narrative counseling by a publication of the Dulwich Centre in Adelaide, where narrative counseling as understood in this study, originated:

- Barbara Wingard & Jane Lester: “Telling our stories in ways that make us stronger”¹⁸⁹

Wingard and Lester describe how, with health work as a point of entry, the stories of Aboriginal people in Australia have become thick and life-giving. Aboriginal people thicken their stories when they

- see their own stories as sources of pride¹⁹⁰
- regain their identity, and address cultural homelessness¹⁹¹
- resist racial restrictions¹⁹²
- break down isolation amongst themselves to reduce shame¹⁹³
- reconnect with their own ways of healing,¹⁹⁴ and
- fight for culturally-appropriate and accessible services.¹⁹⁵

dealing with trauma in a township in South Africa. MTh dissertation, University of South Africa, 2007.

¹⁸⁷ Julian C Müller & Howard W Stone, “Intercultural pastoral care and counseling: Resources from narrative therapy and brief pastoral counseling”, in *Skrif en Kerk* 19.2(1998):325-341.

¹⁸⁸ Julian C Müller & Sunette Pienaar, “Stories about care: Women in a historically disadvantaged community infected and/or affected by HIV/AIDS”, in *Hervormde Teologiese Studies* 60.3(2004):1029-1047.

¹⁸⁹ Barbara Wingard & Jane Lester, *Telling our stories in ways that make us stronger* (Adelaide: Dulwich Centre Publications, 2001).

¹⁹⁰ *Ibid*, p v.

¹⁹¹ *Ibid*, pp 7,9.

¹⁹² *Ibid*, p 13.

¹⁹³ *Ibid*, p 25.

¹⁹⁴ *Ibid*, p 42.

¹⁹⁵ *Ibid*, p 97.

Thickening alternative stories with women

Fortunately, much work has been done within narrative counseling in co-authoring women's lives. Here two contributions will be discussed. The one is a collection from the Dulwich Centre, the other a local MTh dissertation.

- Dulwich Centre: "Working with the stories of women's lives"¹⁹⁶

This publication offers a host of insights on gender, of which the following is a selection. Gender thickens the alternative story when

- we privilege gender over culture¹⁹⁷
 - people develop partnerships across cultures and genders¹⁹⁸
 - when the stories are told of "(w)omen who have stood up against the pressures of overwhelming sadnesses, losses and violence in their lives and have turned away from the constant voices in their heads that seek to shout them down. Women who have held fast against the pressures of body images and food tyrants reigning down upon them,"¹⁹⁹ and
 - women reclaim their lives from the effects of abuse, speak out, create places for women to talk, present conferences, issue a newsletter, support each other, and protect their children and loved ones.²⁰⁰
- Anna M van Dyk: "The voices of women and young people who experienced domestic violence"²⁰¹

According to Van Dyk, gender thickens the alternative story when

- we undermine the influence of Power and Control on women's lives, and replace it with justice and equality,²⁰² and
- we undermine traditional gender roles based on power and control in families, and replace them with gender roles which enhance non-violence.²⁰³

¹⁹⁶ Dulwich Centre, *Working with the stories of women's lives* (Adelaide: Dulwich Centre Publications, 2001).

¹⁹⁷ *Ibid.*, p 15.

¹⁹⁸ *Ibid.*, p 18.

¹⁹⁹ *Ibid.*, p 29.

²⁰⁰ *Ibid.*, p 85.

²⁰¹ Anna M van Dyk, *The voices of women and young people who experienced domestic violence* (M Th, Pastoral Therapy, University of South Africa, 2000).

²⁰² *Ibid.*, pp 100, 107..

²⁰³ *Ibid.*, p 117.

Thickening alternative stories with children and young people

Again, both studies from the Dulwich Centre and local post-graduate work inform us on the thickening of the alternative stories of children and young people.

- Alice Morgan (ed): "Once upon a time: Narrative therapy with children and their families"²⁰⁴

According to Morgan, children's stories are thickened

- when the counselor is reminded that "I don't have to know the answers to people's problems to be helpful". Children are empowered to thicken their own stories when the power imbalances between them and adults are equalised²⁰⁵
 - through role-playing and drawings
 - when we draw on their magical thinking²⁰⁶
 - when we link their lives to the lives of others, and their families are drawn into therapy,²⁰⁷ and
 - when their resistance is honoured, and we team up against the problem.²⁰⁸
- Elizabeth Morkel: "When narratives create community: Standing with children against stealing"²⁰⁹

While working with a group of boys at a Muslim school who have a reputation for stealing, their alternative stories were thickened by means of honesty meetings, honesty tests, honesty certificates and honesty celebrations.²¹⁰

²⁰⁴ Alice Morgan (ed), *Once upon a time: Narrative therapy with children and their families* (Adelaide: Dulwich Centre Publications, 1999).

²⁰⁵ *Ibid*, pp 14, 231.

²⁰⁶ *Ibid*, p 188.

²⁰⁷ *Ibid*, p 137.

²⁰⁸ *Ibid*, p 135.

²⁰⁹ Elizabeth Morkel, *When narratives create community: Standing with children against stealing* (M Th, Pastoral Therapy, University of South Africa, 2002).

²¹⁰ *Ibid*, Abstract.

- Lynette Steyn: “Empowering young people through narrative”²¹¹

When doing narrative counseling with young people who experienced powerlessness in their relationship with adults, the stories of the young people were thickened by means of

- identity-talk and defining the self in terms of agency²¹²
 - opening up alternative views on power, discipline and punishment,²¹³ and
 - engaging in dialogue with masculinity and femininity.²¹⁴
- Lindi M Claassen: “Deconstructing ‘coupledom’ with young people”²¹⁵

Claassen found that young people thicken their deconstructed narratives on coupledom

- when they shift the dualisms feeding the discourse, such as religious and cultural views on masculinity/femininity dualism, to discourses on holism,²¹⁶ and
- when they shift peer pressure, teasing and isolation to preferred ways of being.²¹⁷

Thickening alternative stories with poor people

How successful is narrative counseling when a patient is unemployed and desperately poor, with no chance of these circumstances changing? How does one thicken an alternative story when it seems to be impossible to formulate alternatives? Narrative counseling, of course, contends that there is always an alternative story, that there is always light, and that no problem is too huge to be shrunk. However, very few studies exist where local narrative counselors co-journeyed with poor people, leaving me without references here while my own counseling journey is with people who (almost) all are desperately poor.

All these studies on the thickening of the alternative stories of people who suffer because of their gender, race, financial status and/or age have this

²¹¹ Lynette Steyn, *Empowering young people through narrative* (M Th, Pastoral Therapy, University of South Africa, 2001).

²¹² *Ibid*, p 71.

²¹³ *Ibid*, pp 79-80.

²¹⁴ *Ibid*, pp 81ff, 86ff.

²¹⁵ Lindi M Claassen, *Deconstructing “coupledom” with young people* (M Th, Pastoral Therapy, University of South Africa, 2002).

²¹⁶ *Ibid*, pp 63-64.

²¹⁷ *Ibid*, pp 64-68.

in common: they tell the stories of how people have been empowered against the problem discourses that keep them captive by exploring the skills that are indigenous to themselves as individuals-in-context. In chapter 5 which deals with the thickening of the alternative story, attention will be given to precisely this, the reconnecting of township people with their own ways of healing – that is, through diaconal, ritual and faith healing as represented in township spiritualities.

Journeying and dreaming ...

At this stage, the study departs from the following hypothesis:

- The faces of religious discourses can be identified and described through the insights of social construction theory in an exploration of the spaces between harmful and healing discourses; they can be named as power discourses, body discourses, identity discourses and otherness discourses.
- The process of deconstruction can be of therapeutic significance; by means of narrative counseling the effects of harmful religious discourses on the health of the patient can be minimised, and those of healing discourses maximised.
- A pastoral counseling practice can be constructed based on the narrative deconstruction and reconstruction of religious discourses as social discourses; this process can lead to healing, alongside practices acknowledged by religious institutions, such as prayer, unconditional belief moral regeneration, as well as forms of diaconal, ritual and faith healing; this practice can exist in a healing way as an intercultural practice which is sensitive towards the needs of women, children, young people, and people who are extremely poor.

Narrative counseling is usually criticised for being focussed on verbal expression. This limits narrative counseling to people with a good western education and a middle to upper class existence. The following story undermines this criticism.

Journeying with stories: Lintle walks with God, not with crutches

Lintle is 27 years old, a black woman from a poor part of Atteridgeville. She was referred for counseling sometime in 2002. Lintle had finished Std 9 (Grade 11) and was living off a disability grant with her father. Lintle was brain damaged

when her boyfriend, in an act of domestic violence, hit her over the head with a piece of wood. The brain damage was pretty bad. Lintle had difficulty in speaking, and she was walking with crutches, drawing her lame legs behind her. Her concentration was severely impaired. We externalised Anger as the problem constantly stealing Lintle's happiness. Lintle said that she was angry 90 per cent of the day. She was angry because of her injuries; she was angry because the man who had caused her injuries was walking around free, wooing other women; and she was angry because her father had frequently been calling her stupid.

By the time we were moving on to the alternative story, I was despairing of the process. Verbally, Lintle was communicating with great difficulty. Since Lintle was reading with more ease than she could speak, I wrote on a piece of paper: Lintle is a survivor. Also, I wrote a report for Lintle's file. This file was filled with reports from doctors to occupational therapists to psychologists about Lintle's inabilities. In my report I wrote that Lintle was a survivor. I substantiated it with parts from our "conversation" about Lintle's ability to survive her present circumstances. I gave the report to Lintle to read. Her face brightened up.

Struggling to help Lintle find unique outcomes in a desperate story, during the "conversation" I have asked Lintle whether she belonged to a church. Lintle turned out to be an Anglican. Furthermore Lintle was eager to talk about her faith, although it was in broken language.

When Lintle left, I very strongly felt that the session was a failure. The communication was weak and the alternative story thin. .

However, when Lintle returned for therapy the next week, I hardly recognised her as she was sitting in front of the office. She was dressed stylishly and festively. When the session began, she started telling the following amazing story in clear language. The previous evening, she said, she prayed to God to help her speak well the next day at the hospital. And indeed, Lintle was talking extremely well. Also, she said, she has decided to walk with God and not with crutches. And indeed, Lintle was walking with only one crutch. She has decided to study again, she continued. She bought the paper every day to start practicing her reading skills again. And finally, she said,

when her father called her stupid she told him: No, I am not stupid, I am a survivor. Then Lintle opened her hand, and in her hand was the note: Lintle is a survivor.

We have seen in the above overview that studies in narrative counseling, especially in South Africa, have up till now concentrated on middle and upper class people who share the therapist's language and power of expression. However, Lintle's story explains that poor people, with infringed verbal capacity, benefit from narrative practices. In a way then, Lintle's story already presents itself as a validation of the hypothesis of this study.

Journeying chapterwise

Chapters coincide with the aims of the study, and to phases of the MEET process:

Chapter 2 describes the faces of religious discourses in South African contexts. The religious discourses described here will take on one or more of four faces. They are power discourses, body discourses, identity discourses, and otherness discourses. With reference to narrative counseling, this chapter corresponds with the first phase of the MEET process, that is *mapping the problem*, when the counselor and patient map the patient's life story.

Chapter 3 aims at describing the effects of these discourses on people's lives. With reference to narrative counseling, this chapter corresponds with the second phase of MEET process, that is *externalising the problem*, when the effects of the problem on the patient's life are named, and strategies planned to minimise these effects.

Chapter 4 describes the empowerment of patients through *deconstructing* the religious problem discourses towards healing discourses, and *co-constructing* the problem story as an alternative story of healing. This coincides with the third phase of the MEET process, that is *empowerment by deconstructing the problem and co-constructing an alternative story*.

Chapter 5 gives attention to religious discourses and practices that strengthen the alternative story. It will be argued – or rather, explained through narrative practice – that religious discourses which have healing effects on believers (1) allow for alternative, morally functional spiritual resources, (2) reposition and empower believers in terms of gender, class, age and race, (3) co-author with believers their alternative stories, and (4) co-

journey with believers towards re-languaging their belief as their preferred spirituality. It will furthermore be indicated that the religious practices that thicken alternative stories of faith, are practiced by churches as (1) diaconal healing, (2) ritual healing, and (3) faith healing. In terms of narrative counseling, this chapter corresponds with the fourth phase of the MEET process, that is *the thickening of an alternative story*.

Chapter 6 summarises the findings of the research and indicates how pastoral counseling was practiced at Kalafong Hospital, following the insights of narrative counseling. The tenets of religion counseling that explore the spaces between Western medical insights on the one hand, and township spiritualities on the other, are described as one of the pillars for such a pastoral counseling practice.

Journeying with stories: Vagina monologues

Naledi (42) visited the hospital in 2003 for counseling. She said that she felt old and wasted, that she felt too tired to walk far, and that she was constantly plagued with headaches.

Naledi's story was a story of attacks on her vagina.

When she was in primary school, Naledi was raped by her uncle. Being raped as a child was the first attack on her vagina. This was only the beginning.

During the turbulent years of the 1970s Naledi became politically active. In 1986 the 26 year old Naledi was imprisoned and tortured by the Security Police of the previous regime. She was blindfolded, hit and sworn at – and put in a fridge. Ice-cubes were placed in her vagina as well as other things which they told her were bombs. This was the second attack on her vagina, which left her childless for the rest of her life.

The new century (2000) started off with Naledi feeling good about her vagina which she shared with a boyfriend of her choice for almost three years. However, three weeks ago he married her friend. For at least the third time in her life Naledi's vagina was betrayed. She then had to struggle with 'the deserted vagina'. Naledi felt sad and lonely. Moreover, she was concerned about HIV and Aids, which might be the final onslaught on her vagina.

Actually, Naledi did not come for counseling because of her vagina. She came because "Unresolved Guilt" was eating her

up inside. Unresolved Guilt came to stay with her after she was forced as a MK soldier to kill Inkatha members during the Boipatong Massacre of the 1980s. These included children.

Naledi moved bravely towards her alternative story. At present, she is employed with a NGO which works with the orphans of parents who died of Aids. In the light of this work, Naledi distanced herself from calling herself a killer. She renamed herself as somebody who took care of children who did not enjoy the protection of a parent. In spite of her bad childhood, Naledi then found relief in seeing herself as a caretaker of children. In spite of the unprotected onslaughts on her vagina, Naledi was able to rescope herself as the protector of others.

In therapy, also, Naledi found her religious voice again. For a while this voice was silent. She could not pray. Neither could she believe in God's existence. Naledi was an active Presbyterian, and also trusted the ancestors to talk to God on her behalf. "It was the ancestors who made me survive", she said. Naledi decided to revoice her God-talk, talking both directly and with the ancestors as her community of care to God as the One who took away her guilt.

Naledi has restories herself as a caretaker and protector, of both herself and the children with whom she worked.

Naledi's story summarises the narrative counseling process described in this chapter, and opens up the horizon for more stories of a similar nature of people who renamed the faces of reality, stories that will be told in the next chapter.

Chapter 2

The faces of religious discourses: Mapping the problem

This chapter explores and describes the faces of religious discourses as patients have revealed them while telling their problem-saturated stories.

This chapter, furthermore, classifies religious discourses in four types while reflecting on four different ways in which the research population of 270 patients have disclosed their stories.

Power discourses

Religious discourses as power discourses feed on the binary oppositions between divine and human power, and between divinely instituted hierarchical power (such as male power) and social powerlessness. This chapter describes the faces of power discourses, as well as the exploration of dialogical spaces between the power of the discourse and the experience of powerlessness by the patient. From the research population of 270, a number of 117 (roughly 45%) have told religious stories of helplessness vis-a-vis power discourses. Power discourses, then, seem to be the religious discourses which have the largest harmful effect on the health of patients.

Body discourses

Religious discourses as body discourses are constituted by the binary opposition between the body as controlled by societal, traditional and divine law versus the body as self-controlled, between the body as the victim of abuse versus the body as self-contained, and between the body as the victim of sexual urges versus the body as sexually self-expressed. This chapter describes the faces of body discourses which keep patients from taking control over their bodies. From the research population of 270, a number of 52 (roughly 20%) have told religious stories of helplessness vis-a-vis body discourses.

Identity discourses

Religious discourses as identity discourses try to find a place for spiritual identity between the patient's cultural, sexual, economic, gender and other identities. When religious identities insist on overshadowing all other identi-

ties, this may lead to mental stress and dysfunctionality within the patient. From the research population of 270, a number of 40 (roughly 15%) have told religious stories of helplessness vis-a-vis identity discourses.

Otherness discourses

Religious discourses as otherness discourses emphasise the transcendental nature of religion. This chapter describes the faces of otherness discourses as discourses on miraculous healing and discourses on the afterlife. From the research population of 270, a number of 79 (roughly 30%) have told religious stories of helplessness vis-a-vis otherness discourses.²¹⁸

Following now is a description of power, body, identity and otherness discourses as they have been revealed during counseling. However, not only the faces of religious discourses as problem discourses will be described. The faces of the deconstructed discourses will follow to establish belief as part of the patient's alternative story.

Power discourses show their faces

Discourse as social control versus discourse as preferred way of being

Before venturing into the description of religious discourses as controlling discourses, the concept "discourse as control" itself needs to be deconstructed. This needs to be done since patients, most of the time, do not experience religious discourses as mechanisms of social control. Furthermore, their preferred way of being is to find acceptance within the moral discourses of their church.

The deconstruction of "discourse as control", then, lies in exploring the dialogical spaces between

- on the one hand, raising awareness with the patient that religion in some cases does act harmfully as social control, and
- on the other hand, reminding the counselor that therapy is not a simple act of replacing controlling discourses with preferred ways of being, especially when the patient's context does not allow for the individual's preference.

²¹⁸ The percentages add up to 110% because of the overlapping of discourses.

A few examples of this will suffice:

- A well-known controlling religious discourse is “Divorce is against the will of God.” However, the patient’s preferred way of being is to get divorced. In counseling the patient may arrive at the following deconstructed discourse: “Since divorce is not an option for me in my church, I must look for other ways of safety in my house to protect myself against domestic violence.”
- Another controlling religious discourse is “If you have sinned, knowing that it is a sin, you will not get a second chance.” However, the patient’s preferred way of being is to remain within the faith community. During counseling the patient, then, may arrive at the following deconstructed discourse: “I need a second chance, and I am going to find it in my faith community”.
- One of the most well-known religious discourses is “God has made a man to rule over woman”. However, the patient’s preferred way of being is to live in equal partnership with her man. A deconstructed discourse may then sound as follows: “I want my boyfriend to feel like a man, but as a woman I need him to recognise our relationship publicly and treat me with respect.”
- A patient may report that she understands the Qur’an to say “It is evil for a woman to fight back”. However, the patient needs to voice her resistance against verbal, physical and spiritual abuse in the domestic sphere. Her rescoped discourse may sound as follows: “I know the Qur’an says fighting with your husband is bad; maybe I can find somebody to share this struggle alongside me in a way that will be effective and moral.”

Journeying with stories: Mosa prefers acceptance by family and culture

Mosa (23) was referred for counseling when she was 34 weeks pregnant. It was, of course, too late to even consider abortion, but Mosa was considering adoption. Her reasons for this were (1) she already had another child of five who was displaying aggressive behavior because of the coming baby; (2) she was unemployed and struggling to support her child, living with her mother; and (3) she has not bonded with the baby who was about to be born. Mosa emphasised that she was a responsible person who was able to make good decisions about her life. The externalised, problematic discourse was the voice of her mother who was resisting the adoption on cultural grounds.

Her mother claimed that the black culture did not allow adoption. How were they to explain to the family that Mosa was very pregnant one day, and that the next day there was no baby? Her mother also said that the ancestors would punish Mosa if the baby was taken out of the family. Mosa pointed out that her mother, who was a staunch Christian, in this matter did not refer to the Lord at all, but only mentioned the familial ancestors.

When Mosa left after the session, she asked for papers to arrange for the adoption. Mosa was going to tell her mother to respect her decision.

Mosa returned for counseling once more. She explained that she was financially dependent on her mother, and in a twist of irony would have to keep the baby, even when the baby meant more financial strain, because the cultural tradition was to be honoured.

Mosa then requested the counselor to move towards her accepting the child. She also wanted to be empowered to use effective contraceptives in future. This, then, was done in subsequent sessions.

Mosa's story points to the sensitivity in exploring the dialogical spaces between the controlling discourse, which is situated in additional cultural and economical discourses, and the patient's preferred way of being, which she was unable to exercise within her context. Her only way of undermining the power discourse was to move towards accepting the child, and to engage in contraception to avert similar situations.

Divine power versus human power

Divine power versus human powerlessness

- A description of the binary discourse

Patients often describe feelings of powerlessness in the face of God's anger or apathy, or God's plan to control or purify people through illness.

The voice invited here to understand this discourse better, is that of Dutch theologian Johannes van der Ven. Van der Ven²¹⁹ aptly describes the images of God underlying this discourse as follows:

²¹⁹ Johannes A van der Ven, *God reinvented? A theological search in texts and tables* (Leiden,

- The apathetic God remains unmoved by suffering.
- The retributive God permits suffering as punishment for sin.
- The planning, controlling God permits suffering within the greater context of time, the meaning of which the sufferer will only understand later.
- The therapeutic God purifies people through suffering for them to realise their true humanity.

These images of God support the binaries of the “divine power-human powerlessness” discourse. Patients have reported that these images of God led to them internalising the following discourses:

- I pray to God to heal me, but He is not listening.
 - I am ill, and have suffered loss, because God is punishing me for something.
 - I do not understand the reason for my illness or loss, but I do believe that it is part of God’s plan.
 - I am ill, or I have suffered a loss, because God is purifying me and making me wiser.
- A description of the deconstructed discourse

During therapy counselor and patient explore the dialogical spaces between God as enemy on the one hand, and human being as powerless sufferer on the other, to find outcomes unique to the life story of the patient.

In co-journeing towards a healing relationship between the suffering patient and God, counselor and patient can take notice of what Van der Ven considers to be healing images of God:²²⁰

- The compassionate God is present with those who suffer (as He has revealed Himself in Jesus Christ)
- God, the innocent sufferer, becomes an example for those suffering innocently to identify with other sufferers.
- God becomes the one with whom the sufferer can form a mystical union.

Deconstructing the power-powerless binary in the relationship between God and human beings, the following discourses have emerged during counseling

Boston, Köln: Brill, 1998), pp 212-214.
²²⁰ *Ibid.*, pp 213-214.

where ill people have repositioned themselves vis-a-vis God, and enter into an asymmetrical relationship with God:

- God and I are co-travelers on this journey of suffering.
- I am probably not the cause of my own illness or loss, nevertheless, I can allow it to enable me to meaningfully impact on the life of other sufferers.
- I do not stand in a relationship of punisher-punished with God; rather my suffering brings me in union with God in a unique way of which only I can find words.

In the words of Van der Ven:²²¹ “the notion that God and man are in competition is an obstacle to the faith for many people”. In his search for dialogical space between an absolute transcendent God and a helpless human being, Van der Ven adheres to “the principle of non-competition that is based on the idea of God’s immanent transcendence, which holds that what human beings do and what God does cannot be subtracted from one another ... God does not cancel out the action of human beings, but rather inspires, intensifies and orients that action by placing it on the level of non-obligation and gratuity.”

Journeying with stories: Mookho, the woman who could not pray: “Thy will be done”

On 19 November Mookho brought her nine year old son, Andrew, to the hospital to have warts removed from his vocal cords. This is a minor, non-risk operation which should last a maximum of half an hour. However, something went wrong during the operation, and Mookho’s son was brain-damaged. He spent four months in ICU (the Intensive Care Unit) with painful convulsions and spasms, suffering severely and experiencing terrible pain. On the 24th of March he died. No post mortem was made available, and six months later Mookho was still unable to obtain one.

Mookho externalised a religious discourse as the one which kept her from moving beyond the death of her son. This was Matthew 6:10: “Thy will be done”. It was when she prayed the Our Father, and came to the place where she had to confess God’s will, that sorrow time upon time overwhelmed Mookho.

²²¹ *Ibid*, p 15.

How could it have been God's will for her young son to die, and to die in such pain and anguish?

Mookho did not want to follow the legal road to obtain a post mortem. For her, that was not the way in which "God's will would be done".

Journeying together, Mookho and I further explored the faces of the discourses which kept her captive. The images of God which made her sad were contained in discourses such as "God's will can cause a person to die" and "God's will is punitive". There were socio-cultural discourses which also impacted harmfully on her happiness, such as "A mother whose child has died, is in some way of another responsible for his death".

Mookho's reconstructed story included images of God as provider. She came to see this face of God through nothing less than the Our Father prayer itself. In this prayer, thanks is given to God who gives us our daily bread. That was God's will, Mookho concluded, that we should enjoy what was provided daily. Also, Mookho came to see herself as a provider, as a caretaker. She came to this insight through a life review done during therapy. Through mapping her own life, she found that she had a reputation for caring for her children (she has a daughter of 15). She has cared for Andrew in life and in illness, until death.

Her loss has not stolen love and care from her. She now loves children even more than before. This will make her happy again. This is God's will.

Dreams of divine origin versus dreams of psychological origin

Since Sigmund Freud (1856-1939) and psycho-analysis, the western world believes that dreams come from *inside* the individual. Dreams are the unconscious speaking. Dreams leave the individual vulnerable, trembling before the fears he or she does not dare to acknowledge consciously.

However, whenever dreams were at stake in therapy with the research population under discussion, the belief was expressed that dreams were from *outside* the individual. Dreams are divinely inspired. They are sent to give a divine message to groups larger than the individual.

Nelson Osamu Hayashida's book *Dreams in the African church*²²² is helpful in understanding the significance and interpretations of dreams in

²²² Nelson Osamu Hayashida, *Dreams in the African church* (Amsterdam, Atlanta GA: Rodopi, 1999).

African contexts. For African Christians dreams carry a supernatural message which seek the urgent attention of the dreamer. Dreams contain threats, warnings, requests, directives or revelations (according to a classification by John Mbiti).²²³ The early Christians experienced dreams as coming directly from God, such as when Joseph was guided in a dream to flee to Egypt with the child Jesus (Matthew 1:18-25), and Paul to travel to Macedonia (Acts 16:6-10). The Greeks and Romans of the time, too, saw dreams as divinely sent,²²⁴ as did the Jews of the Old Testament. Then and now, one does not need a special person to explain the dream; one can interpret one's own dreams.

When interviewing church leaders in Atteridgeville, leaders of born-again churches claimed that they were called to start a new church by means of a dream. For them, then, dreams are extremely empowering. One cannot lead a church without such an empowering dream; and empowered by the dream, one takes control over one's followers.

Reflecting upon the patient population, this researcher met with patients who did not see God in a dream, but the ancestral spirit of a family member who had died recently. In the cases under discussion, the ancestral spirit was sad or unfriendly, or issued warnings, leaving the patient with the following discourses:

- My uncle who has passed away, is angry with me because of some unfinished business.
- My mother who has died recently, does not want me to tell people why she died.
- My cousin who has died, is warning me about the neighbours.
- My child who has died, runs after me and calls me "mama, mama"!

In counseling, the exploration of dialogical space was not between divine and psychological interpretations of dreams, since the latter is unthinkable within the context of township spiritualities. The exploration was for dialogue between the threatening dream and the patient's insistence that the counselor should make the dreams go away. This was done by "saying hello" to the ancestor in the dream. When the ancestor was silent in the dream, displaying an accusing attitude, the counselor took on the role of the ancestor and entered into dialogue with the patient. When the ancestor was talkative, whether threatening or in warning mode, the counselor then also played the

²²³ *Ibid*, p 43.

²²⁴ Pieter F Craffert, *Mediating divine power: Perspectives on religion in the biblical world* (Pretoria: Biblia Publishers, 1999), pp 141-143.

role of the ancestor and invited the patient to react to the threats or warnings. The patient was thus empowered to find words to equalise the power between him/her and the ancestor.

Deconstructing the power of ancestors exercised in dreams, led to discourses such as:

- When my uncle visits me again, we'll talk things out.
- My mother visits me because she loves me.
- I am looking forward to my cousin's advice.
- When my child calls me in a dream, I can say hello to her.

Journeying with stories: Lebo dreams himself healthy

On a dark day in 2001 Lebo's cousin was stabbed to death in front of the bank. Lebo was 18, his cousin was 23. For Lebo this was a huge loss. His cousin was his guardian. Lebo and his cousin belonged to a gang which was at war with the gang to which the cousin's killer belonged. Now Lebo was afraid to go to school, or even walk in the streets because of this gang, whose members were looking for him.

Also, this was the third death of a family member Lebo had experienced in a short time. His father died unexpectedly, even though it was of old age. His mother's brother also died unexpectedly, after a bile attack. And then it was his cousin. Lebo saw all three of these bodies before they were removed. Also, he washed his cousin's blood from the pavement after he had died.

Lebo started to have dreams in which his cousin visited him. His cousin did not speak to him. Lebo, who lived in a room in the back yard, started to refuse to sleep in his room.

We externalised "Unsafety" as the problem stealing Lebo's peace of mind from him. He was afraid of the gangsters, and afraid of death. He was sensing that he had some unfinished business with his cousin, but did not know what it was except for the fact that he owed his cousin R2,50.

Apart from making plans to get the schoolmaster, his family, the police and friends to help him develop places of safety, we also thought that we should get Lebo's (deceased) cousin on his side in his struggle against unsafety.

The counselor consequently took on the role of Lebo's (deceased) cousin, and issues of safety were discussed between

Lebo and his cousin, as if they were having a discussion in his dream. Through his cousin, Lebo expressed his preferred ways of safety, by which Lebo displayed remarkable township skills in survival and which he did not want to be disclosed here!

In short, by saying hello to his cousin, Lebo rescoped his fear of death.

Pastoral gaze versus pastoral involvement

It was one of my ideals to extend the counseling done at the hospital to the patients' own faith communities. Patients were asked whether the counselor might contact their pastors to continue with the counseling, thus inviting the faith community into the therapeutic process as a community of care. However, patients expressed their hesitation to disclose the problems governing their lives to their pastors. They were afraid that their problems would be interpreted as sins, and that they would lose face with the pastor and their congregants.

Discourses on the power of the pastor are:

- I must first save enough money for tea and refreshments before I can receive the pastor in my house.
- The pastor told the story of my intimate problems from the pulpit.
- The pastor can drive out the demon which is making me insubordinate.
- The pastor can drive out the demon which is making me hear voices.
- The pastor touched my breasts.
- The pastor said my child died because of my sins.
- The pastor said my husband died because we did not give money to the church.
- The pastor said my depression was a bad spirit.

Eventually, a very simple referral system was indeed established between the hospital and local pastors as caregivers. In therapy the challenge was to explore the patient's openness for pastoral care in the dialogical spaces between pastoral care as keeping an eye on the patient's morals, and pastoral care as empathetic involvement.

In counseling, patients rescoped the discourses on the power of the pastor to discourses on the caregiving of the faith community:

- Now that I am cared for, I am no longer angry at God.
- Through care I have seen the other side of God.

- Caring for somebody else takes my own pain away.

Journeying with stories: Bonolo wants to let her mother rest

Bonolo (43) came for counseling in the latter half of 2003. This was the beginning of a therapeutic friendship which still continues. Her first counseling session was nine months after her mother unexpectedly died at four o'clock on 30 December 2002.

Bonolo is a Pedi who speaks a beautiful rural Afrikaans. She said that, although her mother died suddenly, "ek lankal haar pad gesien het". Bonolo had seen in a dream that her mother would die. After her death, Bonolo often saw her mother's face in dreams, something which deeply disturbed her.

Bonolo, who never married, experienced her mother's death as an enormous loss. Bonolo has been working as a domestic worker in a suburb in Pretoria for the past 12 years. She regularly went home to her mother in rural Kwandebele. She and her mother were friends and confidants, and co-dependent on one another, making clothes which they sold to local buyers, which supplemented Bonolo's small salary as a domestic worker.

We explored in therapy the road ahead. Bonolo said that she saw in a dream the road her mother will travel, from health to death. The counselor asked as a relative influence question whether Bonolo could see the road she and her mother could travel after her mother's death. However, Bonolo was not going to co-journey on that road. She was told at church that her mother would not come to rest while she is still mourning her. And Bonolo wanted her mother to rest. She was not going to say 'hello' to her mother. "Ek wil nie hê my ma moet sukkel waar sy is nie", she said.

Bonolo became fearful that the few other significant people in her life, like her auntie, would also die. She was deeply sad about her mother's death. And yet she could not cry. Eventually she stopped menstruating. Bonolo became very depressed.

Bonolo's circumstances are deprived of care. As a domestic worker, she earns R800 per month. Money is deducted for unemployment insurance, but she has not been registered as a

worker. R30 is deducted whenever she comes to the hospital for treatment or counseling. The family she works for consists of two adults and four teenagers. There are also eight dogs, a cat, and two gardeners. The dogs get very good food. She herself has to cook for the family members and the gardeners. Yet she only receives a handful of porridge each day. She works from 06:30 till 18:00. Also, the washing machine has broken down and she has to do the washing with her hands. She has severe back and neck pain. When she complains, she is told that she is free to leave. Bonolo feels like a prisoner. "Hulle kan mos nie maak asof ek in die tronk is nie. Ek het niemand doodgemaak nie," (I should not feel as if I am in prison; I have not killed anybody), she said.

Eventually Bonolo left her job and went back to her mother's home to stay there. She is making clothes to sustain herself, but financially she is fearful of the future.

It was difficult to deconstruct the power discourses in her life in the absence of accessibility to pastoral care. Bonolo attends a new-born church where the singing and the feeling of belonging to a community of co-sufferers are encouraging her. Also, she pays R26 per month so that the church will bury her when she dies. However, she does not discuss her problems with the pastor whom she'd rather like to impress. Also, she doubts whether he can do anything about her working circumstances and the loss of her mother.

Counseling itself has become a support system to Bonolo. While she was still working, we searched for small tokens of resistance against the power discourses holding Bonolo captive. One day, for instance, she refused to wash the blankets on which the dogs have been sleeping with her hands. Leaving the job was her final act of resistance in this regard. However, now her struggle is against poverty and hunger. Most important, however, is that Bonolo has identified counseling itself as a safe and sympathetic place of sharing and caring.

Hierarchical power versus equal power

Male overt power versus female covert power

- The problem discourse

According to Maureen McBride,²²⁵ patriarchal power supports discourses of authority, might, control, force, aggression, and domination. It does so in the work place, in the church, and in intimate relationships. Patriarchal power discourses are strengthened by images of God as a male ruler and judge. Throughout history, patriarchal power discourses have had a detrimental influence on the fate (and health) of women, as they have been used against women to tyrannize and to terrorize, to rape and to kill, to alienate and to silence, to obliterate their history and to deny their experience, to limit women's horizons and to thwart their ambitions. Women have been, and in most cultures continue to be, excluded from power and decision-making in the political, economic, legal and ecclesial spheres.

In South Africa, women have been given equal power to men by means of the constitution. And during the past fifteen years, women have indeed taken up positions of equality in the public and political spheres. However, it is still in the realm of intimate relationships where women experience powerlessness. Discourses such as the following, which have been extracted from the research population, testify to the way in which the Bible and the Qur'an are still used to disempower women in the townships, and force them into using covert power:

- I am a man as God has made me.
- What I do with other women is not my wife's business; it is something between me and Allah.
- The Qur'an says a man may hit his wife four times.
- I have paid *lobola*²²⁶ and therefore my wife must obey me.
- If I try to commit suicide, my man will feel sorry for me and come back.

Landman, in an article entitled "Women and (c)overt power: Towards a theology of equality"²²⁷, describes the covert power strategies used by town-

²²⁵ Maureen McBride, "Power", in Lisa Isherwood & Dorothea McEwan (eds), *An A to Z of Feminist Theology* (Sheffield: Sheffield Academic Press, 1996), p 182.

²²⁶ Bride's price.

²²⁷ Christina Landman, "Women and (c)overt power: Towards a theology of equality", in

ship women “to bring their emotional needs to the attention of their partners in the absence of women having access to overt and transparent power”. Aida and Falbo²²⁸ use the term “coercive control techniques” and Falbo and Peplau²²⁹ “indirect-unilateral power strategies” to describe the same phenomenon.

Township women, as probably women the world over, use the following covert power techniques to try to gain power in a failing relationship:

- the withdrawal of affection
 - engagement in outbursts of emotion (such as crying)
 - para-suicide attempts or other attempts to be hospitalised
 - falling pregnant
 - enforcing moral guilt
 - harming the children.
- Reconstructed discourses and possible unique outcomes

Over against patriarchal power as domination, women theologians have relanguaged power as “energy”. Maureen McBride, again,²³⁰ rescopes power as something which “is not competitive and has nothing to do with control over another.” She re-images power as “energy, creativity, vigour, passion, wisdom, participation, (and) mutuality-in-relation”. Lisa Isherwood and Dorothea McEwan,²³¹ with reference to Carter Heyward,²³² give a definition of power as divine energy, a definition which according to this researcher can find a meaningful place function in exploring the dialogical spaces between overt patriarchal power and covert female power:

Feminist theology sees power-over as evil while it views mutual empowerment as the goal of spirituality. Women have a great deal of relational power and must learn again that this has divine origins. Power experienced as the energy to connect with others on behalf of whatever strengthens the fabric of life is good, erotic and relational. It is God’s power.

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²²⁸ Yukie Aida & Toni Falbo, “The relationship between marital satisfaction, resources, and power strategies”, in *Sex Roles* 24.1,2 (1991), p 44.

²²⁹ Toni Falbo & LA Peplau, “Power strategies in intimate relationships”, in *Journal of Personality and Social Psychology* 38 (1980), p 618.

²³⁰ *Ibid*, p 183.

²³¹ Lisa Isherwood & Dorothea McEwan, *Introducing feminist theology* (Sheffield: Sheffield Academic Press, 2001, second edition), p 157.

²³² Carter Heyward, *Touching our strength: The erotic as power and the love of God* (New York: Collins, 1989).

Women counselors Carolyn Enns²³³ and Sally Foreman²³⁴ were able to identify a series of relational and sexual problems which are related to inequality in marital relationships. At the same time the research of Andrew Harrell,²³⁵ Mark A de Turck and Gerald Miller,²³⁶ incidentally all men, points to the fact that men and women are happier partners in relationships of equal power, where traditional views of masculinity and femininity have been deconstructed. The patient population has, in counseling, presented the following discourses when deconstructing patriarchal power discourses:

- Since God has made us to be equal, women, men and children should all have access to equal power in family relationships.
- We are all instructed through our holy scriptures to care for one another, and equally for ourselves.
- We all have an equal right to belong to a family and a religious institution.
- God's Spirit gives the individual the energy to strive for the healing and well-being of the whole.

Journeying with stories: Innocent uses covert power

Innocent (31) came to the hospital and asked to be hospitalised because her "body was shaking". She was referred for counseling.

The problem impacting on Innocent's health was a failing marriage. She said that her husband did not love her any more. Actually, she suspected that he had never loved her, but that the pastor of their born-again church had put pressure on him to marry her. They got married in this church in 1997.

Several things made the problem bigger. Her husband's two brothers were staying with them, which led to conflict, especially when one of them hit her seven year old son. Also, money was a huge problem. She had recently lost her job and

²³³ Carolyn Zerbe Enns, "Dilemmas of power and equality in marital and family counseling: Proposals for a feminist perspective", in *Journal of Counseling and Development* 67 (1988), pp 242-247.

²³⁴ Sally Foreman & Rudi Dallos, "Inequalities of power and sexual problems", in *Journal of Family Therapy* 14 (1992), pp 349-369.

²³⁵ W Andrew Harrell, "Husband's masculinity, wife's power, and marital conflict", in *Social Behavior and Personality* 18.2 (1990), pp 207-216.

²³⁶ Mark de Turck & Gerald R Miller, "The effects of husbands' and wives' social cognition on their marital adjustment, conjugal power, and self-esteem", in *Journal of Marriage and Family* 48 (1986), pp715-724.

her husband was providing her with money “in an inhuman way” which led to many fights. However, the main source of conflict, which finally stole the trust from the relationship, was her husband receiving phone calls on his cell phone in the middle of the night. This was a second hand cell phone, with starter pack, which she had bought him when she was still working. Furthermore, verbal abuse was on the side of the problem, her husband inter alia telling her to “voertsek”. Adding injury to insult, also, was the “quick sex”, with him coming to her at night, having intercourse with her quickly, and leaving. This left her sad, feeling degraded.

When the problem left Innocent feeling powerless, she tried to regain power in a covert way. She changed her name to Innocent, and the reason for this would become clear only later. She then came to the hospital and asked to be hospitalised, expressing her hope that this would force her husband to visit her. Counselor and patient then wrote a letter to her husband to invite him to join in the process of her healing. Innocent went home to give him the letter, and came back the next day to be admitted to the hospital.

A week later Innocent was still in hospital, and her husband turned up for couple counseling. Her husband was well-spoken, and Innocent’s voice was not strong during this session, which lasted for almost two hours. Her husband accused her of having an affair with other men, including her previous boss and one of his friends. Innocent explained that her previous boss sexually harrassed her, and when she reported him, she was fired. Also, she contacted her husband’s friend only to hear about the extra-marital affair she suspected her husband had. It now became clear why she had changed her name to Innocent. She wanted to convince her husband by changing her name that she was innocent of the affairs he was suspecting her of having.

We externalised “Lack of Trust” as the problem which forced Innocent into using covert power, and her husband to have quick sex with her and wanting to divorce her. They both undertook to make an effort into making the influence of “Lack of Trust” on their lives smaller. They would not contact other people who might imply an extra-marital relationship, and they would arrange for a family meeting to help solve the problem. The family meeting happened on the 17th of June. When

Innocent came for counseling again on 3 July, she was sad that her husband “was forced into divorcing her by his mother”. She was asked to leave the house. She phoned later and expressed her intent to go back to her husband, cooking and washing for him, and asking him to take her back. Feeling sad that Innocent was once more under pressure to use covert power, the counselor nevertheless respected her decision.

In due time Innocent attended another counseling session. Covert power did not work. She was now divorced and found a job at a toll gate. Her son was staying in Bloemfontein. It seems that Innocent has taken control over her life, although that might not have been her preferred way of being.

The power of culture versus the powerlessness of emotion

- Problem discourses

In her book *Introducing feminist cultural hermeneutics*,²³⁷ Kenyan woman theologian Musimbi Kanyoro points to the consequences of the church siding with hierarchical practices in African cultures:

Many African women will continue to die from sexual violence. Mothers will continue to take their daughters to their grandmothers who will perform a cliteridectomy. Young girls will be married to old men. Young boys will continue to be trained as future dictators, rapists, murderers. The society will answer to these evils by saying, “Boys will be boys; our culture says so.”

Indeed, the patient population under discussion has testified to the influence of hierarchical cultural practices on their lives. The discourses feeding cultural hierarchy are, *inter alia*:

- No marriage without lobola.
- Being gay is sinful.
- The belongings of a deceased man belong to his family and not to his widow.
- The money in the family must be handled by the husband.

²³⁷ Musimbi Kanyoro, *Introducing feminist cultural hermeneutics* (Sheffield: Sheffield Academic Press, 2002), p 65.

- A woman who does not want sex, is a witch.
- Tradition forbids that a man cries for his still-born baby.
- The sangoma has placed a spell on me to make my husband think I am useless.
- Reconstructed discourses and unique outcomes

Kanyoro also points to the inbetween between the hierarchal binaries created by cultural discourse. It is precisely because the African thought system does not make much of a distinction between the sacred and the secular, between the natural and the supernatural, that choices can be made “that are not binary”, she says.²³⁸ The process of **cultural hermeneutics**, which she proposes, aims at doing precisely that, to explore the dialogical spaces between the good and the bad in cultural packages. The *sine qua non* of such an approach is the equality and well-being of all human beings.

The patient population has formulated the following reconstructed discourses and unique outcomes during counseling:

- I shall call in the family to solve the power struggle between me and my husband/wife.
- My husband and I have agreed: A real man does not shout abuse at his wife and children.
- I shall not in the way that I speak create a God through my words who is a punisher.
- I, with the significant people in my life, am stronger than the sangoma’s spell.

Journeying with stories: Botle’s husband is forbidden by tradition to cry

When Botle (28) was seven months pregnant, she came to the hospital for high blood-pressure, only to find out that the baby inside her had been dead for two months. In the place of the baby, the enemy came to stay with her. The name of the enemy was “Isolation”. Botle was isolated by her husband, whose tradition forbade him to mourn the birth of a still-born baby. Botle had to give birth to the baby, alone. It was a boy. She saw him. He was over 500g and declared a person. She had to arrange and attend his funeral, alone. She had to mourn him

²³⁸ *Ibid*, p 66.

and deal with her loss, alone. Her husband never mentioned the baby. He never spoke about his feelings.

How were we going to make the effects of Isolation on Botle's life smaller? Botle said that there was one thing her husband did talk about: having another baby. But she was too scared to try to have a baby now, lest the pain and isolation would come again.

We mapped through Botle's life to find instances when she had been scared before, but eventually ventured into the future successfully. Botle quite spontaneously remembered a crisis she experienced when in matric. She failed three subjects and her parents could not afford to send her back to school. Her brother offered to pay for her, provided that she must pass. Botle was scared. However, she took up the challenge – and succeeded.

Overcoming her fear of the effects of Tradition and Isolation on her life was Botle's first step of resistance against tradition. We then wrote a letter to her husband, inviting him to join her healing process as a significant other.

Botle's husband accompanied her to the next session. When he became aware of the role Isolation played in Botle's life, he was determined to break its influence. He undertook to visit the baby's grave with her on their way home. He also suggested that Botle should take up a job in his business to have her near to him, so that there would be no feelings of being isolated from one another. After he himself had shifted the discourse on tradition, he suggested that she should do something traditional: Botle should visit his aunt whose first baby was still-born, but who consequently gave birth to four healthy children.

In partnership then, Botle and her husband were able to rescope the role of culture in their lives.

Adult power versus adolescent power

Thirty percent of the research population are under the age of 25. Adolescents who report for counseling at the hospital find entrance into the adult world harsh, controlled, unfair or without hope.

Counseling with adolescents at the hospital occurs mainly for three reasons:

- The stress of schooling

Schoolgoing teenagers often report for counseling just before a test or exam. Schoolgoing teenagers, both black and white, classify themselves according to two groups, the jocks and the cool ones. The jocks are those who always do their homework, wear blazers to school, and want to achieve through education. They want to be cool, too, but the real cool ones won't tolerate them in their ranks. The cool ones are those that invest more in friends than in education, and see their future in the opportunities cool people can provide for one another. They do not like the jocks – actually they detest and ridicule them – but before a test or exam often express the wish to have some of the educational skills of the jocks.

Discourses from the research population, in which they express their captivity within adult power discourses, are:

- The teachers expect more from me; I feel like a failure (jock)
- The teachers and my parents do not understand my dreams (cool one)
- Since I failed my grade, I have been hearing voices which make me strong so that my parents and my teachers cannot make me feel bad about myself any more.
- The teacher thinks she is God.
- My mother treats me like an infant, shouting at me to do my homework, but actually I am a young man already.

- Teenage suicide attempts

Suicide survivors in the greater Tshwane Metropolitan are referred to Kalafong Hospital for recovery. Amongst them are a high percentage of teenagers, black and white.

These are the stories which are supported by power discourses vis-a-vis age:

- I am without hope at home: the grown-ups are fighting with one another.
- I am without hope since I have seen my father shooting my mother: the grown-ups are killing one another.
- I saw so many deaths this year, I am without hope.
- Other children also claim that my father is theirs.
- My father let me work as a prostitute.
- My parents don't understand why we teenagers have sex.

- My parents and teachers don't respect me because I smoke, but just look at how they are hurting each other.
- I do not have a father and my mother sent me to a boarding school; she is always absent.
- My father will kill me if he should find out I was pregnant.
- I was raped at church by another man, but I am not going to talk about it.
- The wounded parent

Parents often express their disappointment in the behavior of their adolescent children. These are the parents' problem discourses:

- My child refuses to study.
- My child uses drugs.
- My child is sexually active at a young age.
- My child is insubordinate and unruly.
- My child has chased me out of my own house.
- My son has killed his brother.

When an adolescent has tried to commit suicide, or a parent is desperate about the behavior of a teenager, the rest of the family is called in to join the counseling process. These are the deconstructed discourses of reconstructed relationships between adult and adolescent, discourses which explore the dialogical spaces between adult power and adolescent powerlessness:

- We'll negotiate rules in future.
- We'll respect each other's dreams.
- We'll find a way of communicating our frustrations to one another in future.
- We'll allow our mistakes to be corrected.
- We'll honour each other more than we honour the opinion of society.

Journeying with stories: Kotsi and his mother give and take

Kotsi is a handsome 22 year old who has asked to see a counselor. The problem, he said, was his mother, who is a single parent. She treated him like a child and chased away his friends. The problem, it turned out, stole his concentration, and gave him headaches and insomnia. The problem, he himself

said, was made bigger by his inability to control his friends, his time, and his love for women.

Consequently, we explored Kotsi's strong points. His boss regarded him as a responsible, hard worker. He had lots of friends. And he was an eloquent, well-expressed person, who was also the lead singer in his church choir.

Next, we invited his mother by letter to join the counseling process, which she readily did two weeks later on the 10th of December 2003. She complained that Kotsi was drinking heavily, that he was bringing girls into the house to spend the night with him, and that he was not making any financial contribution to the household, although he had a good job.

Kotsi's mother wanted him to leave the house, but he wanted to stay, thus his quest for a counselor to facilitate the situation. We started negotiating the terms of their future relationship. His mother identified his spirituality, as she saw it represented in him singing the lead in the church choir, as the starting point for a renewed relationship of trust between them, one she insisted should be based on decency and religious morality. Within these parameters, they undertook to show respect for each other's lifestyles.

A week later Kotsi's mother unexpectedly turned up at the counseling room, reporting that things were going fine, contrary to her initial expectations. Kotsi was showing great skills in decently co-existing with her, and she could part with the choice either to control him or to chase him away.

Financial power versus financial powerlessness

Almost 50% of the research population, excluding pensioners or students, are unemployed. Those who are employed earn small salaries of between R700 and R3600 per month. Almost all of them cite financial powerlessness as their problem or part thereof.

The following statements reflect the financial power discourse which keeps them captive:

- My Nigerian husband forced me to start a business, and then he pretended that it was robbed, but I know that he has robbed me.
- Financial problems force me and my daughter to stay in a place from where I am raped every morning on my way to the station.

- When the father of my children died, I found out that he was married to somebody else and I am left with nothing.
- I had to remarry again for financial reasons and now my new husband has raped my son.
- I am lonely because I do not have money for *lobola*.
- My husband lost his pension in a bad deal, but he does not want me to bake cakes for a living.
- After my boyfriend has lost his job, I supported him, but then he left me.
- My husband does not support the children.
- My ex-husband does not pay maintenance.
- My girlfriend/wife spends all my money on frivolous things.

The following deconstructed discourses vis-a-vis money have been presented by patients:

- I have lost my job but I will develop myself as a self-healer.
- I have no money, but I celebrate the fact that I am a caretaker anyway.
- My husband does not support us; I have now applied for a pension.
- My mother who supported us died; I have now applied for a disability grant.
- My ex-boyfriend has burnt my house down, but I shall rebuild it brick by brick.
- I have no money but I am a survivor and I have the Lord and the church on my side.

In Atteridgeville, churches such as the Roman Catholic Church, are distributing food packages to help the desperately hungry. Many born-again churches, too, provide such help, and additionally promise employment and prosperity to their members. In the midst of this, shifting the discourse on money without tangible help is hopeless. Consequently, food is provided to patients on a limited scale from this counseling office. The food is privately sponsored. Children who are too hungry to be counseled, are provided with sandwiches.

Journeying with stories: Limpho needs more than money to survive

Limpho is in her 40s. She lost her husband a year ago. Her two adolescent children aged 17 and 21 are staying with her.

At first we externalised the problem as "Loss". Loss was stealing her sleep from her, and placed a pain in her heart, a

physical pain. She missed her husband. There were things which made the problem stronger. This was the question Limpho asked herself again and again: "Hoekom het die Here so gemaak?" (Why did the Lord do this?) Also, according to her tradition, she had to wear blue clothes for a year after her husband's death, which kept reminding her of her loss. However, the thing which gave the problem its power was finances. Her husband's employer had not yet paid out the money owed to them. And his family was insisting that she should give money to his children from his first marriage.

However, there were things which made the problem smaller. She fondly remembered his last words: "Wanneer ek gesond is, wil ek vir die mense sê jy het my mooi opgepas." (When I am healthy again, I shall tell the people how well you have looked after me.) Also, the people from church visited her and said very kind and uplifting things about her husband.

We then externalised "Finances" as the problem haunting Limpho's life. Since her husband died without a will, our first step was to empower Limpho to find legal aid to sort this out, and help her to get the money from his employer which had then already been due for over a year. In the second place, Limpho decided to compile an ethical will for her husband. In such a will his finances were not bequeathed, but his values and characteristics. What had she and the children inherited from her husband in terms of personality traits and insights into being happy human beings?

It was in answering this question that Limpho was eventually able to shift the financial power discourse to a healthier place, and move towards overcoming the great sadness his death brought. Limpho was assisted in writing this in a letter to her husband. Limpho said "hello" to her husband by telling him about the gold his life had left behind for his family.

Evil power versus good power

In the two previous subsections we have looked at

- *divine* power discourses which control human behavior, and
- *human* power discourses (such as patriarchal, cultural and adult power) which claim to be supported by divine power.

In this subsection, then, we shall look at *evil* power, and the discourses supporting it.

In chapter 1, the results of interviews on healing with leaders of 102 churches in Atteridgeville have been related. It is indicated that all categories of churches, from mainline to born-again, believe that illness is caused by personal sin (immorality and a lack of spiritual commitment), original sin (illness as part of nature), and structural sin (structures oppressing people). However, all these churches also believe that behind all sin, whether it is personal, original or structural, it is the devil at work. Believers are at the mercy of evil forces, which are referred to as satan, or demons, or evil spirits.

A vast majority of the research population, then, belonging to a variety of churches, believe that they are subject to *demonic control*.²³⁹ These are their stories which reflect evil as a power discourse:

- Medicine cannot help me when there is a curse on me.
- When the pain jumps from place to place in your body, it is not a natural illness, it is a demon.
- I cannot hear the blood in my leg; I am possessed by an evil spirit.
- I am evil all over.
- My mother first sent me to a sangoma, and then to Kwaziza Bantu, but the demon remained and she complains that I am still the child of Satan.
- My child dresses only in black; he is lazy, difficult and swears a lot. Is it genetical or is he in Satan's power? (Note: Discourses on satanism were only presented by white people.)

In the above also, the healing practices of the churches in Atteridgeville have been described. Since all churches in some way or another relate illness to evil, healing implies dealing with evil in a religious way. In the churches this is done through prayer and the laying on of hands, exorcism, or the use of traditional methods and medicine. In the counseling which is under description in this study, it is done through deconstruction.

The question which must be asked here is how healing is brought about through the shifting of discourses. In counseling the dialogical spaces between evil and good and their influence on the patients' lives were explored, in order to find a healthy role for evil to play in their lives. The challenge in this regard was mainly twofold:

²³⁹ See Inus Daneel, *Quest for belonging* (Harare, Zimbabwe: Mambo Press, 1987), p 247.

- The first challenge was to look for the healthy role evil can play in a healthy religion, since patients were unwilling to part with the belief that evil influenced their lives extensively. This, of course, differed from patient to patient, and there was no dogmatic prescription from the side of the therapeutic process.
- A second challenge was to respect all the evil role players identified by the patient. Outspokenly Christian patients often identified ancestral spirits, sangoman curses and other evil spirits as the cause of their illness or misfortune, and were of course not reprimanded by the counselor for unchristian beliefs. Respect, then, was also shown for their preferred way of healing which became part of the exploration to lessen the influence of evil on the patient's life, and shift the evil discourse to a healthy place without negating the existence of evil.

These are some of the reconstructed discourses on breaking the control of evil over a person's life:

- On evil's healthy role in a healthy religion
 - My rapists are not evil; the devil in them is evil. I told them God loved them. My rape was a chance to save them from their evil ways.
 - After I have confessed my sins, the church makes me feel a better person; talking about evil relieves my stress.
 - God does not make you sick; the evil spirits in people make you ill; God heals you.
 - The Lord helped me to heal myself from the evil of depression.
 - I sleep with the Bible; this will break the spell of the sangoma's curse and put me in control.
 - I put myself down, but God has a purpose with me; I am a fighter against evil spirits with the Spirit of God.
 - I do not ask God "Why me?" I ask God for power. God gives me power against evil spirits.
- On respecting evil role players
 - The ancestors talked to God on my behalf, and God has now made me a survivor.
 - The devil is there, but he is not my type.
 - The Lord and I are a team against evil spirits.

- I am a nurse; when I see how people can handle suffering, I see the face of the Lord. If it was not for the evil of suffering, I would not have seen God's kindness.
- The Lord gives power; the devil steals it. Therapy teaches me to walk a road with God again.
- Jesus does not give up on me. He knows how strong the devil is, but as a team Jesus and I are stronger.

*Journeying with stories: Christelle subdues evil power*²⁴⁰

Christelle has attended counseling sessions for two years on a monthly basis. She has taken me, her counselor, on a spiritual journey.

Christelle (31) is an Indian woman married to a Shangaan. Christelle has experienced the full force of evil in her life. As a girl of high morals, she was date-raped by a Coloured man when she was 15, and again by an Indian man when she was 19. With the last rape she fell pregnant. It was against her belief to have an abortion, and a daughter was born. "I fell in love with the child", she said. At 24 she married a black man and felt sure that she was going to be safe in future. She did not enjoy having sex with him and hurt during intercourse. He abused her physically and verbally, and cheated on her. Two children, a boy and a girl, were born during the first six years of marriage.

When Christelle went for a hysterectomy, she tested HIV positive. She could only have contracted the virus from her husband. She then found out that her husband had already been tested and knew that he was HIV positive. Christelle had her children tested. Her two children with her husband tested negative. However, her daughter who was born from the rape tested positive. The girl exposed that she was raped by her stepfather. Christelle believed that her husband had raped the child under the spell of a sangoma, but still counted him guilty since people had to follow their minds and not evil.

Christelle got a Protection Order against her husband after he beat her and threatened to kill the children. She moved in with her parents, staying with her three children in a room of a

²⁴⁰ The patient has indicated on her consent form (signed on 2 March 2005) that she wants this name to be used to tell her story.

house with 19 people. While her husband was contesting a divorce, the court gave her custody of the children.

When her CD4 count was 114, Christelle went on antiretrovirals. She was working night shifts in a state department. She was suffering from opportunistic diseases, such as vaginal, eye and airway infections. The antiretrovirals made her tired and nauseous, her hair fell out and she put on weight. Her legs started swelling.

This, then, was Christelle's problem saturated story. However, alongside this story, Christelle told a story of how she has broken the control of evil over her life. Space is lacking to do right to her words and insights. I shall refer to some here:

- (1) She does not blame God, Christelle says. Rather, she calls on God's protection. At night she prays God to remove the evil from the room, and the children then sleep peacefully right through the night. Her husband is using witchcraft to harm the children, she said.
- (2) Christelle has learnt to forgive. This has an enormous calming effect on her. Christelle is indeed able not to demonise anybody: not her rapists, not her husband, and not even the virus. Respecting all people makes her happy.
- (3) Christelle controls her pain by caring for others. "If there are people who care, tomorrow will come", she said.
- (4) Christelle controls her anger by praying to a God of peace, and by spotting the beauty in life. She celebrates life and thanks God for it. God has given her the choice to be happy, she believes, to change a tear into a flower. In this way she "closes the door to the devil". Christelle's husband had an affair with a woman who worked with Christelle. This woman had become very ill, and died. And yet, Christelle points out, she herself is still healthy and surviving well.
- (5) Christelle opens herself up to compassionate friends who listen to her and pray for her. She finds them mostly at church. She goes both to a mainline and born-again church. Because of her low energy levels, she cannot travel far.
- (6) Christelle is not afraid of death. "Death brings new perspectives", she says.

(7) *Christelle is not afraid of life, either. She is spending quality time with God and her children. At her last session Christelle informed me that she was considering getting married to someone who knew her HIV-status.*

Body discourses show their faces

In their book *Introducing body theology*, Lisa Isherwood and Elizabeth Stuart explore “the body as the site of female oppression.”²⁴¹ The oppressed female body is one leg of a binary opposition. The other leg, opposing this patriarchal discourse, is a radical feminist one which looks essentialistically and deterministically at the female body from the perspective of childbearing, reproduction and sexuality.²⁴²

What is to be discovered in the dialogical spaces between the dualism of patriarchy on the one hand, and the essentialism of radical feminism on the other? Isherwood herself provides guidance in this regard both in the book mentioned above, and in an essay “Sex and body politics: Issues for feminist theology”.²⁴³ Inbetween discourses may include:

- the body as a site of resistance to and transformation of patriarchal reality²⁴⁴
- the body as our most intimate space that can be colonised or liberated²⁴⁵
- the “divine body” as stubborn objection of life as it is
- the “spiritual body” as one empowered through theology.²⁴⁶

²⁴¹ Lisa Isherwood & Elizabeth Stuart, *Introducing body theology* (Sheffield: Sheffield Academic Press, 1998), p 15.

²⁴² *Ibid*, p 85.

²⁴³ Lisa Isherwood, “Sex and body politics: Issues for feminist theology”, in Lisa Isherwood (ed), *The good news of the body: Sexual theology and feminism* (Washington Square, New York: New York University Press, 2000), pp 20-34.

²⁴⁴ Isherwood & Stuart, *op cit*, p 84.

²⁴⁵ Isherwood, *op cit*, p 21.

²⁴⁶ *Ibid*, p 23.

The safe body versus the unsafe body*Physical abuse versus physical safety*

Of the 203 women in the research population, more than half (103) reported that they had suffered physical abuse in the form of assault, rape, robbery, hijacking, kidnapping, or forced prostitution. Murders, too, were reported.

These are the women's stories: (When women shared similar stories, the number is placed in brackets)

- Assault
 - I was/am beaten regularly by my husband/boyfriend (21)
 - I suffered brain damage after I was beaten by my husband/boyfriend (2)
 - I was beaten by my boyfriend who also burnt down my house (3)
 - I was beaten by my child who also burnt down my house (1)
 - I was forced by my husband to have sex against my will (3)
 - I was beaten by my husband and chased out of the house (5)
 - I found out that I was divorced only after the divorce had been granted by the court (3)
 - My child was beaten by my boyfriend (3)
 - I was beaten by my mother as a grown-up (2)
 - I was beaten by my stepmother as a grown-up (1)
 - I was bitten by my mother as a grown-up (1)
 - I was pulled with a rope around my neck through the street by my brother until I gave him my pension payout (1)
 - I fear for my life after I have reported corruption at work (1)
 - I am afraid that, although I came for my toes to be separated, the hospital is going to cut off my leg (1)
- Rape
 - My son was raped by my husband (1)
 - My daughter was raped by my brother (1)
 - I was beaten and raped by an unknown rapist (6)
 - I was raped by a person known to me (4)
 - I was raped by my employer (3)
 - I was raped by somebody who pretended that he could give me a job (1)
 - I was raped by a gang of unknown rapists (7)

- I was raped by two men while working as a domestic worker in the house of my employer (1)
- I contracted the HI virus after I had been raped (4)
- I was sexually abused as child by a male family member (7)
- Robbery
- I was beaten and robbed by an unknown person (5)
- Hi-jacking
- I was hi-jacked while travelling in a car (4)
- Kidnapping
- I was kidnapped as a child by another woman and had to work for her like a slave (1)
- Forced prostitution
- I was forced to work as a prostitute by my father (1)
- Murder
- My mother, a domestic worker, had been bitten to death by her employer's dog (1)
- I have witnessed the murder of a nearby family member (5)
- My son was killed at school (3)

Of the 67 men of the research population

- one gay man reported that he was raped by another
- two boys reported that they were raped by men
- one boy reported that he saw his father killing his mother
- one boy reported that he saw members of the mafia killing his father
- one boy reported that he had to witness his father raping the domestic worker
- one boy reported that he was assaulted by gangsters on his way back from school
- one middle aged man reported that he was assaulted and robbed by gangsters
- three men reported that they have beaten their wives/girlfriends

- one man reported that he was afraid that the doctor was going to “reposition his testicles”

Do people living in South African townships have the same opportunities to use their bodies as sites of resistance and transformation as women from the First World? How can township women liberate their bodies, their most intimate space? Can they be empowered by the same Body Theology as their affluent white sisters in Europe, America and New Zealand?

We should first listen to township women’s *reconstructed discourses* before making a few comments on a Body Theology for township people:

- I’ll move on to a relationship where I feel safe.
- My husband and I have worked together to invite healing into our relationship.
- My husband left me with four children; I will pray to God to give me somebody who will carry this with me.
- I’ll venture into a new relationship with realistic expectations this time.
- I’ll make healthy decisions about my body in future.
- I am the caretaker of my own body.
- I am strong when I am connected with God.

Township boys and men offer the following *reconstructed discourses*:

- I shall keep to places where I as a boy feel safe from rape.
- I shall work with my wife to eliminate the things which make me so angry that I abuse her.

Lisa Isherwood wrote an excellent book on Body Theology. However, it hardly mentions physical abuse against women (and men). Township people – actually, more than half of the research population who consist of black, white, coloured and Indian people – seriously have to consider the reality of abuse against their bodies. However, they are not going to do that outside of their relationships.

- In counseling, then, the research population preferred to reconstruct the body as the site of healthy relationships
- the body as the site of teaching each other respect
- the body as the communal concern of the whole family
- the body as liberated through liturgical dancing and praising God

In summary

In search of safety from physical abuse, the body enters into a process of healing, which includes

- the cleansing of oneself from feelings of hatred and resentment,
- the restoring of relationships,
- and an invitation to God to oversee the process.

Journeying with stories: Limakatso has to run in her nighty

Limakatso attended counseling three years since her husband had lost his job. Since then he has physically abused her and their three children, aged 19, 14 and 8. One night she had to run out into the street in her nighty to escape being killed. This was a very painful experience. "That night I wanted to give up," Limakatso says. "I only reminded myself: Jesus never gave up. That was all that kept me going."

Limakatso understands her husband's pain, the pain which came to stay with him since he has lost his job. Yet she asks: "Why may a man pass on his pain to his wife?"

Limakatso got a Protection Order against her husband, but that was not really the way she wanted to go. She wanted to discuss things with him, but he remained silent. She wanted to pray with him, but he did not want to go to church and ridiculed her praying. However, Limakatso's faith remains a strong support system. As her husband passes on his pain to her, Jesus passes on his love to her.

Limakatso decided to call in the family to help solve the problem. She asked her cousin to speak to him. We also wrote a letter to her husband, inviting him to join the counseling process as a significant other.

Neither Limakatso nor her husband attended any further counseling sessions. Hope remains that they have found an inbetween between abusive, patriarchal ways of solving their problems and handling their pain on the one hand, and separating from one another on the other.

Spiritual abuse versus spiritual safety

Which are the spiritual discourses that make the body unsafe? And in which type of relationships do they show their faces?

Spiritual abuse is a newcomer to abuse talk. Abuse talk usually focuses on physical, emotional and verbal abuse. In the meager literature available, spiritual abuse is identified with hell-talk and leadership abuse. In their book, *The subtle power of spiritual abuse*, David Johnson & Jeff VanVonderen²⁴⁷ aptly and boldly discuss spiritual abuse as “spiritual manipulation and false spiritual authority within the church”. In this book, then, spiritual abuse is dealt with as a *power* discourse. In an essay dealing with *Grief complicated by spiritual abuse*, Boyd Purcell too sees spiritual abuse as a power discourse and lists its principal symptoms. They are “anger, anxiety, fear of God/eternal torment, guilt, low self-esteem, panic, a feeling of never being good enough, hopelessness, and shame”.²⁴⁸

However, here we deal with spiritual abuse as a *body* discourse. Again, whenever spiritual abuse is placed on the table as a body discourse in the existing literature, it is defined as spiritual talk which renders sexuality suspicious and makes people feel bad about their bodies. Dennis Linn describes how his sexuality suffered an early death at the hands of a body-unfriendly spirituality which presented good people as “bodiless”:

In the culture in which I grew up, the heroes were priests, religious sisters, and the Blessed Mother. All were celibate and wore flowing religious garb that made them look bodiless. They were so asexual that I remember how shocked I was in seventh grade when I discovered that priests went to the bathroom. Shortly afterward, I begin wondering if it was possible that religious sisters did too. I took on many of the “bodiless” attitudes I perceived in my pastors and religious teachers. They taught endless rules about the “do’s” and “don’ts” of sexuality. Any infringement was a serious sin and especially offensive to God, who (it seemed to me) saw sexuality as bad. I must be bad too, I thought, because I didn’t see how I could ever live up to all those rules.²⁴⁹

Here we are going to look for the faces of spiritual abuse in personal relationships. We are going to look for spiritual abuse where a person gives “self-serving advice *in the name of God*”²⁵⁰ to another, thereby rendering the other person’s body vulnerable.

²⁴⁷ David Johnson & Jeff VanVonderen, *The subtle power of spiritual abuse* (Cape Town: Struik, 1991).

²⁴⁸ Boyd C Purcell, “Grief complicated by spiritual abuse”, in Gerry R Cox, Robert A Bendiksen, and Robert G Stevenson (eds), *Complicated grieving and bereavement: Understanding and treating people experiencing loss* (Amityville, New York: Baywood Publishing Company, 2002), p 165.

²⁴⁹ Matthew Linn, Sheila Fabriacant Linn & Dennis Linn, *Healing spiritual abuse and religious addiction* (New York: Paulist Press, 1994), p 26.

²⁵⁰ Demaris S Wehr, “Spiritual abuse: When good people do bad things”, in Polly Young-Eisendrath & Melvin E Miller (eds), *The psychology of mature spirituality: Integrity*,

The research population presented the following spiritually abusive discourses through which they were robbed of the opportunity to make choices about their own bodies:

- God has ordered the wife not to deny her husband.
- I was not raised to say no.
- God and my grandmother forbade me to have an abortion.
- The Bible does not allow me to have a (sexual relationship with a) boyfriend.
- In the church men have all the say.
- I slept with my husband without a condom because his girlfriend does. Now I am HIV-positive.
- My wife does not want sex, but she does not want me to take another woman either.

If we have to name the discourses holding the bodies of the women from the research population captive, we can refer to them as discourses on Abortion, Pre-marital Sex, and Compulsory Marital Sex.

In her book, *Women, who are you?*, the well-known African woman theologian from the Congo, Bernadette Mbuy-Beya,²⁵¹ refers to body abuse committed against women in the name of religion as *moral violence*. The alternative to moral violence against women, she says, is women's liberation from (culturo-religious) taboos on the one hand, and men's commitment against sexual promiscuity on the other.

In counseling, the patient population has explored the dialogical spaces between liberation on the one hand, and celibacy on the other. They presented the following reconstructed discourses on

- Abortion
 - Abortion is a sin, but the baby has a right to die when living offers no future.
 - The baby has a right not to be born.
- Pre-marital sex
 - I need emotional commitment more than anything else.

wisdom, transcendence (London & Philadelphia: Routledge, 2000), p 49.

²⁵¹ Bernadette Mbuy-Beya, *Woman, who are you? A challenge* (Nairobi, Kenya: Paulines Publications Africa, 1998), pp 63-65.

- I need him at least to pay *lobola*.
- I was previously capable of leaving a destructive relationship; I can do that again.
- Compulsory marital sex
- My wife/husband and I make time to excite each other to have sex.
- I sometimes have sex with my husband although I do not feel like it out of respect for his desires. I feel that he should leave me alone sometimes out of respect for me.
- I now have the courage always to ask my husband to wear a condom.

Journeying with stories: Marina was almost silenced by the Bible

Marina is a white woman who speaks Afrikaans. She is also a professional woman with scarce skills. After she had finished her studies, she went to Europe to practice her profession in order to pay her study debt. She herself belonged to one of the Afrikaans sister churches.

In Europe Marina met and married a French man from a charismatic church. They both longed for a child, and a son was born. Apart from differences of opinion on how to raise the child, a main point of controversy was the fact that Marina found her husband to be too controlling and too sexually demanding. She had to ask permission for everything, and one night he slapped her in front of the baby.

Marina felt trapped. Her husband was taking her on guilt trips with religious discourses to force her into his preferred way of behavior. The Bible was used to tell her that she was not allowed to refuse her husband. Also, the Bible prohibited her from leaving her husband. And then she was not only spiritually trapped, but financially too. She had left her job to look after the baby. If she wanted to practice in South Africa again, she had to pay a huge fine which was beyond her capacity. Also, according to local law she could not remove the baby from her husband's country for more than six weeks without his consent. Eventually Marina convinced her husband that she and the baby had to go on a short holiday to South Africa. When she had not returned after some weeks, he followed them here, and joined the counseling sessions. This was when the term "spiritual abuse" was introduced into the

conversation. The couple honestly spoke about the effects of spiritual abuse on their relationship, and promised each other to eliminate its role in their lives. The couple and their son went back to Europe.

It seems that, when Marina's husband was back in the context of his church and its discourses, manipulating Marina with the Bible no longer appeared to him to be abusive, and the practice continued. At the moment they are separated.

Verbal abuse versus verbal self-defense

Catherine Clark Kroeger²⁵² sees in Psalm 56:6 a reference to verbal abuse: "All day long they twist my words." However, in this study verbal abuse will be used within the following definition: "Verbal abuse is the use of words with the intention to hurt. Words become abusive when they are used in unequal relationships in which the abused do not have equal access to words."²⁵³

In studies done elsewhere in the world, it was found that there was a 75% occurrence of verbal abuse in pre-marital relationships, that is, relationships which eventually evolved in marriage.²⁵⁴ That means that people do not regard verbal abuse reason enough not to enter into marriage. Research on verbal abuse in South Africa is meager, but may indicate that here, as everywhere else in the world, marriage is not a cure for verbal abuse, but makes it more intense and hurtful.

Verbal abuse is aimed at the other person's weak points. In a study "The religious causes of verbal abuse against women", Landman²⁵⁵ indicated that in intimate relationships, when women are the objects of verbal abuse, this type of abuse is aimed at their alleged inability to handle the family's finances wisely, their lack of good bodily appearance, their inadequate sexual performance, and their unfitness as a mother.

Here, we are going to look at verbal abuse against the body, that is, we are going to deal with verbal abuse as a body discourse – as is the aim of this

²⁵² Catherine Clark Kroeger & James R Beck (eds), *Women, abuse, and the Bible: How Scripture can be used to hurt or heal* (Grand Rapids, Michigan: Baker Books, 1996), p 238.

²⁵³ Christina Landman, "The religious causes of verbal abuse against women", in Elizabeth Amoah & Mercy Amba Oduyoye (eds), *When silence is no longer an option* (Talitha Qumi Center, Legon, Ghana: SWL Press, 2002), pp 80-89.

²⁵⁴ Dudley D Cahn & Sally A Lloyd (eds), *Family violence from a communication perspective* (Thousand Oaks, Calif: Sage Publications, 1996).

²⁵⁵ See footnote 36.

subsection. Landman has pointed to household references to God as a religious discourse supporting verbal abuse against women:

Religions which speak of their God in household terms, that is, as Father or Provider, and furthermore genderise their God as male, convey a message to men that they, as providers of the family, own the bodies in this family. He can punish them as God punishes the people in his household.

The research population has reported the following hurtful verbal abuse against their bodies:

- After having suffered a hi-jacking and housebreak, my husband said that I have bewitched him and that I also look like a witch.
- After I had been diagnosed with HIV, my family said that I was too unclean to cook for them.
- After my husband became impotent, he constantly says hurtful things about my body.
- After I have found out about my husband's affair, he verbally and physically abused me and accused me of having an affair too.

Verbal abuse aims at controlling your partner by blaming and criticising him/her. The idea of verbal abuse as "control" is a constant discourse in the reactions of the research population listed above. Verbal abuse is also aptly described as control by Patricia Evans in her book *Verbal abuse survivors speak out*²⁵⁶ which is based on the written and oral testimonies of more than 200 victims of verbal abuse. Suzette Elgin in her book on *Stopping the pain of verbal abuse*²⁵⁷ names two important strategies in breaking the control of verbal abuse over one's life. The one is for the victim to decide not to participate in verbal abuse. The second is to maintain one's own healthy language environment, that is, to replace abusive words with healthy words of one's own. Or, in this context, to rename one's verbally abused body with words of beauty and self-respect. These were also the routes taken by the research population in dealing with verbal abuse against their bodies, when they deconstructed verbal abuse to the following discourses:

²⁵⁶ Patricia Evans, *Verbal abuse survivors speak out. On relationship and recovery* (Holbrook, Massachusetts: Bob Adams, 1993).

²⁵⁷ Suzette Haden Elgin, *You can't say that to me! Stopping the pain of verbal abuse - an 8-step program* (New York, etc: John Wiley & Sons, 1995).

- When my husband/boyfriend verbally and physically abuses me, I speak back in positive words.
- My husband/boyfriend verbally and physically abuses me, but I have other people who care for me.
- When my husband/boyfriend says nasty things about my body, I give my body other nice names.
- I'll abort the baby I am expecting to protect him from his father's verbal and physical abuse.

Journeying with stories: Cruel words injure Lisebo's soul

For the past 20 years Lisebo's husband has assaulted her physically. She has been working as a domestic worker in suburban Tshwane for 18 years now. Even there he comes and beats her while she works. He has even beaten her up when she was 8 months pregnant with their third child. Her employers support her and have written a letter to her husband to warn him not to come there and assault her. When this did not help and he beat her up again, she went to the police to make a case against him. However, she does not want to divorce him and thinks of withdrawing the case. After she opened the case against him, he has not physically assaulted her again, but the verbal abuse has grown in intensity. He told her that she was "n hoervrou wat met die polies slaap" (a prostitute who sleeps with the police) and that the children were not his.

Lisebo belongs to an Apostolic Church and attends services there regularly in spite of the fact that her husband tries to keep her from going. Here she finds another and safe language environment where people speak good words to her and honour her as a moral person.

Also, in counseling Lisebo has discovered that she herself is a person who could speak healing words. Her employer ("miesies") is at the moment experiencing marriage problems. Lisebo is the one who gives her advice and has become a beacon of light in her employer's life with her wise and healing words. Lisebo allowed her traumatic experiences with her own husband to make her wise, and a counselor to other women.

Sexual loneliness versus choices

The patient population under discussion report two discourses which lead to sexual loneliness amongst single people:

- *Sex is not allowed*: “The problem is that I want to serve God even as a single person. Why has God given me sexual desires if I am not allowed to satisfy them?”
- *Sex is not available*: “The problem is that all the men are taken. Why is God not sending me the right man?”

Not enough has been written about the sexualities of single people. And the books which have been written, are not available in South Africa, nor do they address local issues. Also, pastoral counselors seem to be unable to move beyond abstinence as the only manifestation of single morality.²⁵⁸ Furthermore, masturbation seems to be an immoral alternative to penetrative sex in most books dealing with single life from a Christian perspective. This is so in a South African context as well. During the said interviews with church leaders done by this researcher in Atteridgeville, they all responded negatively to a question whether their church allows masturbation. Most of these leaders expressed surprise through their body language that such a question was even asked.

When John Landgraf wrote his book, *Singling: A new way to live the single life*,²⁵⁹ he was Professor of Theology at Central Baptist Theological Seminary in Kansas City. In this book he presents another Christian view on single sexuality. In a chapter “Sex and singling”²⁶⁰ he states that “legal-institutional marriage is certainly not and cannot be the only context for proper sexual expression”. In this chapter he describes several growth tasks pertinent to sexual singling:

- *Become your own best lover*. Here Landgraf describes masturbation²⁶¹ as “an invaluable singling skill.

²⁵⁸ See Rick Stedman, “Sexual struggles”, in Douglas L Fagerstrom (ed), *Counseling single adults. A handbook of principles and advice* (Grand Rapids, Michigan: Baker Books, 1996), pp 243-259.

²⁵⁹ John R Landgraf, *Singling: A new way to live the single life* (Louisville, Kentucky: Westminster John Knox Press, 1990).

²⁶⁰ *Ibid*, pp 120-138.

²⁶¹ Masturbation has been renamed “erotic celibacy” by women theologians such as Lisa Isherwood (2000).

- *Get your sexual ethics clear.* Here Landgraf describes skills in making healthy decisions about your body when having to decide about having sex or not. There are three basic choice options in moral decision-making, Landgraf says. They are (1) to follow the law, (2) to simply follow your own needs, or (3) to serve humankind in one's choices. One's choice for or against sex is moral when it produces an increased capacity to trust one another, greater authenticity and integrity in the relationships, enhanced self-respect, and the fulfillment of individual potential.
- *Explore your non-sexual options.* Here Landgraf describes alternatives to sexual activity, such as becoming involved in other people's concerns.
- *Woo and win the people you want for your life.* Here Landgraf gives a delightful description of the benefits of friendship.
- *Avoid courting inappropriate people.* Do not simply date (and eventually marry!) somebody simply because society wants you to be part of a couple, is what Landgraf seems to be saying here.

The research population presents the following alternative singling discourses which reflect their right to choose rather than to be victims of sexual loneliness:

- I am never going to allow the woman who took my man away to make me so angry that I want to kill the children.
- I am not ever going to become so lonely again that I hate my body and want to cut it.
- I am going to celebrate my body although my boyfriend comes and goes.

However, the dilemma of women's loneliness and their lack of power in intimate relationships remains, which is well illustrated in the novel of the South African writer Dianne Case, *Toasted Penis and Cheese* (1999). The main character, Jennifer, moves from the distressed body, to the discovered body, and finally to the recreated body. "Yet, she is also confronted with the limits of this discovery".²⁶² This is also the story of township women, who have as yet not found a discourse which will empower their bodies to the full. The voices of coupledom, loneliness and social alienation are powerful and steal their choices from them.

²⁶² Bettina Weiss, *Tangible Voice-Throwing Empowering corporeal discourses in African women's writing of Southern Africa* (Frankfurt am Main, etc: Peter Lang, 2004), p 162.

Journeying with stories: Nthati felt liberated to make choices

Nthati was 38 years old when she was referred for counseling. She was very depressed. She was previously in hurtful relationships but had now found the person she really loved and felt safe with. They had met a while ago and did not have any sexual intercourse before he was admitted to prison for an offence Nthati chose not to reveal.

Nthati referred to this new friend of hers as her boyfriend, and she expressed her wish to have a baby with him. The problem was that her friend, whom she desired to be her lover and the father of her child, had full-blown Aids, and was dying in prison. Nthati had been informed by a doctor that it was possible to “wash” the sperms of a person infected with the HI-virus, thus making it possible for him to have a baby who will not inherit the virus. Of course, neither a prison nor a state hospital have such a “washing machine”, but Nthati had a dream of getting a job and saving money for him to undergo such treatment. Nthati did not experience it to be a problem that prisons did not allow sexual intercourse between prisoners and their visitors. Because he was ill, he would be freed soon, she believed.

During counseling we explored Nthati’s caring side. Nthati experienced this to be extremely empowering. Everybody had been telling her that she was “not lekker up there” for wanting to have a baby with a person living with Aids in prison. To look at herself not as a desperately lonely person, or as a person who has lost her sanity, but as a caring person whose care had made the life of another person better, had an amazing effect on Nthati’s mental state.

Two weeks later, Nthati attended another counseling session. She has now proudly taken up her role as caretaker. She brought with her a letter she has written to God, thanking God that he was looking after her, and for making her realise that she was a caring person. She was even taking care of the flowers in the house, watering them – something her mother usually had to do. She was also taking more care of her nine year old son and took him to the movies. This was, of course, a boy she had with another man she was living with before. “Leaving my son’s father was the best thing which ever

happened to me”, she said, “because he assaulted me and insulted my family.”

At this stage, we started talking about Nthati’s ability to leave a destructive relationship. I get out of a relationship when I know that I cannot change him or the circumstances, Nthati said. Nthati felt sure that she would also be able to leave the relationship with her new boyfriend, who was still imprisoned, the moment she felt that the relationship had become destructive.

Nthati left therapy knowing that she had choices. She could choose to have a relationship and a baby with her new boyfriend. Or she could choose to leave. However, it is not an easy choice, and the road lying ahead of Nthati is hard and bumpy.

Identity discourses show their faces

Do you *have* an identity? Or *are* you an identity? These are the questions philosophers usually busy themselves with. However, in this section we shall ask:

- What are the (religious) identities governing the lives of the research population? And, of course,
- What would have been their preferred (religious) identities?

When a person’s identity has been robbed, that person’s spirit dies. Seodi Venekai-Rudo White (and others) in their book on gender violence call the stealing away of identity *spirit injury*. Or in their own words: “‘Spirit Injury’ leads to the slow death of the psychology, the soul and identity of the individual”.²⁶³

Have religious discourses robbed the research population of their identity? When the patient’s religious identity is placed in binary opposition to his/her other identities, which are cultural, financial or gender focused, the answer to the above question may be yes. It has been found that when religious leaders insisted that their adherents gave priority to their religious identity at the expense of all other identities, tension developed within the patient because of the conflict of identities. When a patient is, for instance,

²⁶³ Seodi Venekai-Rudo White, Dorothy nyaKaunda Kamanga, Tinyade Kachika, Asiyati Lorraine Chiweza, Flossie Gomile-Chidyaonga, *Dispossessing the widow: Gender based violence in Malawi* (Balaka, Malawi: Montfort Media, 2002), p 12.

advised by her pastor to submit to her husband according to Old Testament laws, her religious identity comes into conflict with her gender identity as defined by contemporary human rights.

In therapy, of course, we explored the dialogical spaces between fixed identities which are opposing one another in order to shift the identity from fixed to dialogical. In exploring dialogical identities, it may be useful to remind oneself briefly of the insights on “identity” of the philosophers who have informed narrative therapy: Paul Ricoeur, Jacques Derrida and Michel Foucault:

- Ricoeur introduces the term “narrative identity”, with a reference towards “I am what I am because of how I am narrated”.²⁶⁴ This researcher sees this as an important insight for narrative therapy which invites many voices into the process of identity narration, including those of the patient him- or herself and those of significant others.
- Derrida aims at deconstructing the self by gaining insight into the social and linguistic processes by which tradition is constructed. Edward Sampson²⁶⁵ sums this up as follows:
 Derrida’s works revolve around the fundamental structuralist study that all social practices, including the meaning of subject and subjectivity, are not simply mediated by language, but are constituted in and through language. Therefore, it becomes important to examine both the signifying system of language and the tradition by which language has thus far been understood. Derrida’s aim is to deconstruct that tradition and so provide a better understanding of the manner by which persons are constituted in social and linguistic practice.
- Finally, it was Foucault²⁶⁶ who liberated humanity from the ideal of “finding oneself”. He did this by deconstructing the self into many selves, and unfixing identity into a variety of shifting identities. Narrative therapy, then, empowers the patient to find him- or herself situated within several selves, and co-authoring his or her life as one within many preferred identities.

²⁶⁴ Paul Ricoeur, *Figuring the Sacred, Religion, Narrative and Imagination* (Minneapolis: Fortress Press, 1995).

²⁶⁵ Edward Sampson, “The deconstruction of the self”, in John Shotter & Kenneth J Gergen (eds), *Texts of identity* (London, Newbury Park, New Delhi: Sage Publications, 1989), p 8.

²⁶⁶ Alec McHoul & Wendy Grace, *A Foucault Primer: Discourse, power and the subject* (Washington Square, New York: New York University Press, 1993), p 76.

In this subsection we are first going to look at the faces of fixed religious identities within township spiritualities. Then, we shall explore the dialogical spaces between fixed religious identity when it comes into conflict with other identities. Under “other identities” we shall understand those identities which have earlier been identified as therapeutically significant to this study. They are religious affiliation, culture, money, gender and age.

Religious identity within township spiritualities

Based on oral history interviews with church leaders, as explained in chapter 1, religious identity in the township takes on fixed forms by means of the following discourses.²⁶⁷

- Morality as explained in the Old Testament is sufficient and compulsory for Christians today.
- Morality as explained in the Old Testament transcends and is superior to all cultures, also my own.
- My church has been revealed through dreams as the true church, and offers prosperity and health.
- It is unthinkable to practice one’s faith outside of a church.

Religious identity in the township, then, is old testamentically moral, mercilessly churchy, with an indispensable focus on faith healing.

Here I shall call this a *post-colonial religious identity*, in that it is an identity assumed by Christians who have reclaimed their religiosity from its western forms of expression. Yet, religious identity in the township also is not “African” in any generic sense. It is a (albeit fixed) mixture of

- a variety of African cultures
- adapted forms of traditional and charismatic Christianity, and
- contemporary peri-urban legends, needs and fears.

With each of the churches (there are at least 150 churches in Atteridgeville alone) taking on its own fixed form of religious identity, the challenge of therapy is to enter into dialogue with the patient’s prescribed religious identity in order to harmonise it with his/her preferred identity.²⁶⁸

²⁶⁷ I have described the main characteristics of township spiritualities in my M Th presentation, “Relanguaging religious and cultural discourses”, which was presented on 4 March 2002 and gave access to the present study.

²⁶⁸ Relevant here is an article on postcolonial religion written by Ananda Abeysekara, “Identity for and against itself: Religion, criticism, and pluralization”, in *Journal of the American Academy of Religion* 72.4 (December 2004), pp 973-1001. On page 975 Abeysekara notes

Journeying with stories: Letsatsi choses a life without self-mutilation

*Up till today, Letsatsi (20) is the only black woman I have met in counseling who had mutilated herself.*²⁶⁹

*Letsatsi was admitted to the hospital early in the academic year after her mother had become concerned about her depressed state of mind. Her mother did not know that Letsatsi was mutilating herself. Letsatsi did this by scratching her arms with bottle pieces against the vein, an act which was very painful but left marks almost invisible to the outsider, especially since her arms were black. Her mother also did not know that Letsatsi was overeating and throwing up.*²⁷⁰ *Letsatsi was staying with her mother after her parents had divorced. While they were still married, she often saw her father beating her mother.*

We externalised Letsatsi's problem as Bad Self-Esteem. An identity of failure was holding her captive. Letsatsi belonged to a local church which upheld a strict apartheid between men and women. Men and women were even seated separately in church. Letsatsi thought that God and the church were not happy with her. The latter spoke badly of her and said that she was too bossy, too honest.

Not only has she failed the church, Letsatsi also felt that she had failed her parents. She has failed her first year at the technicon, studying electronics. Lately she has not attended classes because of her depression. She was without energy and slept all day.

A counseling session was set up with her parents, but this turned out to be painful. Her father experienced the session to be an accusation against him, and allowed only one solution to the problem: Letsatsi must pull herself together and study in order to have a future. She must scale down on her friends, as well as her music and church activities.

that, parting from the foundationalist concerns of (postcolonial) identity “does not necessarily guarantee safe recourse to the obvious opposite: antiessentialism, namely, that culture is not homogeneous, that identity is not fixed, that religion is not essential, and so on.” This is a relevant warning and describes the challenge of the therapeutic process to be described in this section.

²⁶⁹ During the same time, I have engaged in counseling with three white women who mutilated themselves by cutting across their lower arms. Two of them were 19 years old; the other one was 40 years of age.

²⁷⁰ Again, I have not encountered other black women with eating disorders, only white teenage girls.

Letsatsi's preferred identity, then, seemed to be in conflict with the fixed identities forced upon her. A fixed church identity wanted her not to take leadership in church. A fixed age identity expected from her to achieve as child and to centre her activities around a financially viable career. A fixed gender identity convinced her that only girls with slim bodies were socially acceptable.

Letsatsi attended further counseling sessions bringing her friend, Charmaine, along. Charmaine assisted Letsatsi in venturing towards preferred identities. Charmaine appreciated Letsatsi's fun side, and took the bottle pieces from Letsatsi whenever she wanted to scratch herself.

Letsatsi preferred an identity which was different from that of her father. She wanted to invest in good relationships with people, and to communicate well with them, especially with children. She preferred to internalise softness, tenderness and selflessness as characteristics of a good daughter and a good Christian. She despised pride. She also wanted to be a fun person, and with the help of Charmaine she discovered how well she was able to communicate fun. She decided to use this characteristic, and this identity, to communicate fun at church as well.

By finding her preferred identity, the depression and urge to self-mutilate lifted.

Religious identity versus church identity

In an article on "Zionists, Aladura and Roho: African Instituted Churches", Afe Adogame and Lizo Jafta²⁷¹ describe the core of the "church identity" of the African Instituted/Independent Churches (AICs) as follows:

- The AICs hold tenaciously to the Bible as the source of all their knowledge.
- Angels occupy a conspicuous place as mediators and intermediaries between the human and the supersensible world.²⁷²
- Prayer forms the core of their spirituality.

²⁷¹ Afe Adogame & Lizo Jafta, "Zionists, Aladura and Roho: African Instituted Churches", in Ogbu U Kalu (ed), *African Christianity: An African Story* (Pretoria: Department of Church History, University of Pretoria, 2005), pp 309-329. Summarised verbatim here.

²⁷² *Ibid*, p 321.

- Belief in spiritual agency remains a cornerstone of the AICs' worldview, a worldview that incorporates both this-worldly and other-worldly orientations.
- Special emphasis and attention is placed on spiritual healing, prophecy, visions and dreams, trance, exorcism.
- Dietary prescriptions and prohibitions are similar in most of the AICs.²⁷³
- The AICs offer a celebrative religion and engage a prodigious use of ritual symbols. Music, drumming, dancing characterize liturgical systems. The appropriation of spiritual songs, hymns and sacred language as a revelatory medium is central to the ethos and rhetoric of the AICs.
- The use of concrete objects occupies a very fundamental place in their cosmology and praxis. Some of the ritual objects which are prominent in the ritual life of the AICs include consecrated water, candles, perfumes, incense, palm fronds, hand bells, staffs, spears and consecrated oil. Others are girdles, crosses, sacred numerology, invocation of psalms, and the appropriation of esoteric language in prayer and hymns repertoire.²⁷⁴

This description supports the findings of this researcher on church identity which have been described earlier. Although Afe and Jafta are describing the religious worldview of the AICs, which in our study have been called "born-again churches" according to the people's own designation, it was found in counseling that a majority of patients, whether they belonged to mainline or born-again churches, sought the help of faith healers, and accepted moral prescription as a route to faith healing, that is, as a way of successfully influencing the powers of the other world to affect healing.

In counseling, then, it became clear that patients internalised fixed church identity as moral prescription: In order to get healed, one is to follow the prescriptions of the Old Testament as interpreted by the church, that is, the specific church to which the faith healer belongs or has founded; one thus communicates with the power of the other world to negotiate healing.

This chapter is concerned with discourses based on fixed church identity which conflict with the patient's preferred religious identity. Internalised religious discourses which endeavour to convince the patient population of a fixed church identity are:

²⁷³ *Ibid*, p 322.

²⁷⁴ *Ibid*, p 323.

- The only place to get healed is in Lagos with Pastor Joshua.
- My church does not allow me to use medicine when I am ill.
- I am a Hindu sometimes going to a Christian church, but none of them can console me after my child's death.
- My church says my child is a satanist because he dresses in black.
- My church only makes provision for families, and I am single.
- My church says I am evil because I am gay.
- My church regards dreams as messages of misfortune.

The conflict between fixed church identity discourses and the preferred religious identity of the patient often led to the patient feeling helpless and depressed. The effect of fixed identity discourses will, of course, be described in chapter 3. Here the exploration of dialogical spaces between fixed and fluid church identities will be described. Empowering religious discourses which allow dialogical church identities, and which were reached in counseling, are:

- I can be sure of God's love for me even though I sometimes transgress.
- With God on my side, I shall approach life with realistic plans.
- Since I feel connected to God, I do not run away from my problems any more.
- I deal respectfully with my dreams and see in them God's care for me.

Journeying with stories: Kekeletso is torn between the Bible and his pain

Kekeletso (46) visited the hospital for counseling in 2003. He worked at a well-known chain store. He belongs to a born-again church. His problem-saturated story centered around his wife being unfaithful to him and spending vast amounts of money which he cannot afford. Furthermore, he doubted whether she loved him since she has told some of his friends that she was only using him.

Looking for love, Kekeletso started an extra-marital affair in September 1999 but ended it, because the Bible says that you should have only one wife. In December 1999 he had an operation. His wife did not visit him, but was with her boyfriend. When he was discharged he assaulted the boyfriend, and later also his wife.

He felt bad about it, because he was a Christian. The Bible says you may not hit your wife. The Bible also says you must

forgive, but he finds it difficult to forgive and forget, since his wife is not mending her ways. Also, his wife does not want to have children, while he does. He wants to divorce her, but the Bible says you may not divorce your wife.

Kekeletso was torn between his church's interpretation of the Bible, and his own needs. In counseling, he felt that he was failing as a Christian. During counseling we explored his spiritual needs, and also the strong points of his spirituality. We found that he was a sensitive, committed, fatherly person who took his faith seriously. After we had empowered Kekeletso as a spiritual person, he was empowered to take good and moral decisions on his life. As a spiritual person, Kekeletso decided to stop the verbal and physical abuse coming from his side, and not to be provoked into it at all. We also wrote a letter to his wife inviting her to join us in counseling to discuss both the spiritual and physical sides of their relationship. She did not turn up, but Kekeletso was convinced that he could now take a spiritual decision about divorce and look for a partner who will be his spiritual equal.

Religious identity versus cultural identity

Is religion, especially missionary Christianity, opposed to culture? Or can it be mediated through culture? JNK Mugambi's academic view²⁷⁵ is that "Christianity is not a culture, but the Christian faith can be expressed and communicated only through cultural media".²⁷⁶ Yet, many patients found their preferred religious identity in conflict with the fixed cultural identity with which they have been born.

Internalised religious discourses convincing the patient population of a fixed cultural identity are:

- Being a Christian makes it okay for me to marry without *lobola*, but my culture demands it.
- My church and my culture say that, because I was raped, I am a bad woman.

²⁷⁵ JNK Mugambi, "Christianity and the African cultural heritage", in Ogbu U Kalu (ed), *African Christianity: An African story* (Pretoria: Department of Church History, University of Pretoria, 2005), pp 516-542.

²⁷⁶ *Ibid*, p 516.

- My church and my culture say that I have to remain in the house for a year after my husband's death.
- My husband has convinced the pastor that I am a witch; but he wants me out of the house to bring his girlfriend in.
- The sangoma has placed a curse on me so that my husband will not love me any more.

Alternative religious discourses which allow dialogical cultural identities, and which have been explored during counseling, are:

- Culture cannot allow a man to rape; God wants us to respect each other's bodies.
- God allows me to mourn my husband's death in other ways than to abuse myself.
- I am not a witch; I am a Christian.
- The Bible is stronger than a curse.

Journeying with stories: Puleng sleeps with the Bible

Puleng (43) has three children. She suffered her first blackout in October 2002 when she finally could not pay the children's school fees and they were told that their reports would be held back. She then went to cash loans, but it only made her financial situation worse. In March 2003 she suffered her second blackout, and a third one in June 2003, just before she came for counseling.

Part of her financial dilemma was her husband not supporting the children. He had a girlfriend, and the two of them wanted Puleng out of the house. Puleng was convinced that the girlfriend had paid a sangoma to put a spell on Puleng to make her go away, and to make her husband think she was useless.

Puleng considered going to a sangoma to put a spell on the girlfriend which was stronger than the one put on her. Whether she indeed did this, is unknown to this researcher. However, Puleng was also a member of a missionary church. During counseling we talked about the power Puleng derives from praying and sleeping with the Bible to protect her against curses. We also spoke about her worth as a worker and a mother, which boosted her self-esteem. Also, Puleng made plans to leave the house and escape her abusive circumstances,

and to do this in such a way that her children would not be harmed.

Puleng left the session, empowered as a spiritual person who still honoured her culture.

Religious identity versus financial identity

In poverty-stricken township circumstances, people look at their church for financial relief. Churches in Atteridgeville which draw the most members, are churches that clothe themselves in a prosperity clause, whether written or oral. However, churches' prosperity talk often clashes with the reality of the patient's poverty.

Religious discourses convincing the patient population of a fixed financial identity are:

- Why did God allow my husband to leave me with four children and no money?
- I paid the pastor to pray for me to get a job, but things are just going worse.
- My church guarantees jobs for all.
- My church says a pre-nuptial contract is unchristian.
- I must praise God even when I do not have food.
- When I do not have food, I read the Bible.
- I cannot leave my boyfriend; I am financially dependent on him.

Almost all, if not all, patients report financial difficulties as one of the main reasons for their depressed state of mind. This is, of course, a problem which cannot be dealt with only by shifting discourses. Often, patients are simply too hungry to counsel. This researcher, then, has started on a limited basis with a feeding scheme that provides dried beans and canned meat to desperately poor families. However, shifting discourses has a healing effect, also on the hungry.

Alternative religious discourses which allow dialogical financial identities, and which were explored during counseling, are:

- I shall work as hard as I can while I wait for God's answer.
- God is powerful, but not a Quick Fixer.
- I must go on with my life; I cannot sit around and read the roof.
- I was robbed, but I have overcome bigger difficulties with the help of God.

- Although my husband has lost his job, I shall work on our relationship.
- I shall live beautifully with my poverty.
- My husband was a gambler; I prayed for him and he stopped.
- I am a survivor; I shall not be the victim of finances.

Journeying with stories: Palesa survives financial traumas

Palesa is 29 years old. All of those years have been regulated by financial discourses. When she was seven, her mother died, leaving her in the care of a stepfather, a stepgrandmother, and later also a stepmother. Her stepgrandmother took Palesa's school money, and she was forced to leave school in Standard 1 (Grade 3). When she was eleven years old, her stepfather tried to rape her. She ran away but had to go back because she had no money. Her stepmother beat her badly when Palesa told her about the attempted rape. She lost so much blood, that she was taken to hospital. Actually she only found out that her stepfather was not her real father when he died the next year and his family chased her away. Her stepmother accused Palesa of killing her (step)father with muti, and said that Palesa was not entitled to anything he owned. Having nowhere to go, and nobody to care for her, Palesa became a streetkid.

When she was 14 years old, her brother whom she loved dearly died. She was very sad, also because she experienced great financial difficulty in arranging a funeral for him. When she was 16, she started working for a white family as a domestic worker, but they left for Cape Town. They wanted her to go with them, but she was scared because she did not know where Cape Town was. The next year she started working for a black family. The husband wanted to have sex with her. She said no. First the wife started acting funny towards her, and then she was chased away by them both. She was 18 when she came to Pretoria (Atteridgeville) where she worked as a rep for "expensive things" such as pots and dinner sets. She saved enough money to buy a plot near Polokwane where she was born. However, she gave money to her sister for a house, but the sister gave the money to the church. Palesa was sad and hurt that her sister had cheated her in this way.

During this time, she also had a boyfriend, and opened a few accounts for him. She was 20 when she fell pregnant with

this boyfriend. She lost her job, her boyfriend and what was left of her family. She moved into a women's shelter in Pretoria with a small baby. The baby was very weak, and after three months in hospital the baby was placed in foster-care. Another four months later Palesa found a job at a chain store, but it was closed down the same year. The next year saw Palesa, who then was 26 years old, finding a three days per week job at another chain store, where she was still working when she was admitted to hospital in February 2003 after a suicide attempt. At the time she was living in a garage with a new boyfriend and her baby who was returned to her. The three of them were living on R300 per month.

During therapy we discussed the influence of financial stress on Palesa's life, which was huge enough to convince her to take her life. We also discussed the ability of religious belief to make this influence smaller. Looking back at her life, Palesa became aware of how often in the past she has survived financial distress. Being hospitalised as a "para-suicide" she now renamed herself as a "survivor". Palesa explored the role of belief in her being a survivor of financial difficulties, and in giving her hope for the future. Palesa discovered that her preferred religious identity was to attend a church which would assist her in her quest for financial survival, and not one which took large sums of her livelihood in return for religious promises of financial security.

Religious identity versus gender identity

Internalised religious discourses convincing the patient population of a fixed gender identity are:

- Fixed female identities (women given identities by men)
- A true Muslim's wife may not work.
- A true Christian wife may not deny her husband.
- God and the pastor don't like women like me who are assertive and sexy.
- My husband brings his girlfriend home, but is jealous of me and warns me from the Bible.
- I stood by my husband when he was on drugs, but he rejected me after I was raped by a gang of black men.

- My husband is verbally abusing me. I cannot speak to the bishop because my husband is a priest.
- When my husband and I were hijacked and everything stolen from our house, my husband said I have bewitched him.
- Fixed male identities (men voicing women)
- A woman I hardly knew seduced me to have sex with her; later she asked for money for an abortion because she said I made her pregnant; when I gave her the money she made a case of bribery against me. She said I bribed her to remain silent about her pregnancy.
- My girlfriend has left me for a Nigerian who has more money.
- Fixed male identities (men voicing men)
- God has made me a man. My extra-marital affairs are between me and God.
- I am not a worthy man. A real man must (1) have a house where he is the boss, (2) be the breadwinner, and (3) have a healthy body.

In the above, we hear the voices of men only: men giving women identity, women assuming these identities, and men voicing the fixed identities of manhood.

In counseling, then, the challenge was to empower women to voice their own identities. However, the aim was not to establish a new (feminist) essentialism. Feminist essentialism, as defined by Feminist Standpoint Theory, would replace a discourse such as “My husband loves me when I please him” with “I am a strong, independent woman who does not need a man to complement me”.

The challenge of narrative counseling here is to explore the dialogical spaces between

- male and female moral identity, and
- gender essentialism (whether patriarchal or feminist) on the one hand, and the total negation of a person’s relationality on the other.

The challenge, in short, is to explore *self-in-relations*. And that goes for both women *and* men in counseling, and especially for couples.

“Self-in-relations” is a concept used by Elisabeth J Porter in her book *Women and moral identity*.²⁷⁷ Three further insights of Porter are important for this study in the narrative exploration of (moral) identity:

- The self should not be voiced *in opposition to others*, but *in relation to others*. “In standard moral philosophy, the moral self is viewed as a disembedded and disembodied being. The tension is between universal selves and particular individuals. Feminist moral theory, on the other hand, views the self as closely entwined with significant others and thus emphasises the domain of particular others in relations with one another.”²⁷⁸
- Moral identity is self-dignity. It “should ensure that one is not the instrument of another’s will”.²⁷⁹ Yet, moral identity is an identity in “dialogue to determine shared values, common purposes and the conditions whereby human potential might be realised.”²⁸⁰
- A narrative approach to moral identity has two inseparable components:
 - I am the subject of a history, and
 - I am part of others’ stories.

“Moral identity is built on the basis of recognising the mutual dignity of self-reflective others.”²⁸¹

Alternative religious discourses which allow dialogical gender identities as moral identities, and which were explored in counseling, are:

- Women revoicing themselves-in-relations
- I shall pray to God to give me the strength to tell my husband I love him, but he must stop abusing me.
- I shall pray to God to give me the power to fight the satan of pain which my husband gives me.
- God wants me to feel good about myself although I am not good enough for my mother and my husband.
- I put myself down because I am a woman, but God has a purpose with me.

²⁷⁷ Elisabeth J Porter, *Women and moral identity* (Sydney, Australia: Allen & Unwin, 1991), p 196.

²⁷⁸ *Ibid*, p 13.

²⁷⁹ *Ibid*, p 17.

²⁸⁰ *Ibid*, p 196.

²⁸¹ *Ibid*, p 20.

- Being a caring mother and wife will convince my husband to buy food and not beer.
- When my husband verbally abuses me, I speak back in positive words.
- I shall undermine my own loneliness, rather than to enter into another abusive relationship.
- Although my husband is impotent, I stay with him because I married for love, not sex.
- Sometimes I swallow (= keep my mouth shut), sometimes I speak up.
- My husband has had an affair for the past 18 years; I shall not allow his dishonesty to steal my happiness.

- Men revoicing themselves-in-relations

- God has given me love and life; I shall not spoil it again.
- I shall call the whole family together to help me and my wife solve our problems.
- When I want to beat my wife, I shall ask God to take control.
- I'll bring my wife for counseling, so that we can both stop our extra-marital affairs.
- I shall call my wife to hear if she wants to share my blanket again.

Journeying with stories: Kananelo and Disebo struggle with gender roles

It is difficult to summarise a counseling relationship which has been stretching over many years now, since 24 April 2002, and during the first three years alone encompasses more than 50 formal counseling sessions.

Disebo and I had our first counseling session in Ward 2B after her fifth suicide attempt. She asked me to write down a prayer for her. She thanked God that she survived the suicide and asked God to help her to use this as a chance to become the person she wanted to be. She wanted to be a "happy, independent lady, of worth to somebody, a mother one day, with a good job, and trusted by her father." Kananelo, her boyfriend, was visiting her regularly. He, too, had five para-suicides behind him, and more were to come. Disebo was 26 years old at the time, and Kananelo 30 years of age.

They were both experiencing a variety of problems. Over the course of time this evolved as the problem which exercised the largest influence on their lives: they were unable to enter into a permanent relationship because both were unemployed.

This problem was enlarged by the fact that their parents did not support the relationship. Also, Kananelo was drinking heavily, especially on “after tears parties”, that is, parties held after funerals, where drinking was free. Also, because they were not sure of their future together, the couple suffered from a total lack of trust, the one often suspecting the other of having an affair, which in turn led to the “deserted” partner attempting suicide. Eventually Disebo fell pregnant. This brought the couple closely together. However, Disebo suffered a miscarriage after four months. Disebo, who belonged to a born-again church, tried to cope with this by praying, but it was a prayer of resistance and disappointment: “God, you walked with me for four months. Now you’ve left me. Do you have a purpose with this?” However, Kananelo suspected that Disebo had an abortion, and that she did not want to marry him, but become an independent woman. After this the couple broke up – and reunited several times. At one stage Disebo obtained a protection order against Kananelo for harrasing her, but it was withdrawn. For years the relationship, which Kananelo once said he wished could remain “evergreen”, experienced numerous winters followed by spring.

In a letter to Disebo, Kananelo “diagnosed” himself as a failure (a “failer”). He could not make Disebo happy. He could not get a job. He could not say no to the beer.

Disebo, on the other hand, was torn between her family’s expectations of a future husband, and Kananelo.

Both being very religious, Disebo and Kananelo have very traditional views of one another. Disebo wants Kananelo to be successful and the breadwinner. Kananelo wants her to be the mother of his children.

Yet, while the couple have traditional views of one another, they do not have traditional views of themselves. In counseling, Disebo expressed her preferred identity as that of an independent “lady” with her own job, yet one who is also a mother and a loving partner. Disebo has, indeed, explored the dialogical spaces inbetween dependent motherhood and full independence. Her preferred identity was, indeed, that of a “self-in-relations”.

Recently, after having finished her training, Disebo has found a job in a small computer company and eventually became one of the directors. In this capacity she met a teacher

with whom she fell in love. The relationship flourished. However, after she became a director, the teacher suddenly stopped contacting her. "I think he is threatened by my success", Disebo said. She then decided to go back to Kananelo, who has learned to love her in spite of the untraditional gender role she fulfills.

This, as Disebo herself put it, was when the breakdown in her relationship with Kananelo became a breakthrough. She realised that the gender stereotyping which was always hindering the relationship, has now become its strong point: Kananelo was less sexist than other men, and it was their relationship which has made him so.

Kananelo, too, has discovered during counseling that he succeeds in an "inbetween view" of Disebo. He has started to work for a bank, and hopes that business will pick up. He has learned to listen to the voice of his love for Disebo, and not to the voice telling him that a woman director may be a threat to his manhood.

Religious identity versus age identity

More than a third of the research population are under 25 years of age, and can be called "adolescent".²⁸² It is especially high school children who frequent the counseling service of the hospital's outpatients, since no counseling is available in township schools. Although "age identity" should ideally be dealt with in this section across the life course, special attention is given here to adolescents because they constitute a large part of the research population, and exploring the healing significance of religious identities within this group is a greater challenge than at any other age.

Jenny Hockey and Allison James, in their book *Social identities across the life course*,²⁸³ provide three insights which are valuable in the narrative description of the faces of the discourses which keep adolescents captive. These insights are:

²⁸² Friedrich L Schweitzer (in *The postmodern Life cycle: Challenges for church and theology*, St Louis, Missouri: Chalice Press, 2004, p 55) reminds us that "(a)dolescence is no longer a well-defined period of transition with the task of preparing people for adulthood. Rather, adolescence has become a period of life in its own right. It has extended toward childhood and toward adulthood, thus turning into a protracted span of ten, fifteen, or even twenty years."

²⁸³ Jenny Hockey & Allison James, *Social identities across the life course* (London: Palgrave Macmillan, 2003).

- *'Age' is a discourse*, one which can impact prescriptively and harmfully on adolescent behavior : “(I)n popular representations of the life course, the passing of time is rendered orderly through a series of age-based identities which, it is implied, each individual will naturally take on.”²⁸⁴
- *Age identity is embodied:*, that is, the body of the adolescent is both objective (flesh), socially constructed and contextualised.²⁸⁵
- *Age identity is viewed in terms of dualisms*, that is, “(d)iscussions of identity have been limited by working within a set of binary oppositions which can be summarised as follows:
 - agency versus structure
 - individual identity versus social identity
 - the individual versus the collectivity
 - group versus category
 - self versus other
 - internal classification versus external classification
 - virtual identity versus nominal identity
 - change versus continuity”²⁸⁶

The adolescent contingent of the research population for this study, indeed, reported that the discourses governing their lives were harmfully prescriptive, socially constructed and dualistic:

- Prescriptive discourses
 - My mother told me to pretend to be stupid in order to get a Christian husband.
 - My church tells me not to drink, have sex or smoke, and yet I am not happy.
 - My mother has chased me out of the house; she says I drink too much, my friends are too loud, and I have too many girlfriends.
 - God, my father and the church are not pleased with me.
- Embodied discourses
 - Why did God allow my father to rape me as a child?

²⁸⁴ *Ibid*, p 82.

²⁸⁵ *Ibid*, p 125.

²⁸⁶ *Ibid*, p 12.

- I must have a child before I am twenty; if I die without children, I shall not be buried.
 - At a youth camp I was told that I shall go to hell if I practice my homosexuality.
 - I have problems in communicating with girls.
 - My mother is a soldier and away a lot, my father is absent.
 - My mother compares me to other children and shouts at me.
 - My boyfriend is selfish and abusive, but he is all there is.
 - I have seen family members being murdered right before my eyes.
 - After I failed my grade, I started hearing voices telling me my parents and the pastor are wrong about me.
- Dualistic discourses
 - My parents expect me to be a good child, but they assault each other and rape me – and then go to church.
 - My boyfriend left me after he made me pregnant, but he is still a youth leader in the church.
 - My mother thinks it is her right to physically, verbally and emotionally abuse me. She is an elder in the church.
 - My family makes me feel useless.
 - I am HIV positive after I was raped by my uncle, who is a bishop.
 - I want to go to school, but we do not even have enough food to eat.

In *The postmodern life cycle: Challenges for church and theology*, Friedrich Schweitzer²⁸⁷ describes aspects of the preferred religious identities of adolescents. These are

- an expression of faith which is their own faith, and which is different from the faith of the church
- a separation between personal religion or spirituality on the one hand, and the church as an institution on the other
- a lasting interest in God

Exploring the dialogical spaces between a fixed age identity for adolescents on the one hand, and their preferred religious identity on the other, Schweitzer points out that, for adolescents too, “there can be no fixed identities under the conditions of postmodern life”.²⁸⁸ Schweitzer finds that the

²⁸⁷ Friedrich L. Schweitzer, *The postmodern life cycle: Challenges for church and theology* (St. Louis, Missouri: Chalice Press, 2004), pp 49-58.

²⁸⁸ *Ibid*, p 51.

plural self and plural identities are of theological significance in the following ways:

- Plural identities acknowledge that the human person is always more than what the person does and achieves – the person is and remains God’s creature.
- Plural identities point to the relational character of the self: “The relational character of self and identity obviously contradicts all individualistic views of human existence... which is central to the Christian understanding.”
- Plural identities are a sign of God’s liberation: “the experience of the plural self may be understood in relationship to God’s liberation influence on human life, which frees the human person from the restrictions of having to conform to a narrowly defined individualistic identity.”

Empowering religious discourses which allow dialogical age identities are:

- I am not too young to learn what healthy religion is.
- I have the right to look for excitement in the church.
- A child has a sacred right to safety, also from being raped by family members.
- I’d like to make a tape of gospel music so that other teenagers can share in my experiences of not being good enough for my family.
- I have been sexually abused as a child, but I also have other identities.

Journeying with stories: Is Moses bewitched or dumb?

Moses was 22 years old when he came for counseling. He spoke Afrikaans and was dressed in Muslim attire. His mother brought him to the hospital, because he was suffering from frequent spells of dizziness.

Previously, Moses has been to a traditional healer who told him that he was too emotional and oversensitive (“Ek praat te veel met my hart”). That was what made him feel dizzy, the traditional healer said.

Moses had also been to a Christian priest who drove the devil of dizziness out.

Moses then went to another Christian priest who told him he was bewitched (“getoor”). This priest baptised Moses. Moses has not told his Imam about that. In spite of his Muslim

dress, Moses said that he belonged to the Old Apostolic Church.

However, Moses was still feeling dizzy. Eventually his mother brought him to the hospital, but the doctors could not find any physical reason for his dizziness.

Moses, then, was referred for counseling.

Things were troubling Moses. One was that his family often told him that he was stupid (“dom”). They let him work in a shop, lifting and shifting boxes. Moses felt that if he could get his driver’s licence, he could work on deliveries which would be much more exciting. Also troubling him, was his girlfriend. Actually, he thought that girls did not like him very much. That troubled him.

We did not externalise Moses’s dizziness, but the low estimation people have of him. The identity given to him by adults at home and in the church/mosque was that of a dumb boy who could not do a decent job or start a family on his own.

In counseling, then, we explored Moses’s other identities. It took some time and effort for Moses to say nice things about himself. His given identity, that of incompetency, had taken over his life. However, eventually Moses started to identify himself differently. He was a caring person, a good boyfriend, a good worker who was trusted at the shop, and somebody who was able to make good plans for the future.

While his previous identity convinced Moses that he was a child who was unable to grow up, his self-defined identities empowered him to take on adulthood – from his own perspective. After three sessions, Moses felt strong enough to take on life on his own.

Otherness discourses show their faces

Paul Griffiths²⁸⁹ has reminded us that “religion” as a separate entity (in the Western world) can be traced back to the sixteenth century when Christianity was split into different “religions”, a split which was of political significance. This initiated the eventual separation of church and state, culminating in the “secular” state, that is, the state that was governed by principles different from that of “religion”.

²⁸⁹ Paul Griffiths, “Introduction”, in Charles Taliaferro & Paul J Griffiths (eds), *Philosophy of Religion: An anthology* (Oxford: Blackwell, 2003), p 3.

Aylward Shorter and Edwin Onyancha, too, remind us that secularism (in its Western form) is creeping upon Africa through globalisation, the power of the mass media, and the rapidity of urbanisation.²⁹⁰ Secularism, according to their definition, “refers to a situation in which religious faith, for one reason or another, is felt to be superfluous.”²⁹¹

What, then, is the nature of religious identity in peri-urban areas such as Atteridgeville? Has secularism stolen the people’s yearning for otherness?

Each patient from the research population under discussion confessed their committed affiliation to a religious institution, such as a church, mosque, or temple.²⁹² There were six patients only (from 270) who said that they were “not attending church any more”, and they were from the surrounding “white” suburbs. An overwhelming majority of the research population, then, seems to be closely attached to the supernatural and to merge their identity into the otherness offered by religion.

By “otherness discourses”, then, are meant the accounts according to which the religious community has authored the life stories of believers to make room for the supernatural nature of religion. It is the experience of this researcher that the otherness discourses which author the lives of the research population, centre around two themes which will consequently be discussed:

- The otherness of religion can heal my body and spirit.
- The otherness of religion secures life after death.

Suffering versus healing

The research population consists (mainly) of patients who visit the out-patients’ clinic at Kalafong Hospital, as indicated in the first chapter. They are not hospitalised, except for those who have attempted suicide. Those patients who are referred for counseling, usually are people who are not physically ill, or rather, the doctors have been unable to detect a somatic cause for their illness, and for that reason have advised them to go for counseling.

The only somatic “illness” from which patients who come for counseling suffer, is HIV and Aids. These patients are usually referred to the Immunology Clinic which offers its own counseling, which is known for its standards of excellency. However, almost every patient who comes to this

²⁹⁰ Aylward Shorter & Edwin Onyancha, *Secularism in Africa. A case study: Nairobi City* (Nairobi, Kenya: Paulines Publications Africa, 1997), p 5.

²⁹¹ *Ibid*, p 14.

²⁹² There are 8 Muslims and 1 Hindu in the group; the rest are Christians.

researcher for counseling, is affected by HIV and Aids in one way or the other.

It is in respect of HIV and Aids that religious discourses on supernatural healing emerge during counseling.²⁹³ These discourses on the “otherness” of religion are:²⁹⁴

- I am a leper now; only Jesus can save me.
- My church claims that it is HIV free.
- I am part of God’s plan to reduce the number of people of earth so that there can be a fresh beginning, as was the case with Noah.
- If you wear traditional clothes, you will be cured of HIV because God loves the African Renaissance.
- I shall not take the HIV test; I have already lost my baby; what more does God want to do to me?
- If I cannot hear the blood in my legs, has God sent me HIV?
- I fear my husband has HIV, but I must sleep with him; my body belongs to him; it is God’s will.
- Women are the carriers of HIV, because God loathes women’s sexuality.
- If a man rapes a woman and gets caught, but it is found out that the woman was HIV-positive, it should serve as a mitigating factor in court.
- God is punishing me; God is disciplining me.
- God has abandoned me; God has let me down.
- God will heal me if my faith is strong enough and if I serve him well.

Alternative religious discourses of hope for those affected and infected by HIV, and which were explored during counseling, are:²⁹⁵

²⁹³ During interviews with church leaders in Atteridgeville, there was only one church which claimed that it could cure HIV/Aids. However, there are churches that claim that you would stay HIV free if you joined their church. This situation has changed in that there are more churches now that claim that they cannot cure Aids, but that they can indeed cure one from the HI-virus. This was revealed during a meeting of the Circle of Pastoral Workers at Kalafong Hospital on 6 April 2005.

²⁹⁴ See also Christina Landman, “Spiritual care-giving to women affected by HIV/Aids” in Isabel A Phiri ea (eds), *African women, HIV/AIDS and Faith Communities* (Pietermaritzburg: Cluster Publications, 2003), pp 189-208.

²⁹⁵ See also Christina Landman, “The Bible as a source of healing for women affected by HIV/Aids”, in Mercy Amba Oduyoye & Elizabeth Amoah (eds), *People of faith and the challenge of HIV/AIDS* (Ibadan: Sefer, 2004), pp 267-300.

- I'll celebrate life every day that I am alive
- God gives you the choice to be happy
- Death is God saying, come home.
- Since I have told my mother I was HIV positive, we grew closer.
- I am going to live beautifully with Aids.
- I am not asking God, why me; I ask God for power.
- The Bible tells stories of God caring about people's sickness.
- The Bible teaches me not to give up hope; it shows me the faces of people who have hoped and were better off because of the hope.

Journeying with stories: Cindy becomes a healer

Cindy is a coloured woman who is 40 year of age. She was diagnosed with the HI-virus ten years ago. She is not taking any anti-retrovirals. Twenty years ago, she was diagnosed with bipolar disorder. After she was head girl of her school, in her second year as a university music student, she started suffering severe episodes of depression and mania. The bipolar disorder introduced years of incapability to finish her studies and to keep a job. She eventually finished her B Mus degree, but was unable to keep a job for more than three weeks at a time, except for that of organist at the local church where she still earns a small honorarium. Also introduced into her life was what eventually became her biggest enemy: loneliness. That was why, when she was 32, she went on a date hoping to get pregnant, but came back HIV-positive.

Cindy has survived all her diagnoses through her spirituality, which took on a variety of forms, but eventually grew and shifted. Just after she was diagnosed with HIV, Cindy felt that she was chosen by God to die. God was reducing the number of people on earth drastically so that those left can start afresh. She was part of this plan of God.

About five years ago Cindy's family raised money for her to go to Lagos, to the Prophet Joshua. She believed that he would cure her of the HI-virus as well as of the bipolar disorder. When she was there, she stopped drinking her medicine for the latter. When she came back, she was admitted to Weskoppies Psychiatric Hospital where she stayed for six months. She believed that she was Jesus, and that she was expecting twins.

Cindy has now stabilised and is travelling the spiritual road with even more conviction than before. She often speaks to God

about the "Virus". Sometimes she tells God that she is angry with Him, and blames Him for the Virus. At other times she thanks God for sending her the Virus, because it protects her against relationships which will harm her, and has forced her into abstinence. She still feels she is part of God's plan, but also part of God's healing. "God wipes away a tear a day", she says. It remains a continuous struggle, however, to live with the Virus. You cannot escape it. When you put on the television, all you see is "n snotkop minister wat kak praat oor HIV" (a stupid pastor who talks rubbish about HIV), opening up the wound again. No, you cannot escape it. You can smell it in the air, you can touch it, it touches you, she says. To find meaning in all of this can only happen when you take Jesus' hand and say: the boat is sinking, help me to keep swimming.

In counseling as well as in the process of self-healing, Cindy has discovered something very important about herself: she too is a healer. When and where she touches people, their pain seems to go away. Cindy now is visiting people and easing their pain, presenting herself as a compassionate person who is not afraid to touch the sick.

Grief versus consolation

Of the research population of 270 patients, 91 reported that they have suffered the recent loss of a mother/father, son/daughter or brother/sister. This is more than a third of the research population. Loss through death includes:

- a husband who died of natural causes (9)
- a husband who was shot (2)
- a son who was murdered (4)
- a child who died in a car accident (3)
- a son who was shot for some reason (7)
- a child who committed suicide (3)
- a child who died of Aids (8)
- a child who died of natural causes (18)
- a brother/sister who died of natural causes (6)
- a sister who died in a car crash (1)
- a sister who was shot (2)
- a brother who was murdered (2)
- a baby who was still-born (2)
- a baby who died soon after birth (13)

- a mother who committed suicide (1)
- a mother who died of Aids (2)
- a mother who died of natural causes (10)
- a mother who was bitten to death by a dog (1)
- a mother who died in a car accident (1)

People who suffer losses like these look at religion for consolation. Religion, as an otherness discourse, is

- to provide them with meaning in the light of the meaningless death of a loved one
- to guide them towards appropriate means and time of mourning
- to give them hope for this and the afterlife
- to ease their guilt about the death.

However, often religion as otherness discourse contributes to the emotional pain of the patient. Grief discourses which keep the patient population captive, are

- I was told to stop mourning my son after the tombstone had been erected on his grave.
- Jesus can raise my son from the dead.
- Is my son who committed suicide in heaven?
- My deceased child calls me in a dream every night; I must be guilty of her death.
- When my baby died, the priest said: "It was time".
- When my wife died, the *sangoma* said it was jealousy because she had a job.
- My son was killed with a cork opener because of jealousy.
- I was shocked in God when my mother died and we lost her pension.
- The pastor said I shall not find peace after my husband's death before I have given money to the church.
- God took away my baby.

In exploring the dialogical spaces between the insistence of church and family to take leave of the beloved one on the one hand, and the bereaved's anger towards God on the other, Michael White's suggestion of "Saying hullo again"²⁹⁶ proved to be especially useful. By saying hello and not good-bye to the lost one, the bereaved repositions him- or herself vis-a-vis the lost

²⁹⁶ Michael White, "Saying hullo again: the incorporation of the lost relationship in the resolution of grief", in *Dulwich Centre Newsletter*, Summer 1988.

relationship, empowering him- or herself to perpetuate the gains of the relationship in the future. This practice of empowerment has been repeated from a psychoanalytic perspective by Shira Ruskay whose position is abstracted as follows: "It is generally accepted that the successful resolution of grief work is to say goodbye to the deceased. Yet, many bereaved individuals resist this therapeutic agenda, reluctant to relinquish the love object. By examining the aspects of the relationship that bereaved individuals are reluctant to forfeit, grief work can become an opportunity for them to incorporate their lost relationships in the present and future."²⁹⁷

Alternative discourses which liberate and console the patient population, and explore a repositioning of "hello" towards both God and the object of bereavement, are

- My deceased child is with God now, but I shall also keep his memory alive.
- I shall take sand from my child's grave, put it in a bowl and plant a flower in it to remember her.
- After my husband's death, God sent me friends who do not make me angry.
- I have closure on mourning my child, but I shall keep him alive in my memories.
- The death of a baby is always a tragedy; but God will give me the power to stand up again.
- I am not angry at God because my husband died; God is my only source of strength.
- I shall kick sadness out of my life, as I kick my opponent in karate.
- I miss my baby, but I cherish the memories of taking care of her. God has made me a caretaker.
- When my son died of Aids, God wanted me to go on with my life and not sit and read the roof.

Journeying with stories: Tumelo gets closure

Tumelo has attempted suicide after years of desperation about a lack of a roof over her head. During counseling she revealed that a house has now been assigned to her by government, and that she would have a house in a few months' time. During

²⁹⁷ Shira Ruskay, "Saying hello again: A new approach to bereavement counseling", in *Hospice Journal* 11.4(1996), pp 5-14.

counseling, she also mentioned that her son had died during the week.

Tumelo experienced grief because of the death of her son, but also displayed remarkable consolation. Tumelo mentioned that she belonged to a church which followed this practice when somebody died: the person is buried on Saturday, and on Sunday the prophet gets word from God whether the deceased has gone to heaven or to hell.

The first reaction of this researcher was one of shock. I was appalled at this practice and the power exercised by the prophet. I was worried about the mental effect it would have on Tumelo. However, it soon became clear that Tumelo experienced this practice as consoling and a way of closure.

When she attended another counseling session, Tumelo reported that her son was in heaven. She experienced closure and was looking forward to her new house. During counseling, then, the practice which gave Tumelo consolation and closure was supported, rather than undermined as the counselor's first reaction was. Tumelo experienced mental joy because of that.

Summary

In this chapter I have explored and described the faces of religious discourses as they have been revealed by the research population. I have described these discourses as power discourses, body discourses, identity discourses and otherness discourses. I have looked at the faces both of the discourses which keep the research population captive, and the faces of the deconstructed discourses which keep them going.

In chapter one I have described narrative therapy in terms of the MEET process, that is, as a fourfold process of **mapping** the patient's problem-saturated history, externalising his/her problem, empowering him/her by means of skills they already have, thus guiding him/her towards telling an alternative story. In this chapter, I have engaged in the first step of the MEET process, that is, in mapping the patient's problem story. I have done this by describing the faces of religious discourses as they have been shared by patients.

I have also ventured into further phases of the MEET process, externalising problems and deconstructing harmful religious discourses. However, the emphasis was on mapping the faces of religious discourses as they present themselves in the life stories of patients.

In the next chapter I shall focus on the second phase of the MEET process and externalise the problems experienced by patients. Furthermore, I shall look at ways in which these problems have been minimised during counseling.

Chapter 3

The effects of religious discourses: Externalising the problem

This chapter deals with the second phase of the MEET process, that of **externalisation**.

This chapter hopes to achieve three aims by dealing with this process of externalising the patient's problem:

- In the first place, this chapter wants to describe externalising conversations between the counselor and counselee, and to name religious discourses that hold patients captive as problem discourses.
- In the second place, the chapter hopes to describe the effects of religious discourses on the lives of patients as they have been described by the patients themselves.
- In the third place, the chapter will describe the process of evaluating the effects of religious discourses on the lives of the patients as negotiated between the counselor and counselee.

Published voices on externalisation

In one of the most recent books published on narrative counseling, *Narrative counseling: Social and linguistic processes of change*,²⁹⁸ Peter Muntigl confirms externalisation as a process that entails the following:

- separating the patient from the problem
- identifying the problem not through diagnoses or classification, but through the “indigenous knowledge” of the patient
- mapping the effects of the problem on the patient, eventually
- reformulating the patient's negative identity claims

The voices of narrative therapists on “Externalisation” will now be invited into our conversation – with reference to these four aspects.

²⁹⁸ Peter Muntigl, *Narrative counseling: Social and linguistic processes of change* (Amsterdam/Philadelphia: John Benjamins Publishing Company, 2004), pp 181-194.

Separating the patient from the problem

Michael White and David Epston in their ground-breaking work on narrative therapy,²⁹⁹ describe externalisation as “an approach to therapy that encourages persons to objectify and, at times, to personify the problems that they experience as oppressive.” Even at this early phase in the development of narrative counseling, White and Epston were able to identify the gains of externalising as

- decreasing unproductive conflict between persons over who is responsible for the problem
- undermining people’s sense of failure in the light of the problem
- paving the way for persons to cooperate with each other against the problem, and
- opening up new possibilities for persons to take action in retrieving their lives from the problem.

In summary, then, the purpose of externalisation is to “open up new possibilities for interacting with the problem without being paralyzed by the effects of self-blame and self-judgement”³⁰⁰.

Thus the first gain of externalisation has been established: Externalising the problem gives the patient the distance to regroup against the problem.

Identifying the problem, not through diagnoses or classification, but through the “indigenous knowledge” of the patient

Stephen Madigan³⁰¹ aptly points out how Michael White’s practice of externalising problems is based on Michel Foucault’s insights on

- *social control through internalised discourses*. According to Foucault, three types of discursive practices³⁰² objectify people and render them controllable through social discourses. These are

²⁹⁹ Michael White & David Epston, *Narrative means to therapeutic ends* (New York, London: WW Norton, 1990), pp 38-39.

³⁰⁰ Wally McKenzie & Gerald Monk, “Learning and teaching narrative ideas”, in Gerald Monk, John Winslade & Kathie Crochet, *Narrative therapy in practice: the archaeology of hope* (San Francisco: Jossey-Bass Publishers, 1996), p 99.

³⁰¹ Stephen P Madigan, “The application of Michel Foucault’s philosophy in the problem externalizing discourse of Michael White”, in *Journal of Family Therapy* 14 (1992), pp 265-279.

³⁰² “Discursive practices” are the practices through which discourses are formed.

- practices that divide people into classes (for example: Social and spatial dividing practices confine the poor and the insane to shacks and asylums)
- practices that classify people scientifically (for example: People are described in terms of mental disorders according to the use of DSM IV³⁰³ technology)
- practices that convince people to turn themselves into subjects (for example: Believers internalise the discourse that truth is mediated through external authority figures such as a priest or a pastor).
- local knowledge as alternative knowledge. Foucault distinguishes between
 - the “global knowledges” of the powerful, and
 - “local knowledges”, that is, alternative forms of cultural knowledge that have been silenced and disqualified by global totalitarian knowledge.

It is the latter, namely “local knowledges”, that is explored in narrative counseling to externalise problems and name them according to the indigenous knowledge of the patient. These insights, Madigan indicates, have been used by White in therapeutic contexts to

- externalise internalised problem discourses, in order to
- liberate the counter-discursive practices of a person’s local knowledge.³⁰⁴ Counter-practices of local knowledges erode “the socially produced aspects of the problem that are perpetuated by classification and totalisation techniques”.³⁰⁵

The second gain of externalising the problem, then, is that space is opened up for the patient’s indigenous knowledge to name his/her problem in a way that will, eventually, free and heal him/her beyond the pain and captivity of societal and professional labelling.

Mapping the influence of the problem on the patient

Through relative influencing questioning the counselor assists the patient to map the influence of the problem on his/her life. In a chapter “Exploring the

³⁰³ *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision (Washington DC: American Psychiatric Association, 2000).

³⁰⁴ *Ibid*, p 272.

³⁰⁵ White in Madigan, *ibid*, p 275.

effects of the problem” in her book *What is narrative therapy?*, Alice Morgan³⁰⁶ points to questions that can be asked to explore the effects of the problem on the patient’s sense of self, on his/her view of him/herself as parent, partner, worker, on his/her hopes and dreams, relationships, work, social life, thoughts, physical health, moods, etc. Mapping the effects of the problem on the patient is important, she says, for two reasons: (1) The impact of the dominant problem story in the person’s life is powerfully appreciated and acknowledged; and (2) exploring in detail the effects of the problem may lead to the discovery of unique outcomes, and allow for an alternative story to emerge.

To these gains, Morgan adds a warning that counselors should not move too quickly beyond externalisation and the exploration of the effects of the problem on the patient’s life, lest the patient feels that his/her problem situation is not taken seriously by the counselor. To this Payne and Madigan add warnings of a different kind *re* externalisation, that is, externalisation being used in a way that is too modernist or too simple:

- In a chapter “Assisting the person to describe the problem” in his book *Narrative therapy: An introduction for counselors*, Martin Payne³⁰⁷ warns that “externalizing is of limited value unless it is used within a framework of post-structuralist assumptions. The whole point of ‘externalizing conversations’ is to assist the person to break away from the concept of the problem being part of her, ‘within’ her, an aspect of ‘her’ assumed ‘fixed character’, or in any way ‘pathological’. Unless the therapist has himself broken away from these ways of thinking, externalization is pointless and even potentially damaging.”
- Madigan³⁰⁸ points to the discourses that hold patients captive as complicated and interwoven, a *community of discourse*, that influence and shape the therapist’s externalizing questions as well as the patient’s problem story. He warns that “without an acknowledgment of the politics which make up this discourse, externalizing conversations might only prove to enhance and support pathologizing descrip-

³⁰⁶ Alice Morgan, *What is narrative therapy? An easy-to-read introduction* (Adelaide, South Australia: Dulwich Centre Publications, 2000), pp 39-44.

³⁰⁷ Martin Payne, *Narrative therapy: An introduction for counsellors* (London, Thousand Oaks, New Delhi: Sage Publications, 2000), p 62.

³⁰⁸ Stephen Madigan, “The politics of identity: considering community discourse in the externalizing of internalized problem conversations”, in *Journal of Systemic Therapies* 15.1 (Spring 1996), p 48.

tions of persons – the very ideas externalizing conversations attempt to undermine”.

The challenge of externalisation, then, is to give the counselor ample time to trace, with the patient, the effects of the problem on the patient’s life, a part of the narrative journey that should not be taken lightly.

Reformulating the patient’s negative identity claims by evaluating the effects of the religious discourses on the patient’s life

Michael White³⁰⁹ describes externalising conversations as spaces in which patients are encouraged to provide an account of the effects of the problem on their view of themselves and of their relationships, that is, people are invited to tell how the problem is affecting their identity as self, as worker, as relational person, etc. Reformulating the patient’s negative identity claims is eventually done through deconstructing the problem discourses, and will be described in the next chapter. Here note is taken only of Morgan’s description³¹⁰ of how the effects of the problem are evaluated by asking the patient to consider and give an opinion of each effect. “This is important,” Morgan says, “because the therapist does not presume anything about the person’s experience of the problem... The therapist can never know what the effects of the problem mean to the person whose life they are discussing. Only the persons themselves knows this and the therapist needs to consult them in order to ensure that they understand the situation.”

An overview of externalising practices with the research population will now be given according to the fourfold distinction made by this study between religious power discourses, religious body discourses, religious identity discourses, and religious otherness discourses. The shortened stories of 40 patients are given, 10 from each type of discourse. The tenth story will be more elaborate, and will be a continuation of the “Journeying with stories” series that is followed right through this study.

³⁰⁹ Michael White, “Deconstruction and therapy”, in *Dulwich Centre Newsletter* 3 (2000) , p 29.

³¹⁰ Morgan, *op cit*, pp 42-43.

When religious discourses are externalised***Religious power discourses****Patient 1*

The patient is a 34 year old black South African woman who held a good job in government. A Nigerian man convinced her to leave her job, take a huge loan to start a computer shop, and to marry him. Soon after she opened shop, the shop was robbed. She has reason so suspect that her new husband is behind the burglary. She feels she cannot trust him any more. She now has to deal with a baby, lots of unpaid bills, and no job. Her church forbids her to divorce.

The patient has externalised “Feeling Hopeless After Getting Married” as the problem discourse regulating her life. The effects of “Hopelessness” on her life are tiredness, disinterestness in life, and sleeplessness. “Hopelessness” is strengthened by the stance of her church against divorce. The patient remembers times during which her family has taken care of her when she felt hopeless. She is considering going back to her home town to restart a new business with the help of her family, since her husband is not fulfilling the role of head of the family any more, and does not deserve to be part of her family. For this she needs the support of the faith community, that is, from both a community of care and a community of discourse, the latter supporting her to undermine power discourses that leave her hopeless.

Patient 2

The patient is a Muslim from Pakistan with four children, aged between four and eight. Her husband has another wife in Pakistan whom he visits every six months. He has forbidden the patient to work, and assaults her, claiming that this is according to Allah’s will. The patient externalised “Helplessness” as the problem holding her captive. The Imam’s refusal to help her makes Helplessness very strong. The effects of the problem on the patient are anxiety and anger. The patient is repositioning her view of Allah. Allah is not necessarily on the side of her husband, or on the side of the Imam. Allah may be approached to resolve the situation to the benefit of everybody.

Patient 3

The patient (33) is a Muslim from Pakistan with two children aged nine and thirteen. Her husband does not allow her to work. She has been married twice

before. Both her husbands died. She has now been married a third time, and after 3 months wants to leave her husband. He is obsessive and jealous. She has left him with the children to go and stay with her parents, but he came to fetch them, threatening to kill them if they left him again. We have externalised “Feeling Trapped” as the problem keeping her captive. “Feeling Trapped” has made her consider suicide as the only way out. The discourse, “A good Muslim woman should not leave her husband, no matter what”, is strengthening the problem. The patient is making long term plans to undermine the effects of “Feeling Trapped” on her life. These plans include confidence in Allah that gives her the right to a healthy life.

Patient 4

The patient is a 47 years old South African Muslim woman, and unemployed on cultural grounds. Her husband divorced her three years ago, but she went back to him. A week ago he sent her a letter and a bag with her clothes. The patient wanted her husband to receive her back. We externalised the problem as “Helplessness”. To counteract Helplessness, we decided that I would phone her husband and talk to him. However, he expressed his refusal to take her back, saying that they were divorced and living with her would mean to live in sin. The patient insisted that the only problem with the relationship was that she could not hold her urine, but that she would carry her bag of medicine with her wherever they went, to control the problem. The effect of the problem on the patient was utter desperation, sadness and tears. The patient insisted that only her ex-husband taking her back would diminish the effects of “Helplessness” on her life. She refused to invite alternative stories, such as “Acceptance”, into her life.

Patient 5

The patient is a white woman in her thirties. When the father of her two children died, the patient found out that he was married to somebody else. She has inherited nothing from him, and is struggling to survive with the two children. She is employed in a low-salaried job. She has externalised “Having children” as the problem discourse. The problem has serious effects on her life and she wants to make an end to it all. The fact that “God and my mother forbade me to have abortions” makes the problem stronger. The patient is angry because she did not have a choice in having children, but is strengthened by the idea that now she has a choice in how to deal with her children. She is considering giving priority to her children and to move on in her sexual relationships. She considers that God may take her hand in this.

Patient 6

The patient is a 41 year old black South African woman. She is unemployed and worships at a mainline church. Her husband divorced her after 16 years of marriage because she did not enjoy sex. The reasons why she did not enjoy sex were because her husband wanted sex every day and she was not raised to say no. Also, he did not prepare her body well and had a very huge penis. He had numerous extra-marital affairs. These and the divorce make her feel rejected. Also, she is very lonely since her divorce, longing for a boyfriend who would respect and accept her. "Rejection" makes her feel powerless, as if she was possessed by a demon. "Rejection" makes her feel angry, so that she shouts at the children. Believing that God will send her the right man is bringing some relief from "Rejection". The patient takes the possibility into account that even "the right man" may bring further rejection and not excitement. She subsequently tries to shift her attention away from "the right man" to the good things her children have inherited from her. These are things like coolness, going to church, respect, and good looks. This gives her a new identity as a successful mother and makes the effects of "Rejection" on her life smaller.

Patient 7

The patient is a Venda woman in her twenties. She worships at the Seventh Day Adventist Church. Her husband abuses her. He brings his girlfriend home. When she complains, he breaks her things and does not speak to her for days. He is jealous, and he does not allow her to work. We externalised the "Satan of Pain" as the problem. Satan fills her heart with pain. He convinces her that she does not want to live any more and wants to take her own life. He thinks he has the right to treat her as his belonging. The patient has decided to deal with this problem in the traditional way. In the first place she is going to call the two families together to help her and her husband sort out the problems. In the second place she is going to pray to God. After much discussion, she has decided that this will not be a general prayer asking for miraculous intervention. She will pray (1) that God will give her faith in herself, (2) that God will make her husband her number one friend again, (3) that God will give her the power to fight the satan of pain, and (4) that God will give her the power to tell her husband that if he wants her to continue loving him, he must stop assaulting her.

Patient 8

The patient is a black South African woman in her fifties. She has four children, but has recently lost her twins through death. When her husband died, she found out that they had been divorced. She works in a chain store for a basic salary. The problems causing her sorrow are “Loneliness” and “Not enough money”. What works for her, is to pray to God when the sorrow becomes big (“As die hartseer groot word, begin ek te bid”). She now also considers seeking legal aid as part of the divine plan to get her back on track.

Patient 9

The patient is a black South African woman, 38 years of age. She worships at an Apostolic church. She is employed as a domestic worker. Her husband abuses her physically and emotionally. She has opened a case against him at the police station. This increased his anger and the abuse intensified. We externalised the problem as “Abuse”. “Abuse” gives her hypertension, makes her to forget things, causes her to sleep badly, and convinces her not to wash and put on nice clothes. “Abuse” feeds on the discourse that women are bad and should be kept in place by their husbands’ fists. The patient experiences God to be great, and that He wants her to lead a life of respect. She plans to build a house of her own where she and the children can be safe.

Journeying with stories: The pastor intervenes with Ntsebo’s life

Ntsebo (47) came for counseling monthly, and attended counseling three times. Ntsebo had been a breadwinner since she was 15 years old. While working and providing for the family, she nevertheless obtained matric and at the time of counseling was holding a good job in the finance department of a chain store. When she was 23, she fell pregnant and gave birth to a daughter who was now 24 years old. In 1999, when she was 43, Ntsebo got married. This was when her headaches started. She felt totally powerless in her marriage. Her husband used her as a babysitter for his children, with his family always coming first. He abused her, and eventually chased her away. Ntsebo welcomed this, but the pastor of their church intervened and insisted that they should reunite. They belonged to a born-again church, the Charity and Faith Christian Church. This church did not allow divorce. Ntsebo felt that even the power to divorce was taken away from her.

We externalised the problems as "Powerlessness" and "No trust in the church". The problems had severe effects on Ntsebo's life. Because of the pastor's intervention, she could not close the abusive relationship. "Powerlessness" stole her closure, and her peace of mind. She felt depressed, and the problems convinced her that her future was without hope. Most of all, "No trust in the church" stole all her trust from her, and the church became the problem while she had always looked to the church for encouragement. She could not go to the pastor for help as always, because she could not trust him with the problem.

We started the second session evaluating the effects the problems had on Ntsebo life. Ntsebo decided to counteract the effects of "Powerlessness" by believing that she still was able to make healthy decisions about her life. She made the following plans: She was going to call in the family and the pastor to help solve her marriage problems, as the custom was. If the problems were solved, she was going to ask for God's grace to help her forgive her husband for all the verbal abuse. Similar to the Financial Management Plan according to which she worked in her professional job, she was going to work at her relationship according to a Forgiveness Management Plan.

However, the third session commenced with bad news. Since the previous session, something had happened that strengthened the problem enormously. She had found out that her husband had an affair with another woman at the church, a close friend of Ntsebo whom she trusted. This made the problem, "No trust in the church", very strong. Her husband had confessed and asked for forgiveness, but Ntsebo was uncertain whether the affair had ended. Whenever she raised the issue with her husband, he said that she was oversensitive, which made her worry whether the verbal abuse was going to stop in future.

Ntsebo eventually decided to undermine "No trust in the church" with the "God of second chances". Deconstructing the problem discourse made her feel powerful and in control. Whether this deconstructed discourse restored her trust in the church and in marriage is not clear. Ntsebo did not report for counseling again.

Religious body discourses

Patient 1

The patient is 36 years old and belongs to the Bethesda Apostolic Church as well as to the Apostolic Church of Zion. He is employed in a low-salaried job. He has had two children with his first wife. The one child died, and the other, now eight years old, was taken away from him when his wife died. He has been unable to establish contact with the child who is now living with his grandmother. The patient has since married another woman, and has two children with her. However, since he is unable to pay his *lobola*, his wife's parents have refused to hand her and the children over to him to come and stay with him. He tries to save money for *lobola*, but the bank does not want to give him a loan (R8 000,00) on his small salary. The patient suffers from a stomach ulcer which is worsened by the fact that he does not have enough money to buy any other food than *pap* in the evenings. We externalised "*Lobola* makes my body lonely" as the problem governing his life. The patient makes no distinction between *lobola* as a cultural discourse, and religion supporting this discourse. Although the patient has been able to identify the effects of the *lobola* discourse on his life, and especially on his body, he has been reluctant to deconstruct this discourse, saying that when his daughters grow up, he would insist on *lobola* for them too. The patient eventually committed suicide by stepping in front of a train on New Year's Day. "Loneliness" has won.

Patient 2

The patient is 30 years old and worships in the Zion Christian Church. He does not earn enough money to pay his *lobola* for the wife he has already have one child with. We have externalised "Loneliness" and "Helplessness" as the problems in his life. These problems have caused him stress and heart problems. The problems have also convinced him to try to commit suicide three times. The problems are strengthened by the discourse: "When a believer experiences problems, it is God trying him". The patient is exploring times in his life when God has been his friend, and not his temptation, and has helped him to overcome difficult situations.

Patient 3

The patient is white and at the age of 44 underwent a mastectomy, after which her husband has refused to touch her. She belongs to the Apostolic

Faith Mission. We externalised the problem as “Nowhere to cry”. The problem is supported by the discourse that women are not to discuss their bodies with the pastor. The effects of the problem on her life were depression, sadness, and a feeling of being rejected by her husband and the church. The patient started working towards financial independence and the expansion of her support systems.

Patient 4

The patient is a 47 year old black South African and a Jehovah’s Witness. She is employed but has grave financial difficulties. She suffered physical abuse from her stepmother when she was a child, from the nuns where she went to school, from her ex-husband through whom she was infected with HIV, and eventually also from her teenage children who are assaulting her. We have externalised the problem as “Loneliness”. “Loneliness” has convinced her that nobody wants her, and that life is not good. She cannot even go to church, because “Loneliness” tells her that the people there despise her. “Loneliness” has also told her that she cannot have a boyfriend when she is HIV positive, and that it is against the Bible, anyway, for a single woman to have a boyfriend. Eventually “Loneliness” has caused her to die spiritually, believing that not even God wants her. “Loneliness” is made stronger by religious discourses which place God out of reach for people who are infected with HIV, and which keep single women from intimate relationships.

The patient is now trying to diminish the influence of “Loneliness” on her life by looking at the Bible as a book that inspires people to live a good life, and promotes healthy friendships.

Patient 5

The patient is a 34 year old Tsonga woman, belonging to a born-again church. She is employed as a domestic worker. She complained that she cannot hear her blood. She continuously tapped on her legs to illustrate to me that her blood was too weak to be heard. We externalised “Weak blood” as the problem haunting her, making her depressed and tired, and leaving her with a sore heart (“my hart is seer”). We considered the fact that the patient had no husband and no family to help her raise three children, as reasons why her “blood was weak”. When I suggested her taking an HIV test to help us find out why her “blood was weak”, the patient lost interest in further counseling.

Patient 6

The patient is a 26 year old Pedi woman who washes dishes at a private clinic. She worships at the Lutheran Bapedi Church. We externalised the problem as “Insecurity”. Her boyfriend does not trust her, since he had been cheated by women often before. She does not trust him, because he has paid a R4000 deposit in lobola for another woman. According to his culture he cannot get the money back, and he still owes the full R10 000 for her lobola. She now wants to get pregnant to force him to marry her. Supporting the problem, then, is the belief that a woman has no other power to get a man to marry her, than to get pregnant. The effects of the problem on her life are pains in her breasts and neck, headaches and depression.

The boyfriend attended the next session, and they both decided to fight “Insecurity” by healthier means than her getting pregnant. They are rather going to try communication, leaving the lies and blaming behind, and having romantic fun with one another.

Patient 7

The patient is a 49 year old Venda woman who came for counseling with her husband who has recently lost his job. She, too, is unemployed. She does not go to a church, but “prays to God”. We externalised the problem as “Headaches”. The patient suffers from excruciating headaches. Her children do not go to school, do not work, have burnt down the house on a previous occasion, and some are in prison. Making the problem stronger is her sex life with her husband. He does not want sex with her. She thinks it is because he is afraid “to get her headaches”, which is another way of expressing that he is afraid that she is HIV positive and will transfer it to him. He again, thinks that her headaches will worsen if he has sex with her, that is, he thinks that she suspects that he is HIV positive. HIV tests were done and the couple were both HIV negative. Plans were made to encourage romance and trust between the couple.

Patient 8

The patient is a black South African man, 35 years of age, who came for counseling because he is being looked for by the police after he assaulted his girlfriend. He is unemployed and goes to a born-again church. We externalised the problem as “Rejection”. Rejection makes him beat his girlfriend and burn down her house. The problem is strengthened by the

discourse that a woman should tend to the wishes of her man, otherwise she deserves a hiding. The patient agrees to counseling in anger management.

Patient 9

The patient is a black South African woman, 30 years of age, who worships in the Church of Christ and is employed in a low-salaried job. We externalised the problem as “Rejection”. Her boyfriend has left her for another woman. “Rejection” makes her angry and depressed, and wants to make her kill the children. The discourse strengthening the problem is that a woman has no power but to kill a man’s children to teach him a lesson. The patient is now considering other healthier means of making the problem smaller, such as a refusal to let the other woman make her so angry again. She is asking whether God wants us to hurt each other, or whether God wants us to develop our inner strength to deal with problems.

Journeying with stories: Bokang looks for ways to survive her body

Bokang is a black woman in her thirties. She works at the toll gate for minimum wages. She worships at the Roman Catholic Church. Also, she has been under treatment from a traditional healer (sangoma) to become pregnant again. She has one child.

Bokang had been raped that morning at 05:35. This was the third time she has experienced a rape. The previous one was exactly a year before. Her mother and sister have also been raped on different occasions.

Bokang has reported the rape to the police. This has reminded her of the previous time when she reported a rape a year ago. And she remembered what an ugly experience going to court was.

We externalised the problem haunting Bokang as “My body is bad”. “My body is bad” convinced her that her boyfriend was going to reject her because she had been raped. “My body is bad” made her assume that she was now HIV positive and that she deserved it. “My body is bad” furthermore informed her that the rape had made her pregnant, and that the baby then would not be her boyfriend’s. “My body is bad” made her fear that she would have to go to court again, where lawyers would prove that her body, indeed, was bad.

Bokang's boyfriend David accompanied her to the next session. He helped a lot in making the effects of "My body is bad" on Bokang's life smaller. Since the rape they had made love twice, which made Bokang feel much better about her body. David tried to be with her as much as possible, trying not to leave her alone. He helped her to sleep, but also not to sleep too much. Also, they went to church together to pray. David had convinced Bokang that the rape was not punishment from God, but an accident. He helped her to find a new job where she does not have to stand next to the road waiting for transport to the toll gate, so that no more accidents can happen to her.

Religious identity discourses

Patient 1

The patient is 40 years old, white and divorced. She holds a good middle-income job. She asked what the problem with her was, since nobody wanted her. She felt rejected by her father, God, her ex-husband and her boyfriend. After her boyfriend lost his job, she supported him, but he left her anyway. Separating the patient from the problem, we externalised the problem as "Rejection". "Rejection" was strengthened by the pastor touching her breasts and ejaculating in his pants, since this was not the type of attention she wanted. The effects of the problem on the patient were tiredness, and an uncontrollable urge to drink and overeat. The patient decided that, with an alternative identity as a person of faith, she could look on the internet for dating partners. She eventually remarried a person she had met over the internet.

Patient 2

The patient is a white teenager in Grade X who was brought to the hospital by a friend who thought the patient was a suicide risk. The patient worships at the Apostolic Faith Mission, which forbids her to drink, smoke or have sex. We externalised "Tension" as the problem that wanted to steal her life away from her. "Tension" is strengthened by the demands of the peer group at school, that vary considerably from what the church prescribes as correct. "Tension" declares war between her church identity and her sexual identity. "Tension" is furthermore made strong by the feeling that she is not in control of her life, and that she is unable to perform well. At the merit evening for

achievements in sport the previous week, “Tension” almost made her pass out. Other effects of “Tension” on her life are headaches, neck pain, and back pain. “Tension” also convinces her that life is not exciting enough. She likes going to church, and it “makes her feel better” – but it lacks excitement. The patient moves towards making the effects of the problem on her life smaller by looking for excitement in church activities and by planning her immediate future as a life filled with healthy excitement. However, the patient is not convinced that these plans will make her happy.

Patient 3

The patient is a white woman from Zimbabwe who is presently living in a nearby mission. She is in her thirties and is half-employed at the mission where she works for her board and lodging. Her mother committed suicide when she was a girl, and at present she was experiencing problems with her boyfriend. We externalised the problem as “Nothing is working for me”. This problem caused constant tiredness and back pain – and irritability with the people around her. Strengthening the problem is the religious discourse that “Everything will turn out well if only one applies Biblical principles”.

The patient is looking at alternative Biblical principles that will allow her to be angry and sad once in a while – while still being supported by her loved ones. She is also exploring the fact that suicide is not against the Bible, yet it does not have to be a solution to her problems.

Patient 4

The patient is a Venda woman, 43 years old, who worships with her husband in the New Baptist Church. She attended counseling with her husband. The couple were unwilling to talk about the problems in their lives, but it seems that “Constant menstruation” has stolen their intimate life from them. The problem was strengthened by the religio-cultural discourse that people were not to talk about their sexual lives. The effect of “Constant menstruation” on their lives was a deteriorating relationship. These effects were increased by another religio-cultural discourse that menstruation blood was a sign of God’s dissatisfaction about a person’s life. Although the couple was vague about the problem(s) ruling their lives, they felt that the only way to solve them was “to become more Christian”.

The couple had internalised guilt, and resisted externalising the problem. However, they are working on shifting the discourses influencing their intimate life, starting from the notion that Jesus was in contact with a menstruating woman and did not find her repulsive or unclean.

Patient 5

The patient is a 43 year old black South African woman who worships at the Jehovah's Witnesses. She is employed in a low-salaried job. We externalised the problem as "Witchcraft". Her husband wants her out of the house. His girlfriend, therefore, has paid a sangoma to put a spell on her to make her go away and make her husband think that she is useless. The problem causes blackouts, fears, insomnia, forgetfulness, anger and stress. The patient sleeps with her Bible to counteract the influence of "Witchcraft" on her life. She believes that she should be strong and not move out of the house. She considered going to a sangoma who can put a stronger counter-spell on her husband and his girlfriend. However, during counseling we identified healthy voices that were stronger than that of "Witchcraft". These are the voice of Jesus' salvation, the voice of her plans to move out of the house in two years' time when her eldest had finished his tertiary education, and the voice of a good self-esteem telling her that she was a woman of worth.

Patient 6

The patient is a 39 year old black South African woman, who worships in the International Assemblies of God. She is unemployed. She has obtained a protection order against her abusive husband, who then tore her Bible in two. We externalised the problem as "Helplessness", even in the midst of her Christian identity. "Helplessness" is made strong by the fact that she has nowhere to go with four children, and no job. "Helplessness" has made her feel very depressed, so much so that she does not want to live any more. Making "Helplessness" stronger is the discourse that a woman should accept her fate because God and the law cannot protect them. The patient is looking at alternative roles that do not leave her a victim in relationship to her husband, and a passive believer in her relationship with God. She is renaming herself in phrases such as "I put myself down, but God has a purpose with me", and "I am a fighter with the Spirit of God."

Patient 7

The patient is a 74 year old Tswana woman who lives on a farm and worships in the Lutheran Church. After her daughter and husband have died, she is afraid that she may die alone and not be buried. Her remaining two children, two middle-aged sons, have their own careers and do not want to stay with her on the farm. "Fear of dying alone" has convinced her that life is anyway not worthwhile and that she should make an end to it. The problem is

strengthened by the discourse that if one dies alone and goes unburied, her memory would not be honoured and she will not become an ancestor. We wrote a letter to her son who attended the next session during which trust was re-established between them and the patient's fears accommodated.

Patient 8

The patient is a 20 year old Zulu woman who worships in the Mormon Church. She is a student at the technicon but has suddenly lost interest in her studies. She has attempted suicide. We externalised the problem as "Not good enough". The patient felt that she was not good enough for God and the church people, and especially not for her father. Strengthening the problem is the discourse that a good child should perform well out of gratitude towards her parents and God. The patient is finding relief from the problem by reminding herself that she has been chosen by God.

Patient 9

The patient is a black South African woman in her forties who worships at the Methodist Church. She works as a cleaner for a low salary. We externalised her problem as "My daughter makes me fear". Her daughter brought shame on the family by using drugs, living with her boyfriend and behaving herself badly in public. The patient is, furthermore, afraid that people will come and kill her because of her daughter's drug debt. The problem has convinced the patient to try to kill herself to get away from her daughter and the problems surrounding her. The discourse that strengthened the problem is that the parent is the reason why a child has turned out bad. The patient is standing up against the problem by singing to the Lord without shame.

Journeying with stories: Diboko is tired of caring

Diboko is in her forties. She has four children between the ages of 5 and 19. She lives with her four children in a one-roomed shack in the notorious squatter camp of Olievenhoutbos. She works as a cleaner in Johannesburg, earning R1000,00 per month of which R300,00 goes for transport. Her problems started long ago, when she was 3 months pregnant with her eldest child. Her husband has since then, almost 20 years ago, stopped supporting her financially, and has been seeing other women, while she was forced to have three more children with him. She was prevented from aborting them because she is a

Christian. He has now finally deserted her and “married” another woman with “lobola”.

We have externalised “I do not want to care for other people any more” as the problem stealing the joy of life from her. She has always believed that a good Christian mother cares for her children, no matter what. However, she does not have money to care for them any more, and nobody supports her, especially not her husband who is not acting like a Christian father should. We started evaluating the effects of the problem on her life, and Diboko reported even more of these effects. “Money brings Stress” and “Husband brings Pain” are discourses that make the problem bigger. The effects of these problems on her life are not only that she does not want to care any more, she is also tired, angry, wants to scream at people, and cannot handle noise. Worst of all is that she does not want to pray any more. The problems have placed distance between her and God. She furthermore often finds herself lying to other people, something she as a Christian does not want to do.

Dikobo belongs to the Apostolic Faith Mission Church, from which she derives her identity as Christian mother and wife. This is the place where she feels free, where she feels good about herself, and where she can dance. In deconstructing the problem discourse, therefore, Diboko starts identifying herself as a church person with integrity, who belongs legitimately to the faith community. She started praying to God for somebody who will carry her burden with her as a Christian mother and wife.

Religious otherness discourses

Patient 1

The patient is 49 years old and worships at the Zion Christian Church. She is unemployed. She has lost several close family members, including two of her own children, during the past few months. Most recent was the death of her son through a stroke at the age of 36. This is not only an emotional loss, but also a financial one, since he has been supporting her for several years. We externalised “Death” as the problem haunting the patient. “Death” strengthened her fear in two ways. In the first place, she was concerned about the nature of the church in heaven. Since all those who had died belonged to

different churches, she was concerned about their well-being in heaven, and wanted to know which church reigned in heaven. In the second place, “Death” made her so sad, and weakened her to such an extent, that she feared that she might die unexpectedly, and that she would not be able to bury her mother. The problem was made strong by the discourse that God had a preference for a specific church, which is the true church. The patient is now trying to make the effects of the problem on her life smaller by exploring traces of God’s unconditional love in her life, and by extending this belief to both the here and the hereafter.

Patient 2

The patient is an 18 year old black South African who was abducted from her mother when she was five. She has never known her mother, and was made to work for her new mother “like a slave”. At the age of 18 she left the women who pretended to be her mother and came back to Pretoria to look for her real mother, but has been unsuccessful. She worships in the New Apostolic Church, and goes twice a day to a born-again church to pray. We have externalised the problem as “No response”. The discourses keeping the problem in place are: “A worthwhile God answers all prayers”, and “A good boyfriend is always available to attend to his girlfriend’s needs”. The effects of the problem on her life are that she is very dependent on her boyfriend and very demanding of God. She is also very depressed, and cries easily. The patient has started to identify other supporting family members and friends in her life, as well as other religious groups where she is socially supported. She has also started looking at help from God’s side in small things, giving God “some space to walk beside her”.

Patient 3

The patient is a black woman in her forties and partly employed. Her husband died a year ago. She thought that she had inherited the house and its contents from her husband, but his family came and took the contents of the house from her to give to his children from a previous marriage. Also, they want money from her for these children. She has two children of her own. We externalised the problem as “Loss”, that is, the loss of her husband, and the loss of their shared belongings through his family. The effects of the problem on her life are insomnia, “pyn in die hart” (pain in the heart) and sadness, both for the loss of her husband and the behavior of his family. The question “Hoekom straf die Here my so, ek is ‘n goeie vrou?” (Why did the Lord do

this while I am a good woman?) strengthened, and validated, the effects of the problem on her life.

The patient is now trying to diminish the effects of the problem by looking at culture doing this to her, that is, making her sad and sleepless. It is not the Lord punishing her but the patriarchal side of culture holding her captive. She is looking at ways of undermining the cultural discourses and practices that leave a widow powerless and poor.

Patient 4

The patient is a black woman of 39 who worships both at the African Methodist Episcopal Church (AME) and at the Zion Christian Church (ZCC). She is a domestic worker who lives in during the week, and goes home on Fridays. Six months ago she went home on a Friday and found that her baby had died. The baby's name was "The Lord has given". She could not understand why the Lord has taken away what the Lord had given. She has four other children, but she dreams of this child every night. She dreams that the child runs behind her in the street and shouts, "Mama, mama, wait, I'm coming!" This "Loss" has affected her life in such a way, that she does not care for her other children any more. And she feels guilty. She feels that the Lord is punishing her for something, that is why the Lord has taken away her baby. Also, with the child, she has lost other dreams, such as being mother to a small child again.

To undermine the discourse "God is punishing me", a discourse that is strengthening the feeling of loss, the patient is looking at her support systems, "the people God has sent to help her". She is looking for support from the baby's father, her family and her employer. And she is changing her image of God as Punisher to that of God as Supporter.

Patient 5

The patient is a 32 year old black South African and worships at the Roman Catholic Church. She has lost her job, and we externalised "Depression" as the problem overtaking her life. During counseling she became empowered to take some of her life back from "Depression". She did this by identifying what makes her happy, and that includes mainly going to church.

Patient 6

The patient is a 47 year old black South African and worships at the Charity and Faith Church. Her husband is unemployed and she has a low-income job.

Six months ago they were thrown out of their home because they could no longer afford it. Her husband is now living with his mother and she with her sister, in different “townships”. We externalised the problem as “Depression”. During counseling the patient decided to outwit “Depression” by turning to God as the Problem Solver. Her problem has already become smaller with her husband allowing her to travel with the church’s women group. This gives her dignity and joy.

Patient 7

The patient is a 42 year old black South African man who worships at the Roman Catholic Church. His parents and brothers are already deceased and his sisters have taken ownership of the house at his expense. He lives in a back room, and they rule his life, chasing away his girlfriends. He used to have a good job, but is now unemployed. This was after he had taken some meat from the fridge, and his sister had him arrested and sent to jail for ten months. He feels that nobody has any respect or consideration for him. “No respect” has made him lonely, and makes him feel that he wants to go to sleep and never wake up again. The patient is working on giving himself new names that would imply his human dignity. He feels that the church and God will support this.

Patient 8

The patient is a 37 year old Tsonga woman who worships at the New Apostolic Church and is employed with a low income. She has been raped and lives alone with four children. We externalised the problem as “Fear”. She is afraid when she is alone or has to walk home late at night after work. “Fear” makes her very depressed. She is not afraid or depressed when she is at the church, singing and praying. “God, the priest and Dr Hitchcock³¹¹ are on my side”, she said. We are now looking into ways in which God can be present in self-protecting ways when she is alone or walks alone.

Patient 9

The patient is a black South African woman in her twenties, worshipping at the Methodist Church. She is unemployed. About a year ago, her baby of one year became seriously ill. She took the baby to Polokwane where the Zion

³¹¹ Dr Hitchcock is a doctor at and head of the Family Medicine Clinic (outpatients) at Kalafong Hospital.

Christian Church prayed for the baby and poured water on her. The baby died soon afterwards. We externalised the problem as “Sorrow”. “Sorrow” was trying to convince the patient that she wanted to commit suicide and join her baby in heaven. However, remembering herself as a person who cared for other people, and can still care for many others in future, made the effects of “Sorrow” on the life of the patient smaller.

Journeying with stories: Sakti finds no closure

Sakti (49) came for counseling six times, the first time seven and a half weeks after her son died in a motor car collision in Diepsloot on 15 December the previous year. He was 28 years old.

Sakti has two children, the one 30 years old, stern and married. The son who died was like sunshine. He was the party type, but looked after her well. He died on the 15th, but she only found out about it on the 16th. Since then, life has no meaning.

Sakti is a Hindu, and we externalised her problem as “Religion does not console”. The effects of this were a deep depression and a desperate feeling that the pain will never end. Throughout the next sessions we evaluated the effects of the problem on her life, and Sakti testified that the religious ceremonies held to bring closure, only made things worse. Eleven months after her son’s death, there was an unveiling of the tombstone. This, Sakti said, rose her desperation to an all time height. It did not bring closure. It made her feel that everything was too final now. He was out of her life for good. This increased the effects of the problem on her life: the insomnia, the pain in her shoulders and back, the headache, the unclarity of her mind, the depression.

At a later session, Sakti described another effect of the problem on her life. She was feeling caught between two fires. As a religious person, she felt pressurised by the closing ceremonies of her religion to leave the loss of her son behind her and regain her happiness; however, as a mother she felt guilty towards her deceased son whenever she was happy, as if she was disloyal to him. At a next session, with the anniversary of her son’s death coming up, Sakti started making plans to outwit the effects of “No closure” on her life. She was going to see the acceptance of his death as a way of applauding his mischievous and happy-go-lucky lifestyle. She was going to

pray for him to rest. She was going to see herself not as a weak mother, but as a mother filled with happy memories. Thus, on anniversary of his death she was going to do happy things, putting flowers on his grave and being with her children and other family members.

Sakti, then, was not going to wait for the otherness of religion to console her; she was going to accept the day-to-day practical things religion offered to strengthen her relationship with her deceased son and her remaining children.

Summary of findings

Profile of research population

The aim of this chapter was to describe the second leg of the MEET process, that is, separating the patient from the problem by **externalising** the problem. In this chapter, then, the externalisation of problems in the case of 40 patients (of the original research population of 270 patients) has been discussed. Ten of them pertain to power discourses, ten to body discourses, ten to identity discourses, and again, ten to otherness discourses. Nine of the ten patients were discussed briefly, with the tenth patient being discussed more fully and within the “Journeying with stories” series.

In chapter 1, five variables that are of therapeutic significance have been distinguished. They are (1) race, (2) gender, (3) (un)employment, (4) age, and (5) religion. The profile of the 40 patients discussed in this chapter vis-à-vis these variables, is as follows:

- *Race*: A majority of patients, that is, three-quarters (30), are black. There are six white patients, and four Indian patients.
- *Gender*: A vast majority of patients (35) are women. Five of the patients are men.
- *(Un)employment*: Half of the patients (20) are unemployed. Six of them are women who, for culture-religious reasons, are prohibited from working. Four of the patients have recently lost their jobs. Two of the patients are students. Of those employed (20), 19 fall into a minimum income group, that is, with a salary less than R1 200-00 per month. The patients, then, are generally very poor with grave financial problems.
- *Age*: Most of the patients are in their thirties (17) or forties (15). Two patients are teenagers, four are in their twenties, one is in her fifties and one in her seventies.

- *Religion:* Three of the patients are Muslims, and one a Hindu. Amongst the Christians there are hardly any patients that share the same church. Twelve of the patients belong to a mainline church, and nine to born-again churches. There are three Pentecostals, and seven belonging to a Zionist/Apostolic church. There are two Jehovah's Witnesses, one Seventh Day Adventist, and one from the Mormon church (Church of the Latter Day Saints).

In summary, these patients reflect the research population in terms of race, gender and income. They are mainly black women who are very poor. The problems ruling their lives are "poverty", "social loneliness", "losses" and "oppressive cultural practices".

Externalisation through indigenous knowledge

When healthy people become ill

The 40 patients discussed in this chapter are not physically ill, or rather, they are not supposed to be physically ill. They have been referred for counseling because the doctors at the hospital could find no reason in terms of organic malfunctioning to explain why they are suffering from bodily pains. This, of course, signals that not only viruses, bacteria and cancers make people ill. People become ill, too, when the discourses controlling their lives have unhealthy effects on their bodies. The fact that organically healthy people suffer from physical pain also signals that medicine alone cannot heal people fully, but that the unhealthy discourses holding them captive need to be deconstructed.

In this chapter we have looked only at (1) the effects of unhealthy discourses on the lives of a section of the patient population, (2) the problems that we externalised that cause these effects, and (3) the culturo-religious discourses that make that problem stronger. The deconstruction of the problem discourses will be discussed fully in the next chapter.

The effects of religious discourses on the patients' bodies

The patients under discussion have described the effects of the problem on their lives mainly in physical terms:

- Religious power discourses

The patients here are trapped in unequal and abusive relationships that are religiously sanctioned. Consequently, they externalise the problems influencing their lives as

- “Hopelessness”, “Helplessness”, and “Powerlessness” in the light of the church and people taking control over their freedom
- “Feeling trapped” in marriages where they experience abuse and no respect
- “Rejection” and “Abuse” in relationships where they have no power to negotiate affection.

The effects of these problems on their lives present themselves physically and are expressed by the patients as follows:

- My body feels tired
- My hands don't want to work
- My feet do not want to walk where life takes it (disinterestedness in life)
- My body cannot sleep (insomnia)
- My heart pounds in my breast (anxiety)
- My head snaps (anger)
- My body wants to leave this world (suicide ideation)
- My heart feels lame and my eyes start crying (desperation and sadness)
- My body is possessed by a demon (powerlessness)
- The Satan of Pain has invaded my body
- Satan has filled my heart with pain
- Nobody keeps my body warm (loneliness)
- I don't have enough money for food; my stomach aches
- My body cannot relax (tension)
- My head forgets things
- I lost interest in washing my body and putting on nice clothes
- My head keeps on thinking (depression)

- Religious body discourses

The patients here feel helpless because their bodies are controlled by religious and cultural practices that have unhealthy effects on their lives. Consequently, they externalise the problems influencing their lives as

- “Loneliness” in the light of *lobola* that cannot be paid
- “Rejection” in the light of religious prejudice towards those infected with HIV
- “My body is bad” in the light of culturo-religious prejudice against those raped.

Again, the effects of these problems on their lives present themselves physically and are expressed by the patients as follows:

- I want my body to go away (suicide ideation)
 - My heart wants to jump out of my chest and it is painful (stress)
 - My body feels rejected by my husband after my mastectomy
 - My body is lonely because I am HIV positive
 - My body is lonely because the Bible prohibits a single woman from having sex
 - My heart pains because I cannot hear the blood in my legs (fear of Aids)
 - My blood feels weak
 - I’ve got pains in my breasts and neck, and headaches
 - When my boyfriend feels rejected, he beats my body
 - When my boyfriend left me, I wanted to kill our children
 - After I was raped, I knew my body was bad
- Religious identity discourses

The patients here feel tension, stress and rejection because of culturo-religious identities prescribed to them to which they cannot adhere. Consequently, they externalise the problems influencing their lives as

- “Punishment” because they cannot please God adequately
- “Not good enough” because they cannot serve their husbands or children as good women of faith should
- “Witchcraft” because somebody has paid a *sangoma* to place a curse on them
- “Fear” of dying alone and not become an ancestor.

Again, the effects of these problems on their lives present themselves physically and are expressed by the patients as follows:

- I overeat and drink too much
- I’ve got headaches, back and neck pain

- People work on my nerves (irritability)
 - I keep on menstruating and my husband finds my body unclean
 - My head becomes black (blackouts)
 - I want to stop my head from thinking over and over again (depression, suicide ideation)
 - I fear that nobody will bury my body
 - I mutilate my body so that the other pain can go away
 - I do not want to live any more
 - I do not care any more
 - I want to scream
 - I cannot handle noise
 - I cannot pray any more
- Religious otherness discourses

Of the forty patients described in this chapter, a third (14) saw suicide as the only solution to their problems, and several of them have already attempted to commit suicide, some more than once. They have done this, or considered doing it, in spite of the fact that they are deeply religious. This means that they believe in the healing power of belief, but that the problems controlling their lives are so powerful, that they cannot benefit from the healing offered by their religious belief. Often these problems convince them that their religion has misled them into believing that there is a way out. Consequently, they externalise the problems influencing their lives as

- “Death”
- “Losses”
- “Depression”
- “Fear”
- “Sorrow”, and
- “Religion does not console”.

In this section on “religious otherness discourses” the effects of the problems on the lives of patients present themselves less physically than in religious power, body and identity discourses. The effects of the problems are rather expressed in terms of questions, doubt and uncertainty:

- Which church will be the true church in heaven?
- How can a worthwhile God not answer my prayers?
- Why has the Lord done this to me?
- Why is God punishing me?

- Why could the priest not pray my baby back to life?
- All the funeral rites could not console me after my son's death

Indigenous knowledge identifying problem discourses

As can be seen from the above, the patients under discussion used the insights of township spiritualities to give an externalising name to their problems and to describe the effects of these problems on their lives. Township spiritualities, as defined in chapter 1 are unique compilations of

- traditional Christian insights on salvation,
- traditional African concepts of healing, and
- human rights as the gift of liberation theology.

As such, township spiritualities form an indigenous knowledge system (IKS) that is informed by and informs patients on spiritual healing. Higgs and Van Niekerk (2002:38) define *indigenous knowledge* as “knowledge coming from local people themselves, knowledge available in the land, in its history, its culture, its memory, its geography and its linguistic heritage. It can, therefore, be said that IKS in general refers to intricate knowledge systems acquired over generations by communities as they interact with their environment”.

In counseling it was found that the different aspects of township spiritualities – namely Christian, traditional African and human rights – have been internalised by patients in different measures which prioritise them differently during times of trauma. Christian belief in salvation, for example, may take second place to traditional African claims when the patient believes that (s)he has been cursed by a *sangoma*. And the individual's rights may be severely tested when traditional African culture insists on *lobola*.

In this chapter, the challenge was to describe how, during counseling, the problem and the religious discourses supporting them were identified according to the indigenous knowledge of the patient, that is, according to what the patient has internalised through township spiritualities.

This chapter, also, deals with religious discourses that have an unhealthy and sickening effect on the patients' lives. As said, the deconstruction of these discourses will follow in the next chapter.

Religious discourses that have been externalised as problem discourses in this chapter are as follows:

- Religious power discourses

The patients here feel hopeless, helpless, trapped, rejected, lonely, and abused. These make them suffer from tiredness, disinterestedness, insomnia,

anxiety, anger, suicide ideation, neck and back pains, tension, depression and headaches. The religious power discourses that strengthened these feelings and their effects can be divided into two:

- (1) Prescriptive discourses that leave the patient feel powerless
 - Divorce is against the will of God, even when there is abuse
 - The Iman and my husband know best what God wants
 - A good Muslim woman does not leave her husband
 - A good Christian woman does what her husband tells her
 - Abortion is against the will of God
 - Women are bad and should be kept in place by their husbands' fists
- (2) Discourses that tell the patient to wait for God's power to be revealed
 - God will send me the right man
 - God will conquer the Satan of pain
 - God will help me if I pray enough
 - Religious body discourses

The patients here feel lonely, helpless, insecure, isolated, and rejected. This makes them suffer stress, sexual cravings, pains in the breasts, neck and back, headaches, as well as murderous and suicidal thoughts. The (culturo-) religious body discourses that support these feelings and effects are:

- (1) Cultural discourses that prescribe rituals
 - Bodies can only be owned when *lobola* has been paid
 - A man must marry his pregnant girlfriend
 - A woman may kill her children to teach her unfaithful husband a lesson
- (2) Religious body discourses that internalise guilt
 - God is trying me through *lobola*
 - Women must not discuss their bodies with their pastors
 - The Bible does not allow a single woman to have sex
 - Headaches are signs of HIV and punishment from God
 - A good Christian woman attends to her husband's wishes
 - A girl who is raped deserved this.

- Religious identity discourses

The patients here feel rejected, helpless and fearful. They feel that they are in the power of witchcraft, a punishing God and unsympathetic men, that is, both their husband and the priest/pastor. They suffer from headaches, back and neck pain, constant menstruation, blackouts, self-mutilation and irritability. The religious identity discourses that strengthen these feelings and their effects are as follows:

(1) Culturo-religious discourses that instill fear

- The sangoma's curse can only be counteracted by another sangoma's curse
- A grateful child should please God, ancestors and parents
- A bad child is to be blamed on the parent

(2) Religious discourses that instill/display mistrust in the church

- The pastor thinks he has the right to touch my private parts
- The church lacks excitement
- The church pretends that everything will work out well when Biblical principles have been applied
- The pastor teaches that constant menstrual blood is a sign of God's dissatisfaction
- The church is unwilling to help women
- It is of no use to pray any more

- Religious otherness discourses

The patients here are in crisis because they feel that religious rituals have not, in the light of losses and death, brought the consolation it promises. Religious otherness discourses that increase the crisis of the patients are

- There is only one true church
- God answers all the prayers of worthwhile people
- Everything happens within God's plan
- God is a Punisher
- If you really believe, you will be healed
- If you are a true believer, you will be consoled

Reformulating negative identity claims by renaming God

Re-naming, re-storying and deconstruction are the business of the next chapter. Here it can be noted that the “negative identity claims” of the patients under discussion show a preference for hierocratic and patriarchal God images. Patients, then, claim a negative self-identity in the light of a God whom they experience as One who

- punishes
- sides with men
- controls women
- uses cultural practices such as *lobola* to show who is the Boss
- lets *sangomas* go their way
- is unmovable on issues such as abortion and divorce
- sometimes withholds help for no apparent reason
- has no place in His divine plan for those infected with HIV
- easily gets dissatisfied with us
- listens only when one persists for a long time

With deconstructing and re-naming unhealthy religious discourses on the table in the next chapter, it suffices here to say that re-naming and re-storying God will be a special focus point in the upcoming chapter.

Conclusion

In this chapter, then, the problems and problem discourses influencing the lives of 40 patients have been externalised according to Peter Muntigl who described externalisation as a fourfold process of

- separating the patient from the problem
- identifying the problem through the patient’s indigenous knowledge (here: township spiritualities)
- evaluating the effects of the problem on the patient, and thus
- enabling the patient to reformulate his/her negative identity claims.

The externalisation of problems and problem discourses has, furthermore, informed the research on the nature of township spiritualities as an indigenous knowledge system in which, in times of crisis, African cultural practices take priority over traditional Christian ones, and human rights are in constant conflict with religious prescriptions in spite of the fact that human rights have been given to the people through liberation theology.

In this chapter, too, religious discourses have been externalised as **problem discourses** that have unhealthy effects on the lives of patients.

Consequently, the ugly face of religion came to the fore in this chapter. It is the challenge of the next chapter to show how problem religious discourses can be deconstructed towards healthy discourses, with a healing effect on patients.

Chapter 4

The deconstruction of religious discourses and the co-construction of alternative stories of faith: empowering the patient against the problem

This chapter deals with **empowerment** as the third phase of the MEET process. The chapter describes how the patient is further separated from the problem in a process described by Alice Morgan in *What is narrative therapy?*³¹² as follows:

- Deconstructing the problem discourses. Deconstruction is the pulling apart of taken-for-granted truths.
- Discovering unique outcomes by asking landscape of action questions. Landscape of action questions are questions the therapist asks about the history of the problem while listening to times in the life of the patient when the problem had less or no influence;
- Co-creating a new, alternative story by asking landscape of identity questions. Landscape of identity questions are questions the therapist asks to establish a future for the unique outcome within an alternative, sustainable story for the patient.

These, then, are the aims of this chapter: to describe how religious discourses in counseling are deconstructed, and new stories are co-constructed with patients within which they can live a healthy life as people of faith.

Again a sample of 40 patients is taken. These are not the same patients as in the previous chapter, simply to give as much voice to patients as possible.

Also, since deconstruction is not an infallible process, failures too will be described here.

Deconstructing and co-constructing spiritual healing

All discourses, and religious discourses in particular, feed on binary oppositions. For instance, the discourse “God will heal the true believer” contains the binaries “the One to be pleased” versus “the pleaser”, “belief” versus “un-

³¹² Dulwich Centre Publication 2000, pp 45-72.

belief”, “true believer” versus “false believer”, as well as “healing” versus “unbelief”.

The deconstruction of the discourse, in my view,³¹³ consists of two related steps: (1) the displacement of the binary oppositions, that is, the displacement of the whole hierarchical system of power on which they are based, and (2) the exploration of the dialogical spaces between the binaries.

What will be deconstructed, ultimately, in the next 40 cases, are the answers to the question “what is spiritual healing?” And what will be co-constructed is unique ways of looking at and experiencing healing, ways that explore the dialogical spaces between township spiritualities and western concepts of healing. With township spiritualities and western views on healing being the two poles of a binary opposition,³¹⁴ they oppose each other in at least two aspects:

- Western thinking views illness as caused by *natural* agents, such as viruses or chemical imbalances in the brain, or *unnatural* agents such as motor car accidents or bad socio-economic circumstances. Within township spiritualities, on the contrary, illness is viewed as caused by *supernatural* agents, such as demons, unsatisfied agents, or a judging God.
- Western psychologies, furthermore, often view religion as an agent in itself that makes a person ill. However, in township spiritualities, religion can never be the cause of illness. Illness is caused not by religion itself, but by inadequate forms of dedication and worship that anger supernatural agents such as demons and God.³¹⁵

In what follows, then, counselor and counselee are looking for unique outcomes between these two binaries, deconstructing “eternal truths” on spiritual healing, and co-constructing alternative stories of finding healing through faith.

Supporting this process is the point of the departure of this study, that is, that the deconstructing of religious discourses itself is a form of healing.

³¹³ See also Christina Landman, “Free to be moral, or moral free? Poststructuralism and the deconstruction of moral discourses”, in FA Swanepoel (ed), *Religion, morality and transformation* (Pretoria: Research Institute for Theology and Religion, Unisa, 2001), p 47.

³¹⁴ The differences between “western” and “township” are of course much more subtle and varied. However, here they are described as binaries that stand in opposition to one another.

³¹⁵ See Christina Landman, “Spiritual healing as an indigenous knowledge system”, in CW du Toit (ed), *The impact of knowledge systems on human development in Africa* (Pretoria: Research Institute for Theology and Religion, Unisa, 2007).

Religious discourses are deconstructed

Religious power discourses

Patient 1

The patient is a black woman, 60 years old, a pensioner who worships at the Tshenolo Christian Church. This church believes in angels and ancestors, and that the second coming of Christ has already occurred through their Mother. We have externalised the problem haunting the patient as “Rejection”. Since her husband has left her, she cannot sleep, is anxious and phobic, developed a neck spasm, overeats, and feels depressed. These effects are intensified by the priest of her church who said that her depression and bodily pains were due to an evil spirit.

The patient is shifting the religious discourse, “Depression is caused by an evil spirit”, to discourses such as “Depression and despair are healed by God’s love”, “Love is stronger than evil”, “There is no place for an evil spirit in the community of care” and “God does not make you ill”. The patient is, furthermore, strengthening her alternative story by finding spiritual support from a religious women’s group, and by praying for help to a benevolent God against depression.

Patient 2

The patient is a 51 year old black South African woman. She is illiterate and works two days a week as a domestic worker for a nominal fee. She did belong to the Baptist Church, but is now worshipping in the Uniting Reformed Church (previously the Dutch Reformed Church in Africa). She has lost two children through strokes. Her only surviving child, a son of 35, is the source of her problem. He sniffs glue (“snuif gom”), has left his wife and children, burnt down their house, and has moved in with her. We externalised the problem as “A child that sniffs glue”. She has heard that “die polies sê hulle moenie die manne vang wat gom snuif nie, want die government het nie geld om almal Magalies toe te stuur nie” (the police are told not to arrest those sniffing glue because the government does not have money to send them to rehab). The patient is torn between what she believes are two binary forms of healing, that of the “toordokter” (traditional healer) and that offered by “die Here” (the Lord). Since the “toordokter” has not been able to get her son off the glue, she is now ready to turn to the Lord. In exploring the discourse “What is healing?” we shifted the conversation from seeking healing for her son to seeking healing for herself. The patient found healing

in talking about her strong points, that is, “die talente wat die Here my gegee het” (the talents the Lord has given her). One of them is making bricks. She has, for instance, built her own house. This proved to be an analogy for building her son up, brick by brick.

Patient 3

The patient is a 60 year old Afrikaans speaking white woman, belonging to a Pentecostal church. Her husband decided to go on early pension, but lost all his pension money, about R100 000,00, through a bad investment. The patient has been trying to keep the family afloat by baking cakes, but her husband hates the smell of it and has forbidden her to continue baking. During counseling, her husband did not speak much but inhibited the conversation. He felt that God had made him as man to be the provider, and that his wife was constantly baking cakes to remind him that he had failed in his role as husband and father. He criticised everything she was doing, including her taking medicine.

We moved towards externalising the problem as “Old roles are not working any more”, but the husband resisted talking about the problem. The problem was supported by the binaries “The man is the breadwinner” and “The woman is cared for”. We tried to deconstruct the “The Problem” towards the couple’s need for new roles in providing for the family, but to no avail. Furthermore, the patient found consolation in the binaries “I pray” and “God provides”. Her husband forbade her to come for counseling again. The process of deconstructing the problem discourses was therefore unsuccessful.

Patient 4

The patient is in her late twenties, a South African Muslim woman, who is unemployed. She complains of being raped and assaulted by her husband. We externalised “I am a victim” as the problem in her life. The problem is supported by religious discourses, such as “Religion has to be hard otherwise it is not religion”, “The Qur’an says it is evil for a woman to fight back”, and “As a woman I am evil all over”. These discourses feed on the binaries “The Qur’an prescribes” and “Woman obeys”. We shifted the discourses towards “I love Allah’s loving nature” and “I have access to Allah as a woman”. The patient came for counseling eight times and wanted to be admitted to the hospital for observation and to be sent to Weskoppies where she had been several times before. The process of deconstructing her discourses raised the patient’s suspicions “that you do not take my complaints seriously and that

you do not believe me”. Consequently, she no longer wanted to see either the doctor or the counselor.

Patient 5

The patient is a 46 year old white, Afrikaans-speaking woman who lives at a mission run by a Pentecostal church. Her husband threw her out of the house after she had lost her finger when the hospital inserted a drip wrongly into her finger. He said “hy wil nie ‘n halwe vrou hê wat nie kan tik nie” (he does not want half a woman who cannot type). She is now hitch-hiking with a blind man who also lives at the mission to collect funds for the mission. However, a month ago they were attacked by men with knives and pipes at the side of the road. We have externalised “Fear that it will happen again” as the problem causing her insomnia and nightmares. Strengthening the problem is a discourse on whether God can be trusted.

Going through the assault step by step, we concentrated on how – and how well – she has handled the attack, coming out of it alive. Thinking of the assault as a personal victory undermined the discourses of fear and mistrust. She left with the conviction that God is not only to be trusted, but that He has indeed equipped her to deal well with situations such as the one she has experienced.

Patient 6

The patient is a 31 year old black South African woman who worships at the Reformed Church. In lay language we would call her a *Dopper*. She has a good clerical job at the hospital and “was a happy single mother”. Six years ago she got married, but now regrets this. Her husband has been retrenched and they have grave financial problems so that their youngest daughter cannot go to pre-school any more, and they cannot make the down payment on their house. She considers resigning to pay the loan with her pension payout. She also considers divorcing her husband so that she has fewer people to look after. We externalised the problem as “Depression”. “Depression” convinces her to resign her job and stay at home. “Depression” steals her sleep and her hope.

At first the patient considered an end to her financial problems as the only thing that can heal her. During counseling she started considering other forms of healing, such as resting, gaining control over her life by selling the house and buying a smaller one, and inviting other significant others into her life to help her deal with the problem, such as her mother and the pastor. For the pastor to become involved as a significant other we had to deconstruct the

discourse “The church only wants money” towards an alternative story in which the church cares for people. The pastor of the Dopperkerk in Atteridgeville eventually made this alternative story sustainable.

Patient 7

The patient is a 42 year old black South African woman who worships at the International Pentecostal Church and works as a teacher. I visited her in Ward 2B after she had attempted suicide.

The patient has a teenage son and daughter. Her first husband, the father of the two children, raped their daughter and left the family. Her second husband cannot stand the children and they are fighting constantly, with the patient being the blamed. Also, he beats her up regularly. The patient wants to divorce her husband but cannot do so for two reasons. The first is that there is no pre-nuptial contract because the men at the church said it was un-Christian. If they divorce, her husband who is unemployed would lay claim to her house which is all she still has. The second reason why she cannot divorce him is because the men at the church say divorce is un-Christian. “In the church men have all the say”, the patient said. We have externalised the problem as “No way out”. The effects of this problem on her life are feeling depressed, aggressive and tired, and wanting to take her own life.

The patient is finding unique outcomes in starting to believe that God gives her the right to be safe, and by discussing the situation with her children in order to find a respectful way out for everybody.

Patient 8

The patient is a 35 year old black Pedi woman who worships at the Apostolic Faith Mission and is unemployed. She was taken up in Ward 2B after reporting to Casualty. She complained that she was still suffering from injuries to her leg that she sustained during an accident a year ago in which both her parents and her two children died. When counseled, the patient told the counselor that “The Lord has sent you to give me shelter”. The patient remained for a month in Ward 2B, apparently suffering constantly from emotional setbacks. The patient often called on the religious obligation of the counselor to keep her in the ward. However, landscape of action questions revealed major inconsistencies in her stories. The patient has been referred to Weskoppies Psychiatric Hospital where she hopes to live happily ever after.

Patient 9

The patient is a 58 year old black South African woman who worships at both the Assemblies of God and the Baptist Church. She left a good job to get married, but is now employed as a domestic worker. When her husband died, it came out that he had divorced her earlier without her knowing that, and married another woman who inherited the house. The patient has been left behind with no house, grave financial problems and three children. The patient finds consolation in the discursive practice of praying and fasting, but has deconstructed this into "I am not praying for acceptance but for things to change". The patient's story developed into a unique outcome with her employer going through a divorce and she finding herself in a position to advise her "madam". She gave her advice which she herself was going to follow, that is, to pray for change, to be strong, and to live again.

Journeying with stories: Dimpho walks a new road of healing with the Lord

Dimpho is a 57 year old black South African woman who worships at the Zion Christian Church. She is unemployed. For the past 44 years she has been trapped in an abusive relationship with her husband. She fell pregnant when she was 13, but the baby was still born. She fell pregnant again, but when she was 8 months pregnant, her husband left her for another woman. This time it was a boy. This child is now 34 years old, with four children and no job. When he was a young man, her husband married him to a woman without Dimpho even knowing about it. Dimpho had three more children with her husband. The one was a girl who was later shot dead by her boyfriend. Dimpho's husband returns from time to time to live with her. He regularly beats her up badly, but she is too embarrassed to approach a court about the situation. Two years ago she herself unexpectedly got a letter from court, telling her that her husband had divorced her while she herself was never in court.

I met Dimpho in Ward 2B of Kalafong hospital after she had been seriously beaten up by her (ex-)husband. One of her eyes was blinded, her face was full of wounds, and her body covered in bruises. The police brought her to the hospital, but no case was made against her attacker. Dimpho found consolation in her belief that God has made men this way and that God expects women to be obedient and take their punishment.

After landscape of action questions that revealed how horrific the attack was and how helpless she was feeling to protect herself, the landscape of identity questions assisted Dimpho in pulling apart the discourse that holds her (ex-husband's violence in place. She shifted the discourse "I must leave everything in God's hands" to "With God's help I shall find a place in the old age home". She rephrased her fear that the church would always take her (ex-)husband's side ("Die kerk sê die man is altyd reg) as a question, that is, "Why does the church not speak to my husband?". As a unique outcome, she rescoped God as the One who gave her power ("Die Here gee krag, die duiwel steel krag") and health ("Die Here maak nie siek nie, my man maak siek").

After two more sessions, Dimpho said "Ek het nou geleer om 'n goeie pad met die Here te loop" (I have now learned to walk a good road with the Lord). This empowered her for the journey ahead.

Religious body discourses

Patient 1

The patient is a white woman in her forties and worships at the Apostolic Faith Mission Church. She is unemployed. We have externalised "Sin" as the problem holding her life captive. The patient feels that sin has taken over her life and that her body is fully a vehicle of sin. This makes her feel very depressed. Also, for the past 32 years, God has been appearing to her in dreams, telling her how sinful her body is. We deconstructed the religious discourses that keep the problem in place by exploring the fact that God Himself³¹⁶ took the step to become a body in Jesus Christ. And that Jesus' body was not bad but good enough to suffer on the cross for her. The patient has decided that, when God appears again to her in a dream, she will ask God to touch and heal her as God has done to people when God was a body in Jesus Christ.

³¹⁶ Talking to patients about God in inclusive language, has been too advanced at this stage, but needs to be done in future.

Patient 2

The patient is a black woman, previously from the rural areas. She is 48 years old and worships at the Roman Catholic Church. She attended the counseling session dressed fully in black. Her husband died unexpectedly two months before. She has five children aged between 17 and 29. She said that she did not miss her husband, because he was never at home anyway. However, now she has no income. She has no parents, and only one year of schooling, leaving her without skills to look for a job. We externalised “No money” as the problem causing the pain in her breast, blocking her ears and making her feel hot and dizzy. The discourses supporting this problem are “Women of my age were excluded from education” and “Black, rural women had little opportunity to be educated”. However, the patient like so many in her position, found it fruitless to engage in cultural and racial talk when there was no food on the table. She was also not willing to shift on the discourse “A widow must remain in the house for one year after her husband has died”. However, with no other support available, she did identify God as her source of strength, housing no anger against Him for the death of her husband. The patient was referred to a social worker.

Patient 3

The patient is a 58 year old black South African man who worships at the Zion Apostolic Church. Two years before he was working as a taxi driver when he was severely assaulted by men driving a City Council car. He was robbed of all his money and has been unable to work since then. According to the patient, his left eye, right arm and penis are not longer working. We externalised “I am worth nothing” as the problem making him feel hopeless. The effects of the problem are an inability to work, anger, bad self image, hopelessness and stress. Also, his wife has left him. He has no support systems going, since “mense wil nie iemand hê wat swaar op hulle arms rus nie” (people don’t want somebody who rests heavily on their arms). We tried to undermine the influence of the problem, “I am worth nothing”, on his life. He suggested that we should pray for all his bodily parts to start working again. I suggested that we look at the parts of his body that were still working. Since he has suffered no brain injuries, we looked at the possibility of him creating a job for himself where he has to use mainly his brain. The patient has since found it difficult to secure a job.

Patient 4

The patient is a 24 year old black South African woman who is unemployed and worships at the New Apostolic Church. She is HIV positive. Her baby of one year and one month died three months ago. Moreover, she herself is suffering from sores on her tongue and in her mouth, as well as vaginal infections. She came for counseling with her mother-in-law. She says that she initially met HIV as the “Destroyer of the body” and the “One that makes you feel frightened about the future of your body”. She used to be frightened that people, especially church people, would reject her. However, because of her mother-in-law’s commitment and support, she has now given another name to HIV, that is the “One that unites and bring people closer together”. She wants to teach other people, also church people, how healing this new name for HIV is.

Patient 5

The patient is a 28 year old Indian South African woman, who is unemployed and worships at a born-again church of which her boyfriend is the pastor. She has a daughter of 14 and the three of them live together in a small room. The daughter is difficult and the boyfriend wants to leave because of her. The patient now has to choose between the boyfriend and her daughter. She has to marry the boyfriend because the church does not want them to live together “in sin”, or lose him. The choice has become even more difficult since her daughter was raped in the park across the road from the room where they are living. The child now goes back to the place where she was raped in order to start a relationship with the rapist. After landscape of identity questions, the patient feels empowered by the insight that she has more choices than choosing for or against her daughter. The patient is now considering sending her daughter to Weskoppies for help, and finding a job to make her less dependent on her boyfriend.

Patient 6

The patient is a 65 year old white South African woman who was born in the Dutch Reformed Church, but has recently been baptised in the Apostolic Faith Mission Church. She lives in a mission where she has to clean toilets, receiving only dry bread to eat. She receives a state pension of R720 per month, of which R340 has to be paid to the mission. There is no privacy with four people in a room, and there is also nothing to do to pass the time. The patient is stressed and depressed. The discourse holding her captive is that it

is enough to care for a person's soul, but her body must look after itself. Landscape of identity questions reveal that the patient is a strong woman of the North West, "haastig en taai". This empowers the patient to an extent, but she is afraid to complain about her circumstances since she may lose them too. The patient did not come for her next appointment.

Patient 7

The patient is a Pedi woman in her forties who worships at the Zion Christian Church, is unemployed and lives in the squatter camp with her boyfriend on whom she is financially dependent. She was brought in highly traumatised after she had, yet again, found her boyfriend having sex with a dog. Landscape of action questions revealed that the patient still regarded the relationship as very important. She mentioned the following to be on the side of the relationship: he does not beat her; he gives her food; he does not bring his girlfriends home. We consequently wrote a letter to the boyfriend, inviting him to join us in counseling in a week's time. This was a benign letter, telling him that the patient had identified him as a significant person in her life, and that we believed that he could assist in her healing. The letter raised the patient's hope that the relationship could be saved. However, the patient turned up alone at the next session. She told how her boyfriend, after having received the letter, fled the shack in fear of imprisonment (bestiality is against the law) and left her without food. We undermined the binaries "Hope with boyfriend" and "Hopeless without boyfriend" by identifying her support systems, that were the church, her friends Magdalena, Ruth, Grace and Mary, and the determination not to look for a new boyfriend soon.

Patient 8

The patient is a black South African woman in her thirties. She worships at the Conquerors through Christ Ministries and is self-employed as a beautician. She had been diagnosed HIV positive earlier the day on which she came for counseling. She is convinced that she got the infection from her husband. Her husband has a mistress, and she slept with her husband without him wearing a condom because she wanted to please him and get him away from his mistress. He always tells her that the mistress does not insist on a condom. "My body is going to wither away and die" is the dominant problem discourse terrifying the patient at the moment. However, landscape of identity questions have been guiding the patient to an alternative story. In this story she is going to live beautifully with Aids. And she is not going to ask God "Why me?" She is rather going to ask God for power.

Patient 9

The patient is a 26 year old black South African woman who worships at the Universal Church and is employed in a good middle-income job. She is 19 weeks pregnant but seeks an abortion. The reason is that her relationship with her husband has deteriorated beyond repair since she became pregnant. After weeks of verbal abuse, he started abusing her physically five weeks ago. However, abortion is against the teaching of her church. The patient is struggling deeply with the discourse that abortion is sin. Eventually, her alternative story views abortion as protection for the unborn child, that is, protection from an abusive relationship ensuing from his/her father.

Journeying with stories: Dintle is chronically beautiful

Dintle is a 44 year old black South African woman who worships at a mainline church. She is a pensioner. She has been diagnosed with chronic dermatitis. It is now almost six years that her body has been itching non-stop. And indeed, Dintle's body is covered in sores that seem to be in constant need of scratching. We have externalised "Chronic" as the problem ruining Dintle's body and life. With the chronic itching comes chronic stress. And chronic depression. And chronic backache. And chronic headache. And a chronic feeling of being powerless. "Chronic" is made stronger by several losses Dintle has suffered during the past decade. Her sister has committed suicide, and soon afterwards her husband died of cancer of the rectum.

Six years ago the doctor gave her medicine for the chronic dermatitis that brought great relief, but ceased to work after a while. She then went to a traditional healer, but then the sores and the itching got worse. Now the doctor here at the hospital has given her medicine that works well. However, the medicine helps with the skin sores, but not with the stress, depression, backache, headache and powerlessness.

Landscape of action questions create space for Dintle to speak about other occurrences in her life that make "Chronic" stronger. She has been a teacher all her life, and earned quite a good salary. However, when she went on medical pension because of her skin condition, her brother as head of the family demanded her pension money from her. When she refused to give it to him, he tied a rope around her neck and pulled her

through the street. In addition to her skin sores, indeed, her neck shows the awful traces of the rope and public humiliation. Soon after this tribulation, too, she found her boyfriend with another woman. This made her feel utterly horrible about her body.

The discourse supporting the problem is “God and the ancestors are punishing me for something”. The binaries of the discourse are “God and the ancestors will make this last forever” and “I cannot do anything about it”. We start to deconstruct these binaries by landscape of identity questions to establish her physical beauty. To the question “What makes you chronically beautiful?” she answers “My eyes, my mouth, my smile, my nose, and my body that is still sexy”. In the second place I am asking landscape of identity question as to her relations. To the question “Who chronically likes you?” she answers “My children, the people at the church, my colleagues, most of my family”.

At the moment we are shifting her dominant problem-saturated story of “chronic illness” to an alternative story of “chronic quality of life” and “chronic beauty”, making a benign God and satisfied ancestors important role players in this story.

Religious identity discourses

Patient 1

The patient is a 53 year old white single woman. She holds a good job at a prominent company where she finds reasonable job-fulfilment. We externalised the problem influencing her life as “Spiritual crisis”. The problem came into existence when a pastor from one of the mainline Afrikaans-speaking churches started courting her after she had met him at a camp for religious meditation. The problem was strengthened by his sporadic visits to her amidst his refusal to commit. Deconstructing “Spiritual crisis” brought to light that the problem was fed by the dominant discourse in her church that renders family life as the Christian way of being and allowed little space or activity for single people. The patient was empowered by a reconstructed identity discourse that encouraged friendship of a wide variety amongst single people of religious orientation. She is also empowered by renaming herself not as a single person (a condition) but as a person who is singling (an activity).

Patient 2

The patient is 44 years old, white and married to a man who lost his job and sold the house for cash. She belongs to an Afrikaans-speaking mainline church. She herself is for cultural reasons unemployed, meaning that she stopped working when her first child was born as culture demands. The present crisis in her 23 year old marriage was intensified when she saw her husband's car standing in front of a brothel. We externalised the problem as "God and my husband have taken away my identity". The problem was strengthened by the dominant discourse of Afrikaans society that a woman's identity lay in her married state. This discourse has robbed the patient of proper training when she was young, fearing that a learned woman would not make a good marriage. The patient is both empowered and scared by the thought of developing an identity of looking after herself, financially and emotionally. However, she is encouraged by the skills of women in the Bible to survive alienating circumstances.

Patient 3

The patient is a 33 year old white woman who worships at the Dutch Reformed Church. Both her parents died when she was young and she grew up in a children's home. She ran away time and again, from the home, from school, later from the reformatory, and eventually also from her boyfriend. She started taking drugs. At present she lives in a mission and is unemployed. We externalised the problem as "Failure". Throughout her life the problem has convinced her to run away when she felt as if she was failing. The discourse adding strength to the problem is that nobody likes a girl who has no parents, no home, and no hope of a future. The patient deconstructed the discourse by exploring new identities of herself as somebody who has reason not to run away from things because she has a future. Regarding the Bible as an important intertext to her relationship with God, she started making a study of stories of hope in the Bible. Connecting through hope with God and other people made the problem of "Failure" smaller.

Patient 4

The patient is a black South African woman in her forties. She is employed as a nurse and is a very devoted Christian. She is not married but, all in all, has 11 children to look after with a nett salary of R750,00 per month after 26 years of service. We have externalised the problem as "Why does God not take care of the caretaker?" A unique outcome was the identification of even

more people that are dependent on the patient, that is, three doctors and other staff as well as 50 patients per day. She finds that strengthening her identity as a caretaker is indeed making her stronger, and the problem was made smaller by letting God off the hook as miracle worker, rather inviting God in as friend and helper. Although as a counselor I would have liked to look for more unique outcomes, the patient is finding consolation in discourses such as “You have to praise God even when you do not have food”, and “God takes time to answer.”

Patient 5

The patient is a 30 year old Venda city man, originally from Venda. He is a casual churchgoer. He and his wife both hold good middle class jobs. However, two weeks ago his wife suddenly became ill and was brought to the hospital where she died. The hospital could not tell him to cause of her death. He then went to a sangoma who told him that she died because somebody was jealous of her because she was well employed. We have externalised the problem as “Anger”. The patient is angry because the hospital cannot tell him why his wife died. He is also angry because, as the sangoma said, she might have died because of somebody’s jealousy. The patient is now repositioning himself vis-à-vis his loss. Instead of concentrating on not knowing what caused her death, he is now focussing on the fun her life was. Doing a life review, remembering her without the sorrow, and establishing that their life together was indeed one to be jealous of, are means of deconstructing the sangoman discourse of “death through jealousy”.

Patient 6

The patient is a young black boy, 18 years old and in Grade X. He worships at the Roman Catholic Church. His problem is that he “is ambitious”, but that there are things standing in the way of his ideals. The main one is that he cannot get the right girl and that steals his attention so that he cannot get the grades he wants. Also, his church forbids sex before marriage and he really has a need for sex. We decide for the time being not to talk about sex as right or wrong, but whether sex is on the side of his dreams or his fear of failure. The patient decides, for the time being, that it makes him happiest to be Christ centred, and to engage in prayer which he describes as “advanced”. Also, he enjoys preaching at school, and clandestine sex will spoil his success in doing this.

Patient 7

The patient is a 25 year old black South African man who is studying law. He worships at the Believers Family Church, but his belief in God was shaken when his mother unexpectedly died last year. We deconstructed the discourse “God has taken my mother away from me” by asking what he has inherited from his mother. The patient is discovering that he has inherited sensitivity, strength and selectiveness in friends from his mother. The patient has also identified faith as one of his support systems, and wants to walk a new road with God who has given him a mother of whose moral inheritance he is proud.

Patient 8

The patient is a black South African man in his thirties who is employed in a low-income job and worships at the Zion Christian Church. He is experiencing a serious collision of values in his life. In the first place, he believes like his church in the values of no drinking and no smoking, but he has had a girlfriend for 10 years with whom he has two children, since “life in the township is too hard to be alone”. Two years ago he started experiencing pain after intercourse, and lately his private parts are full of sores and itching. Also, since he does not “share a blanket any more” with his girlfriend, his family from the rural areas want the children to come and stay with him. We have externalised the problem as “A clash between church, township and homeland values”. The patient is shifting the discourse “I have to live according to other people’s values” to “I want to live with values that make me healthy”. The patient has decided that living according to the church’s warning against clandestine sex may be a healthy value.

Patient 9

The patient is a 28 year old black South African man who worships at the Roman Catholic Church and is fairly well employed. He complains that his “things don’t work with women, but with men they work fast”. He wants medicine to make his things work with women because his family wants him to become a father. The church, too, wants him to marry. We have identified the binaries of the discourse ruling his life as “A real man is a baby-maker” over against “A gay man is an embarrassment to his family and the church”. However, the influence of the anti-gay discourse on the patient’s life is very strong and makes him to resist exploring the possibilities of manhood between these two opposites.

Journeying with stories: Ingrid chooses belief that gives her a healthy identity

Ingrid is a white woman in her forties. Her childhood was miserable, and we externalised her problem haunting her since childhood as “Bad Religion”. Her brother and sister were both autistic, and her mother took out her anger against God on Ingrid. On the one hand, Ingrid says, her mother consulted sangomas; on the other she sent Ingrid off to a very strict church school where almost everything was seen as sin and she was instilled with excessive self-blame. Eventually Ingrid went to university where she studied for a professional career. Then, Ingrid says, her mother disliked her even more, because she could engage in a career, something her mother was never allowed to do. At some stage her mother left her father, and went to stay with the pastor. However, Ingrid also was not permitted to practice the career of her choice, and she was told that women were not allowed to become geologists. She settled for a lesser career, also because she was told that a woman would not make a good marriage if she did not act ignorant and stupid. She married a professional man, a staunch Christian. They had two children and divorced after 14 years. When Ingrid discussed her problems with the pastor, he told her story from the pulpit. Ingrid later remarried, again a professional man, whom she regards as her friend. However, anger at the behavior of Christians is still haunting her.

During counseling we looked at the discourses that stole the chances from her to become the person she preferred to be. Some of these discourses are: A woman should not seek a career; a highly qualified woman ruins her own chances at getting a husband; and the only thing a woman’s problems are worthy of, is to be used to warn other men.

When deconstructing these discourses, Ingrid looked at what healthy religion should look like. Healthy religion, we found, should respect women’s talents as Jesus did; it should encourage relationships in which the partners have equal power, as Priscilla and Aquila had; and it should encourage transparency and honesty in all human relations, especially between parents and children, but also between pastors and congregants. Just as Jesus was transparent and honest towards his disciples. Ingrid intended to use these deconstructed dis-

courses to further the relationship with her husband, and to raise her children amidst the skills a healthy religion encourages them to use.

Religious otherness discourses

Patient 1

The patient is a 45 year old black South African woman who worships at the Zion Christian Church. She suffered from tuberculosis when she was a child and is still unable to work because of her lungs. She has five children between the ages of 9 and 24. Her husband has a good job, but does not support them. He does not pay the bills, and there is no food in the house. We have externalised “No money” as the problem causing her to be depressed and to sleep badly. The problem is strengthened by discourses such as “A woman should not bring her home problems to the church, but pray to God to help her”, and “A woman should carry her burden in silence.” The patient is deconstructing these discourses towards “A woman needs allies to help her.” She is renaming herself as “A woman who makes plans” and intends to file for maintenance from her husband for herself and the children at the magistrate’s office.

Patient 2

The patient is an 11 year old black girl, who worships at an Apostolic church. She was involved in a bus accident with 40 other children on their way from school. We externalised “Death came near me” as the problem haunting her. The problem made her feel “sad and shaky”. The patient presented praying as the only way in which “Death came near me” can be made smaller. We added to that ways in which life can be celebrated. We identified people who could celebrate life with her.

Patient 3

The patient is a 57 year old Ndebele woman who worships at the Assemblies of God. We externalised the problem terrorising her as “Losses”. Two of her children died. The one was shot and the other died due to illness. She herself lost her job. Her husband left her and is staying with another woman. The problem makes her feel “that the whole room is a black cloud”. She has considered praying as an option to make the black cloud smaller, so that it would fill only part of the room, and later go away completely. She is now

committing herself to exploring ways in which she can fill her life with meaningful activities. We both knew that she might develop the skills to look for such activities, but that the opportunities would be few.

Patient 4

The patient is 18 years old, and a black South African. She worships at the Charisma Christian Church, and is a student at the Technicon. During the past six months, she has suffered five major losses. Two of her cousins and three of her friends died in car crashes, and one was shot by her boyfriend. The losses have made the patient very sad. "Sadness" makes her not attend classes at the Technicon, not study, not sleep, and evade people. "Sadness" steals her energy and steals away her friends. The patient feels going to church will save her from "Sadness". She feels that church is the only place where death is not final, where there is life beyond death. In future, we feel, we shall strengthen this discourse. The death of her friends and family should also not end the enjoyment of life for her here on earth.

Patient 5

The patient is a 43 year old black South African woman who worships at the Holy Gospel Church and is unemployed. She has three school-going children and no income. Her husband has been jailed for 10 years, and she was financially dependent on her mother's pension till her mother died the month before. The patient feels that she cannot go to church any more because the church reminds her of her mother's absence and of God not helping her. At the next session a week later, the patient brought me her mother's jersey. She told me that I was her mother now, and that school fees were payable. The binaries of the discourses holding her captive are "God the Provider" (through his appointees) on the one side, and "I need to be provided for" on the other. Apart from counseling her on the loss of her mother, I also provided her and her family with food. We both decided to undermine the binary that she was to be provided for. She suggested that I gave her money to start selling ice-cream to children since she did possess a fridge. I helped her with the money but she has as yet not started a business.

Patient 6

The patient is a 50 year old black South African woman, who is employed as a domestic worker and worships at the Roman Catholic Church. She was referred for counseling because she was in a hi-jack two weeks ago. How-

ever, it turned out that she was still seeking closure after the death of her son two years ago. When he suddenly became ill in December, she took him to Polokwane to the Zion Christian Church of which he was a member. There was a long line there for people waiting to be healed, but the prophet saw that he was in special need and took him immediately to where they prayed for him, sprinkled holy water over him, and massaged him, although it was very painful to him. After that, he felt strong and walked on his own. He even wanted to drive home! She was so sure that he would live, that she arranged a party for him on 1st January. However, he passed away on 29th December. How can this be? she is asking, since she had two dreams which indicated to her that he would live. In the one dream there were strong men waiting in line. When they got to the front, their heads were cut off with a saw. But when her son got to the front, he was told “No, not you”. In the second dream, again, she saw a line of men standing, and everyone’s head was pierced with a spear, except that of her son. So, she was so sure he was going to be saved, but he died. The patient is very sad, and believing that God has deceived her makes the sadness larger. The discourse “God was dishonest with me” was shifted to “God taught me how to be strong” when she was reminded through landscape of action questions what she has learned from the hi-jacking. She has learnt how to stay calm, and recover quickly. This saved her life during the hi-jacking, and can help her to survive her son’s death now.

Patient 7

The patient is a 59 year old Ndebele woman who worships at the Seventh Day Adventist Church and is employed as a nurse at a State hospital. She has suffered severe losses during the past decade. First her husband, who is a taxi-driver, was hi-jacked and their combi taken. Soon after that, he was hi-jacked again and R17000 stolen. The police were involved in this and the case was never resolved. Then her sister died of cancer without having told her that she was ill. Then her son was shot dead while driving a taxi. Not long after that her only remaining sister died of an unknown disease. Her only remaining son is a drunk. The binaries of the discourse that strengthens her depression are “A Christian can only pray” versus “Nothing helps”. When the spaces in between are explored through landscape of action questions, the patient is empowered by remembering that she has dealt well with difficult situations in the past, such as a difficult husband, difficult in-laws, and difficult circumstances at work where there has been a shortage of staff. She also remembers that she put down snuff for the ancestors and paid her tithe to the church, and that both these agencies have helped her in the past. The patient

now feels empowered by her support systems, as well as by her own ability to transcend difficulties.

Patient 8

The patient is a 25 year old black South African man and is unemployed. He does not belong to a church but wants to start one. He is receiving visions in this regard, but may not talk about them. We have externalised the problem as “Outsider”. The patient does not feel welcome around people. This makes him sad and anxious. However, he interprets the visions, the isolation and the anxiety as signs that God is calling him to start a new church. Landscape of identity questions here centre around questions whether the visions are bringing greater or smaller sadness. The patient insists that the visions are empowering him to start a new church, the details of which he may not disclose to me. The patient furthermore interprets his own suicide attempt as an attempt from Satan to convince him not to accept this calling from God. The patient is reluctant to explore the spaces between the binaries “God is calling” and “Satan is devious”. After he was discharged from Ward 2B, the patient did not turn up at his next appointment for counseling.

Patient 9

The patient is a young black woman of 17 years. She worships at the Lutheran Church and is in matric. The patient has lost R1200 given to her by her sister to go and bail her sister’s boy out of prison. The patient cannot remember what she did with the money. Consequently her sister beat her. Her sister also consulted a sangoma who told her that their mother has eaten the money. Consequently the mother’s bed caught fire and was burnt to ashes. Also, the patient’s sister was in an accident and sustained injuries to her head which was, according to the patient, punishment for what the sister did to her.

The patient attended many sessions. During her sixth session, that is, four months after she had commenced with counseling, she told me about her visions. The patient claimed that the future was revealed to her through dreams. She told me how she met a “fortuneteller” (Tsepo) who told her that she was the chosen one. As a sign he gave her a pain in the side. She experienced this pain on Wednesdays, the day on which she was born. On Mondays, Tuesday, and Saturdays she received dreams and heard voices. The patient was especially concerned about the fact that the neighbour’s girl came to visit her. A girl could be used, she said, to kill somebody, to get blood, to receive the Holy Spirit, or to obtain knowledge for the exams.

Landscape of action questions revealed that the patient had experienced the pain in her side, as well as the visions and dreams, particularly harshly just before she wrote exams. We externalised “Stress” as the problem inviting bodily pain and nightmares into her life. The binaries produced by the problem are “God sends me messages through visions” on the one hand, and “People are causing me pain and nightmares” on the other. Landscape of identity questions assisted the patient to decide on a Three-P-Plan to counteract “Stress” and to empower herself to distinguish between the grace of God and the deviousness of people. The Three-P-Plan consisted of (1) to Pass matric; (2) to Participate in life as a young person enjoying herself should, and (3) to be Patient but not to take harm from anybody.

Journeying with stories: Mpatsi looks for closure

The CEO of the hospital referred Mpatsi for counseling after she had been sitting in front of the CEO’s office day by day, insisting on a letter from the hospital to have her son’s body exhumed. This was in August. Her son (22) had been buried six months before in February.

Mpatsi was retraumatised by telling the story of her son’s death. He was in a shop, trying to get his money back for a pie that had turned out to be cold. The security guard then shot him, pretending, according to Mpatsi, that he believed that this was a robbery. However, Mpatsi was convinced that it was her ex-husband who had the child shot before the maintenance court could sit.

Mpatsi, a Lutheran, furthermore believed that her son was not dead, and that God had told her that he was alive. She wanted a letter from the hospital to give to the police to have him exhumed so that he could be home for his birthday on 23 August.

We externalised the problem as “Sadness”. Sadness had severe effects on Mpatsi’s life. It made her cry. She could not find any rest; she could not sleep. Sadness gave her constant headaches and made her feet blow up and become very painful. Evaluating the effects of the problem on her life, I asked Mpatsi whether it was Sadness that convinced her that her son was not dead. However, Mpatsi insisted that it was God who told her this, and that she could “feel” that her son was still alive.

We went through several closure procedures, but they were unable to make Sadness smaller. Mpatsi was captured by the

discourse “God raises people from the dead when we believe he can”. She did not want to engage in deconstructing this discourse. She attended several counseling sessions. When her son was not back home for his birthday, Mpatsi stopped coming for counseling.

Summary of findings

Profile of research population

The aim of this chapter was to describe the third leg of the MEET process, that is, empowering the patient against the problem discourse by **deconstructing** the binaries of the problem discourse, and **constructing** an alternative story by exploring the dialogical spaces between the binary oppositions that keep the problem discourse in place. In this chapter, then, the deconstruction of religious problem discourses in the case of 40 patients (in addition to the 40 discussed in the previous chapter) has been discussed. Again, ten of them pertain to power discourses, ten to body discourses, ten to identity discourses, and again, ten to otherness discourses.

The profile of the 40 patients discussed in this chapter vis-à-vis the five variables that have earlier been identified as of therapeutic significance – race, gender, employment, age and religion – is as follows:

- *Race*: A majority of patients, that is, three-quarters (30), are black. There are eight white patients, and two Indian patients.
- *Gender*: A vast majority of patients (32) are women. Eight of the patients are men.
- *(Un)employment*: More than half of the patients (25) are unemployed. Four of the patients have recently lost their jobs. Five of the patients are students and two are pensioners. Of those employed (15), eight fall into a minimum income group, that is, with a salary less than R1200=00 per month. The patients, then, are generally very poor with grave financial problems.
- *Age*: This group is, on an average, younger than the previous group described in the previous chapter. Almost half (18) of the patients are under 25, with four of them teenagers. Ten are in their thirties, five in their forties, nine in their fifties, and three in their sixties.
- *Religion*: In this group there is only one Muslim. There is one casual churchgoer and one who wants to start his own church. The rest (37) are staunch Christians, 14 from mainline churches, 8 from Pentecostal

churches, 9 from born-again churches, and 6 from Zionist/Apostolic churches.

In summary, the patients here (as in the previous group discussed in Chapter 3) are very poor, with more than half of them unemployed and the rest employed in minimum salary jobs. Most of them are committed Christians, with the exception of one casual churchgoer, and one committed Muslim.

Deconstructing spiritual healing

With most of the patients being staunch Christians, what do they regard as healing? Or, what have they experienced as healing during the counseling process? And how do they view the role of spirituality/belief in this healing?

Already in 1969 a local study by Johannes P Theron on *Gebed en genesing in die pastorale sorg*³¹⁷ negotiated a place for pastoral care between the binaries of Western medicine that focused on healing as something purely physical, and spiritual healing that focused on miraculous healing through the gullibility of the believing soul. He argued for an “in between” position where the pastor and believer engaged in dialogue with God, that is in prayer, requesting health for the believer as a whole person. Although the concept “deconstruction” is unknown to this author, he established his position on a healthy relationship between prayer and healing by “deconstructing discourses” that made believers ill and blurred the relationship between them and God. These were discourses such as “I am ill because I sinned”, “God has caused my illness”, “Satan has made me ill” and “Healing is solely the redemption from sin”. Although Theron deals with these discourses in a dogmatic and not a narrative way, one can translate his insights into narrative language. A reconstructed discourse, then, would sound something like “Prayer is inviting God to engage in the health of the believer as a whole person, that is, a human being as a unity of body and soul.”

Recently (that is, in 2003) Walter Thiessen has done just that, namely to use social constructionist views to describe prayer as the invitation to God to get involved in the health of the patient. In an article “Inviting God into our stories: A social constructionist description of Inner Healing Prayer”, based on his doctoral thesis,³¹⁸ Thiessen negotiates between the binaries of “divine intervention as the only true healing” on the one hand, and “decon-

³¹⁷ DD, Universiteit van Pretoria.

³¹⁸ In *Practical Theology in South Africa* 21.3, pp 207-222. This article is based on Thiessen’s doctoral thesis that was accepted in 2003 by the University of South Africa under the title *Prayer in a new reality: A social constructionist perspective on Inner Healing Prayer*.

structing social discourses as a secular enterprise that does not allow for divine healing” on the other. He contends that “a social constructionist perspective provides a lens with which to describe Inner Healing Prayer that is relevant to the current disciplines of practical theology and the social sciences without a reductionistic approach to God’s involvement in the practice.”³¹⁹ This deconstructed view on God, prayer and healing allows Thiessen, then, to interpret Inner Healing Prayer “as a social process in which God is invited to participate in the reconstruction of a person’s reality or story”.³²⁰ (His thoughts have been explored earlier in this study).

The present study, too, deconstructs between Western science and traditional *charismatic* concepts of spiritual healing (as did Theron). The present study, too, deconstructs between prayer as a mechanistic call on God’s intervention, and the patient’s story of inviting God into the healing process (as did Thiessen).

However, the present study also has to deconstruct between Western science and concepts of illness and healing within *township spiritualities*. In a recent, fascinating study Matsobane Jacob Manala, a lecturer in Practical Theology at the University of South Africa, deconstructs between a Western world-view and an African world-view in order to find an “in-between” for Christian ministry. He describes a Western world-view as (1) uncomfortable with supernaturalism, (2) materialistic, (3) centred on human achievement, (3) rationalistic, (4) individualistic, and (5) hooked on change.³²¹ An African world-view, on the other hand, (1) sees life as a holistic unity of inter-relations, (2) is characterised by strong community bonds, (3) views God as the one giving life-force and power, (4) has a heightened sense of the sacred, (5) places human well-being at the centre of their view of life, and that includes the well-being of the ancestors.³²² In between, then, Manala constructs a new story for the healing ministry of the church³²³ that (1) embodies the African communal system, (2) includes the rites of anointing the sick, laying on of hands and exorcism to the sound of Afro-Christian music, and (3) takes the believer’s experience of witchcraft, demons and ancestors seriously.³²⁴

³¹⁹ *Op cit*, p 207.

³²⁰ *Praying in a new reality*, p 3.

³²¹ Matsobane Jacob Manala, *The church’s ministry to the sick in a black South African context* (D Th, University of South Africa, 2007), pp 161-166.

³²² *Op cit*, pp 107-117.

³²³ Manala focuses as an insider on the Hervormde Kerk Family.

³²⁴ *Op cit* pp 243-256. See also MJ Manala, “‘God is the most superior physician’: conqueror of witches and great restorer of health in Africa”, in *Practical Theology in South Africa* 20.2, p 53.

Following in the footsteps of studies as above, this chapter has engaged in describing how harmful religious discourses that held patients captive were deconstructed, and how patients were assisted in constructing alternative stories of spiritual healing.

The deconstruction was mainly

- between the binaries “Western concepts of God and Christian practice” and “African traditional practices as part of township spiritualities” (eg when the ancestors forbid adoption),
- between “church doctrine” and “the needs and rights of everyday life” (eg when the church forbids an abused woman to divorce),
- between “the patriarchal God” and “God who journeys with us on our way to healing”.

I shall forthwith describe the findings of this chapter, that is, how (spiritual) healing³²⁵ was experienced by patients through the deconstruction of religious discourses that affected badly/unhealthily on their lives.

Deconstructing religious discourses and co-constructing alternative stories of faith

- Religious power discourses
 - (1) Unique outcomes between Western and African religiosity
 - The discourse “Depression is caused by an evil spirit” has been restoried as “God’s love can heal depression since God is stronger than evil”, and “I can let other voices in my life speak stronger than the voice of an evil spirit.”
 - The discourse “The toordokter could not help my son, now God must” has been restoried as “God has given me unique talents to build up both myself and the broken people around me”.
 - The discourse “God has given all power to my husband who beats me” has been restoried as “God gives me the power and the right to live with respect; I shall not let the Devil steal it.”

³²⁵ “Spiritual healing” is used here in its traditional meaning, that is, healing that is effected without any material means such as medicine.

- (2) Unique outcomes between religious doctrine and human needs/rights
 - The discourse “According to the Qur’an it is evil for a woman to fight back” has been restoried as “I have access to Allah as a woman and I feel healed by Allah’s loving nature”.
 - The discourse “I shall only believe in God again if he restores me financially” has been restoried as “Healing also includes resting, taking control over your life, and inviting God and the church into your life to make you strong and happy”.
 - The discourse “A pre-nuptial contract as well as divorce are un-Christian” has been restoried as “God wants me to be safe in marriage”.
- (3) Unique outcomes in restorying God
 - The discourse “God has allowed me to be assaulted” has been restoried as “Thinking back, I have found out during the assault that God has equipped me to deal with situations like these. This makes me strong enough to prevent them.”
 - The discourse “I shall pray to God and He must provide” has been restoried as “I shall pray to God to make me strong to change my circumstances, and to follow the advice I have given to my madam to go on with life.”
 - The discourse “The man is always right and may beat me when he thinks necessary; the rest I give over to the Lord” has been restoried as “God is not beating me, my husband is; I shall look for a safe place to live and ask the church to speak to my husband; I shall learn to walk the healthy and respectful road with the Lord.”
 - Religious body discourses
- (1) Unique outcomes between Western and African religiosity
 - The discourse “God tells me in dreams that my body is sinful” has been restoried as “God himself has become a body! Jesus’ body was good enough to suffer on the cross for my sins. I can ask God in the dream to heal my body as he has done with Jesus Christ.”
 - The discourse “A widow must stay in the house a year after her husband’s death” has been restoried as “God also uses widows to be agents of life.”

- The discourse “Chronic illness is punishment from God” has been restoried as “I can look for chronic quality of life and invite God and the ancestors in to be important companions on this journey.”
- (2) Unique outcomes between religious doctrine and human needs/rights
- The discourse “The church only looks after my soul” has been restoried as “I may ask the church to help me with food when my body is hungry”.
 - The discourse “Abortion is sin” has been restoried as “Abortion is protecting the baby against an abusive father”.
- (3) Unique outcomes in restorying God
- The discourse “God has sent HIV and Aids to destroy my sinful body” has been restoried as “My family and I see HIV and Aids as God’s gift to unite people in care”.
 - The discourse “God and the church force me to choose between my boyfriend and my child” has been restoried as “God gives me many choices to journey with the people I love and care for.”
 - The discourse “Why me, God?” has been restoried as “God will give me power to live beautifully with HIV and Aids.”
- Religious identity discourses
- (1) Unique outcomes between Western and African religiosity
- The discourse “The *sangoma* says my wife died because somebody was jealous of her job” has been restoried as “Thinking back, I really think we had a life together to be jealous of. For this I thank God and can remember my wife fondly.”
 - The discourse “My culture and my husband do not allow me to have a career” has been restoried as “Jesus has shown us what relationships of equal power can look like.”
 - The discourse “God and my culture want a man to be a baby-maker” has been restoried as “I shall try to negotiate my identity with God and my family.”

- (2) Unique outcomes between religious doctrine/practice and human needs/rights
- The discourse “There is no place in the church for single people” has been restoried as “I shall look for friendship amongst single people of faith.”
 - The discourse “I have to choose between sex and the church” has been restoried as “I choose to be Christ-centred because that is what I enjoy most.”
 - The discourse “I have to live according to the values of the church even when they destroy my life” has been restoried as “I have to live according to the values that make me happy, many of which I have learnt from the church.”
- (3) Unique outcomes in restorying God
- The discourse “After getting married, God and my husband have taken away my identity as a person of worth” has been restoried as “Women in the Bible are survivors and can teach me a lot about living as a proud woman in my marriage.”
 - The discourse “I need a miracle to continue caring for all my children” has been restoried as “I shall invite God into my life to help and to care for me, and let him off the hook as a miracle worker”.
 - The discourse “God has taken my mother away” has been restoried as “God gave me a mother from whom I inherited sensitivity, strength and survivor skills.”
- Religious otherness discourses
- (1) Unique outcomes between Western and African religiosity
- The discourse “The ancestors tell me in dreams that my son is still alive although he was buried six months ago” can be restoried as “I’ll say hello to my son’s memories and not to his body.”
 - The discourse “God is calling me through visions and anxiety attacks to start a new church, but the Satan is trying to stop me by making me try to commit suicide” can be restoried as “I’ll walk a healthy road with God who is stronger than Satan.”
 - The discourse “A fortune teller has told me that I shall experience pain because I am the chosen one” has been restoried as “I shall reduce

stress in my life, and live an exemplary life as a Christian not harming other people, and not taking any harm from anybody either.”

- (2) Unique outcomes between religious doctrine and human needs/rights
- The discourse “Death is scary” has been restoried as “The church tells me that there is hope beyond death.”
 - The discourse “Death comes unexpectedly to us all” has been restoried as “I shall celebrate life.”
- (3) Unique outcomes in restoring God
- The discourse “God has deceived me” has been restoried as “Thinking back, God has previously taught me how to recover quickly, and I can do that now too.”
 - The discourse “I can only helplessly wait for God to answer my prayer” has been restoried as “God points out to me how I have dealt with difficult situations in the past, and I can do it again.”

Conclusion

In this chapter, religious discourses that have been affecting the lives of patients harmfully have been deconstructed and re-storied as alternative journeys of hope.

Unique outcomes have been described as ensuing from the deconstruction between

- Western and African religiosity
- Church doctrine/practice and human needs/rights
- God as patriarch and God as empowerment
- The patient as a victim and the patient as agent.

In this chapter, then, it was described how patients have found (spiritual) healing by deconstructing between the binaries of the religious discourses holding them captive. In the process they have restoried the relationship between culture and religion, as well as the relationship between church dogma and their needs and rights as human beings. Furthermore, in restoring themselves, patients have found the skills to move from victim to agent in their own life stories. Most important, however, was that patients were able to restory God as the One who empowered them to lead respectful and worthwhile lives.

However, these alternative stories are not to remain “thin descriptions” that fly by night and bring the patient back to square one when they leave the counseling room. The next chapter will therefore describe how patients have thickened their restoried lives **through religious practices** in order to make their alternative life stories sustainable.

Chapter 5

Thickening the alternative story of faith

This chapter describes how alternative stories are thickened in counseling to make them sustainable within township spiritualities. Although a variety of paths were followed to thicken alternative stories, the focus in this chapter will be on *religious practices* as ways of thickening the stories that have emerged from alternative religious discourses.

According to Morgan,³²⁶ narrative counseling tends to make use of the following methods to thicken alternative stories:

- Writing therapeutic letters to the patient
- Including the patient in support groups
- Encouraging the patient to engage therapeutic documentation in the counseling process, such as certificates, photographs, symbols, and
- Engaging the patient in rituals and celebrations.

Of these ways of thickening alternative stories, the first two were not available with the research population under discussion. Writing therapeutic letters to patients is almost impossible. The research population is either illiterate or uncomfortable with written English. Moreover, most of the patients come for a single session of counseling only, since they lack money to travel or, as low income employees, are vulnerable when asking for leave to visit the hospital regularly. Finally, many of the patients do not have fixed addresses or live in squatter camps where mail is not delivered.

It was one of my dreams to form support groups in the hospital itself, for instance for mothers who are physically assaulted by their teenage children, but it was difficult and eventually impossible to get permission for such action. It was another dream of mine to incorporate the churches in Atteridgeville in a network of support to actively thicken the patients' alternative stories within communities of care, but time restraints stood in the way of this dream.

Some of the other ways of thickening the alternative story have been useful in doing counseling with the research population, of which the last two mentioned above stand out prominently. Therapeutic documentation has played a vital and sustainable role in the said counseling, and includes photographs of a lost child and pot plants grown in the ground of the grave of a

³²⁶ *Op cit*, p 75.

deceased. And Ceremonies have been performed enhancing the worth of patients, such as a ceremony where certificates were given to young teenagers for kicking sadness out of their lives after the death of a parent.

Added to these are the healing practices of the churches. Patients often refer to the healing practices in their churches as sources of emotional and physical healing. Here, the healing practices of the churches as ways of thickening the alternatives stories of patients will be discussed within the three categories of healing found in the churches in Africa, namely

- Diaconal healing – as practised by the mainline churches
- Ritual healing – as practised by the (African initiated) born-again churches, and
- Faith healing – as practiced by the Pentecostal churches.³²⁷

In the next subsection, then, the thickening of alternative stories through religious practices as it was done with forty patients will be discussed. Again, as in the previous two chapters, 10 patients will speak to each of power, body, identity and otherness stories. As in the previous chapters, nine of these stories will be in summary, and the tenth more elaborate in the series “Journeying with stories” that has been presented throughout this study.

Alternative stories of faith are thickened

Alternative power stories

Patient 1

The patient is a black woman in her thirties who worships at the All Nations Old Apostles Jerusalem Church. The problem is “Not enough money”. The problem makes her feel powerless, and unable to solve her relational problems. The problem is strengthened by her husband who is unemployed and by the fact that she only works three days per week. The effect of the problem on her life is stress, affecting her body in the form of headaches, body pains, and a burning chest. Her alternative story includes a change in life style and emotionally moving away from her husband’s abusive behavior. Her alternative story is strengthened by her participation in church activities, such as singing in the choir and doing home visitations to Aids patients,

³²⁷ See Othusitse Morekwa, *The interchange, exchange and appropriation of traditional healing, modern medicine and Christian healing in Africa today* (M Th, Systematic Theology, University of South Africa, 2004), p 152.

activities in which she makes a difference: “Die kerk maak sterk; die Here help jou lyf en jou kop” (The church makes one strong; the Lord helps your body and your head). The patient’s alternative story is furthermore thickened by the pastor praying for her in front of the faith community, and anointing her against her illnesses.

Patient 2

The patient is 51 years old, from Mozambique, and belongs to the Roman Catholic Church. He has five children between the ages of 3 and 30. We externalised the problem ruling his life as “Loss”. The patient has lost his business and his wife to her boyfriend. Because of Loss he has grave financial problems and has been deprived of sex for a long time. The effects of Loss on his life are depression and excessive drinking. During counseling he has undermined the influence of Loss by deciding to invite friends back into his life who are not drinkers, and by reminding him that people from the church often come to him for counseling. He has thickened his alternative story by deciding to sing regularly in the church choir, and to make himself available as a counselor in the church, thereby helping other people as “the wounded healer”. His alternative story is furthermore thickened by participating in Holy Communion at the church that makes him feel whole and part of a community of care.

Patient 3

The patient is a 53 year old white woman, who worships at the Pinkster Protestantse Kerk but stays at a mission with her third husband whom she married two months ago. We externalised the problem ruining her life as “Feeling unfulfilled”. Sex between her and her new husband is quick, without foreplay, and only once or twice a week. Also, they have grave financial problems that contribute to her feeling unfulfilled as a human being with financial needs. She works for their board and lodging at the mission, and he has a low-paid job as a security guard. The rules of the mission, moreover, are draconic and leave her feeling unfulfilled as a grown-up and as a person who needs space and who wants to make her own decisions. The discourses strengthening the problem tell her that a woman should not be so fond of sex and make such high sexual demands on her husband. The effect of this problem on her life was a deep depression, and not only feeling unfulfilled, but also powerless.

At the next session, however, the patient came back in high spirits. Her husband, she said, had in the meantime fallen into a depression, and it

was her duty now to snap out of hers and support him, a duty God has lain upon her. She felt that God has placed her back in control of the relationship. Although the counselor was amazed at this unique outcome, it was not for her to prescribe healing to the patient.

The patient is thickening her story of support to her husband by supporting the structures of the mission. She participates in activities on different levels, from cooking to management, thereby gaining influence to help other people at the mission who for different reasons feel unfulfilled.

Patient 4

The patient is a 32 year old unemployed Sotho woman who used to worship at the Fountain of Life Church. She has left this church because the priest told her personal stories from the pulpit. She also felt that the church offered her no support in dealing with her problem, which was loneliness and depression after her husband's death. On the contrary, while suffering financially from her husband's death, the church pronounced doom over her for not giving money to the church. The patient now worships at Heartfelt Family Ministries. Here the patient's alternative story of social interaction, that is replacing her problem-saturated story of self-isolation, is thickened with "biblical interventions" that enhance the communal spirit of the congregation and aim at the inclusive healing of the faithful. Her alternative story is furthermore thickened by the healing practices of the church, that include prayer and the laying on of hands.

Patient 5

The patients are an Indian South African couple in their thirties. They are Muslim and both employed in the middle income class. The wife has externalised the problem as her "husband's constant extra-marital affairs". The effects of the problem on her life were ulcers and suicide attempts. The husband does not see his affairs as a problem and says that God has made him a man, and that his affairs are between him and God. Efforts to engage the couple in the deconstruction of discourses and the thickening of an alternative story failed.

Patient 6

The patient is a black, unemployed South African woman in her thirties. She "adopted" a baby from another woman when the woman was 6 months pregnant. However, when the baby was a year old, the woman changed her mind

and wanted the baby back. The biological mother then turned up at the patient's home with the police and demanded the baby back on the spot. The patient cannot read or write and signed the papers given to her, thereby losing the baby and her will to live. When she had the baby, she belonged to the Zion Christian Church, but now she is not attending any church. The patient expresses her powerlessness in the question, "Why does God not help me, the poorest of the poor?" She is shifting this to identifying herself as a person who can make choices. She considers thickening this alternative story by filling up the empty space with church activities and churchy relationships. She furthermore considers making a choice to expose herself to the healing practices of the church, and to experience God's help in doing so.

Patient 7

The patient is a 19 year old black South African woman who worships at the Lutheran church and is unemployed. Eight days ago her baby of eight months died. The patient is moving from a dominant story of sadness towards an alternative story of "God gives, God takes". She is thickening this story by visiting other women who have also lost their babies, contacts she has obtained through her pastor. Thus "God gives, God takes" is becoming "God makes things better." She has attended a sermon in the church that has explained that women in the Bible also suffered losses and how they overcame their grief. The patient intends thickening her alternative story by exploring this topic further with the help of the pastor.

Patient 8

The patient is a white Afrikaans speaking woman in her fifties. She worships in the Nederduitsche Hervormde Kerk and is unemployed. The patient lives in an affluent suburb, but her husband died unexpectedly from a heart attack a month ago after he changed jobs. This left them without money for food or medical care. The patient is visiting the hospital for free primary health care to hide from the children that there is no money for doctors. The patient's alternative story is focusing on instances in her life when she had been able to overcome difficulties caused by losses and a lack of money. To thicken her alternative story, the patient has agreed that her pastor be called and informed about their situation. The pastor had been unaware of their circumstances despite the fact that he had asked the patient several times after the funeral whether the family needed any help, to which the patient has answered in the negative. The pastor now offered to involve the church in helping the family

with money and food. He also intends to intensify his counseling with the family.

Patient 9

The patient is a 51 year old white Afrikaans speaking woman who worships at the Gereformeerde Kerk commonly known as the Doppers, and is unemployed. After her husband died unexpectedly, she and the children were left with financial problems and without a medical aid, hence her coming to the hospital for free primary health care. She now has a new boyfriend with whom she is enjoying good sex, but he remains uncommitted. It is especially his adopted daughter who does not favour the relationship and stands between them. Emotional and financial restraints cause the patient to suffer from headaches, neck pains and depression. Her alternative story is moving towards looking for spaces of strength within herself and her history. This alternative story is thickened by the patient starting a part-time job at a flower shop, and leading a life in which she feels that God is near – and committed – to her: “Die Here is naby my” (The Lord is near to me). The patient does not often experience going to church as a healing activity, but is going to explore spiritual ways of feeling near to God in future.

Journeying with stories: Rethabile speaks with churchy words against verbal abuse

Rethabile is a 52 year old black South African woman who worships at the Church of Christ of the Latter Day Saints. She is employed in a low-income job. Her husband is accusing her of witchcraft. He also accuses her that she wants to kill him. Last week he accused her of stealing R800,00 from him. Eventually he found the money in his pocket, but did not apologise. He then accused her of practising witchcraft in the house, but eventually it was she who found muti in his car. He furthermore accused her of having sexual relationships with another man, while she knows for sure that it is he who is having extra-marital affairs. Through all this Rethabile has simply remained quiet.

We have externalised the problem as “Painful accusations”. “Painful accusations” convinces her to remain quiet and keeps her from discussing her pain with the bishop of her church, where her husband serves as a priest.

We are shifting the discourse of the quiet wife to an alternative story where Rethabile takes control and speaks back to her husband's accusations in nice words. She is strengthening her alternative story by giving herself cultural and Biblical names that reflect self worth and survival, and enable her "to walk tall". She is going to scrutinise the Bible to find names of women who were made sick and silent by their partners but found a new voice with God's help.

Alternative body stories

Patient 1

The patient is 18 years old. She has recently passed matric, but has since tried to commit suicide. We externalised "A childhood with abuse and without parents" as the problem stealing her life from her. She was sexually abused by her father. Her mother knew but "did not give a damn". For most of her childhood, she grew up without parents with relatives from whom she experienced constant verbal abuse. Even now people are phoning her, telling her that her father is their father too.

The patient's alternative story includes accepting the pastor of her born-again church as her "dad" who loves and cares for her in a healthy and spiritual way. This story is strengthened by her love for gospel music to which she is committed in a bodily way, and in which she participates to the benefit of the whole faith community. Thus the abused body is rescoped as the body singing and dancing to gospel music, that is, music with words that heal the abuse. The patient's alternative story is furthermore thickened by the healing practices of her church that are performed or ordered by her "dad" the pastor. She finds washing her body in water with holy ashes as particularly healing.

Patient 2

The patient is a 20 year old black South African woman who worships at the International Pentecostal Church and is unemployed. She is HIV positive, and was infected by her baby's father, who slept around while she was pregnant, and is now living with a girl who is 14 years old. The father wants to take the two month old baby away from her. During their relationship he has often physically assaulted her, and is continuing to do so, threatening to kill her if she would not give him the baby. The patient's dominant story holds her captive in a helpless and useless body. In her alternative story she

rescopes herself as a worthy mother in a body that is worth looking after. The alternative story is strengthened by the intention to get a protection order against the father of her baby. The alternative story is furthermore thickened by a ritual in her church when the pastor puts oil on her finger as a sign of divine healing, after which she always feels better and healthier, and hopeful that things will change. The ritual engagement of the church in her health convinces her that “God is with me, and God will heal me”.

Patient 3

The patient is a 41 year old white woman who belongs to the the Old Apostles’ Church and is unemployed. While she and her husband were walking on both sides of Church Street to look for their 14 year old daughter amongst the prostitutes, she was dragged into the bushes and raped by three black men. When her husband, who was on the other side of the road at the time, saw that she was missing and crossed the street to come to her rescue, he was run over by a taxi. He is still in a coma. More than the fear that she might have contracted HIV, and more than the trauma of having been raped, the patient is afraid that her husband will reject her because she had been raped by black men. Dealing during therapy with discourses on race and female vulnerability, the patient is thickening her alternative story with the memory that she had stood with her husband when he was on drugs. Her alternative story of self-worth is further thickened by the pastor’s support and involvement in her fears and grief. She loves the rituals in the church, but is still too “ashamed” of the rape to ask the pastor to have a ceremony performed for her in the church by the whole congregation to heal her pain.

Patient 4

The patient is a 17 year old black South African woman who is still at school. The week before, she gave birth to a baby who lived for only four days. Her boyfriend has deserted her, and her father was shot in a hi-jack on his way to the hospital to support her after the birth and death of the baby. “Sadness” has made the patient so weak that she could not stand up from the hospital’s wheelchair. “Sadness” was made more powerful by the patient’s fear of what she would answer at school if somebody asked her where the baby was. The deconstruction of the discourse “I am a victim” has moved towards an alternative story of the patient seeing herself as a survivor, leading to her physically standing up from the wheelchair and being able to leave the hospital on foot to her wounded father’s car. Thickening the alternative story of survival, the patient wrote letters to God and to her baby, explaining to

them her longings and her plans for the future. At first her letters to God were angry and accusing. This in itself brought relief and healing, with the later letters being an outreach to God to take her hand on the road of healing.

Patient 5

The patient is a 55 year old Swazi man who worships at the Anglican Church and has recently lost his job as a journalist at a prominent newspaper. We have externalised the problem as “Not being treated as a man”. First he lost his job, then his sisters kicked him out of the house they have inherited from their parents, and now he has heard the doctor saying that he was going to “reposition his testicles”. For years the patient felt worthy as a man because “I could get any woman at the church I want”, but now he feels that he is losing his manhood. Although women at the church would always make place for him, he is now going to lose that position. Also, he cannot marry a career woman when unemployed. The discourses dominating in the patient’s life are “A true man must have a house where he is the boss”, “A true man must be the breadwinner”, and “A true man must have a healthy body for sex”. The patient is unwilling to shift these discourses towards a greater respect for women. The thickening of an alternative story of reciprocal respect between him and the women in his life, and the role of the church women in that, therefore remains unexplored.

Patient 6

The patient is a white Afrikaans speaking woman of 19 who worships at the Apostolic Faith Mission and is unemployed. She was adopted at five, but with her adopted stepfather physically abusing her adopted mother and the latter leaving, she landed in a children’s home. Her first suicide attempt was at 13 when she cut her wrists. She was placed in her (adopted) mother’s care and attempted suicide again after her mother’s new boyfriend raped her. She was referred for some time to Sterkfontein where, according to the patient’s story, she was raped by a black man. When back at her mother’s, she was raped by her uncle. She attempted suicide a third time by drinking 180 diet pills. Recently she has run away from the house, and was picked up in the streets of Sunnyside to work for a white madam in a brothel in Arcadia. After two weeks of working here, she stood in the door of the brothel and started mutilating herself. The police were called in but when she threw a stone at them, she was arrested. When she was referred for counseling, she was chained to her hospital bed, transferred from Pretoria Female Correctional

Centre where she was awaiting trial, after having mutilated herself again. Her mother refused to pay the R300-00 bail needed to get her out of prison.

We externalised “Lack of love” as the problem ruining her life. After several counseling sessions, the patient started succeeding in making the influence of this problem on her life smaller by explaining the dreams she has for her life, that is, that she would become a veterinary surgeon with a family who love one another, and that she would be able to help young girls in her position. Her move towards an alternative story was thickened by stories in which she has found love with God, expressing herself in basic pietism: “Ek is lief vir die Here en kan na hom toe gaan wanneer ek in nood is. Hy is my Saligmaker” (I love God and can go to Him when I am in need. He is my Saviour). The patient’s case was thrown out of court and she was referred to Weskoppies where she ran away with the delivery man.

Patient 7

The patient is a 26 year old Xhosa woman who worships at the Methodist Church and is a student at the Technicon. She is pregnant and considering an abortion for the following reasons: the baby will be fatherless; the baby will be born in mid-exam; the patient’s mother will be devastated by the birth of an illegitimate child; the patient cannot afford a baby, and is not ready to start a family. The patient foresees a dominant story of isolation if she should have a baby, being isolated from her mother, her studies and her peer group. She presents an alternative story of finalisation and closure through abortion. However, thickening the alternative story by inviting the pastor and the faith community into the process of closure is unacceptable to the patient.

In all my years at the hospital, no patient who was considering abortion was willing to allow any religion talk into the counseling process.

Patient 8

The patient is an Indian South African man in his fifties. During seven sessions of counseling he has mentioned three places where he was worshipping: the Full Gospel Church, the Spadereens, and the Pentecostal Protestant Church. He was a well-to-do business man, but he lost everything through drinking. Presently, he is suffering from alcohol poisoning and liver cancer. Also, the patient has tested HIV positive. The patient’s dominant story of loss and illness is moving towards an alternative story of taking control over the future of his body, with the patient being sober for the past seven months. His alternative story is thickened by the conviction that with God there is always a second chance: “God has given me a chance on life, I do not want to spoil

it". The patient acknowledges the role in this of the faith healing practices of the Pentecostal churches he has been attending. He envisages attending more of these services to thicken his alternative story of future health. "Going to church is like shaking hands with the God of a second chance", he said.

Patient 9

The patient is a coloured woman of 38 who worships at the Roman Catholic Church. She lost her job when it became obvious that she has full blown Aids. The patient's body is covered in oozing sores and she is kept in an isolated room because, according to the nurses, she is praying so loudly that she keeps the other patients awake. Her family has rejected her because of condition, and because she had a black boyfriend ("jou boyfriend was a kaffer") who has also deserted her. In her utter loneliness and fear of death the patient is accepting no other alternative story than that Jesus would be personally involved in her fate and that God would carry her through this crisis ("God is my fancy car"). To thicken her alternative story, the priest of the parish where she worships was called and urgently invited to visit her in hospital. He never turned up.

Journeying with storie: Emmanuelle strengthens her spiritual body

Emmanuelle, a young white woman, was 17 years old when she came to the hospital in search of a medical certificate to qualify for a State pension. She was referred for counseling. The referral from the doctor said that Emmanuelle had been working as a prostitute for the past five years since the death of her mother when she was 12 years old.

Emmanuelle told her story as follows. After her mother's death in 1995, she and a (girl)friend ran away from school. She was raped, first by her friend's stepfather, and later by a gang consisting of four black and six coloured men. She was placed by a court in a place of safety but also ran away from this institution. After she had been caught again, she was placed in the care of her grandmother who lived on the Moloto Road.

Emmanuelle externalised her problem as "Stories people tell about my body". Everybody was telling stories about her that were not true. They said that she was sleeping with many men, was smoking dagga, was drinking a lot, and stole money from her grandma. However, she said, these stories were

untrue. She had been with five men the previous day, but she was only hugging and kissing them, and even then the men were wearing condoms. She only drank one glass of wine with each man, as she did not even enjoy drinking. She was a religious and caring person, she said. It was her sisters who were prostituting, drinking and smoking.

Moving towards the alternative story, I invited Emmanuelle to share her dreams with me. Her main dream was to marry the “right guy”, who must be a gentleman, and to have children. She told me that she had made internet contact with Prince William. His secret code is WOW, which she figured out stood for William of Wales. Her secret code is BOOBS. William had invited her to spend the holidays with him, she said, but after his security guys had seen her file, they did not want her to come. However, she was going to win the lotto and this would enable her to go. They would get married and have three children, two boys and a girl. Secondly, Emmanuelle dreamt about starting her own bakery, “Emmanuelle’s Bakery”. Thirdly, she wanted to play rugby, because her mother raised her as a boy. Emmanuelle felt herself to be equipped to realise these dreams, because she was a religious person who went to church, attended Bible study groups, and fasted. She was a caring person who worried about her sister’s children who had to stay in a children’s home while her sister was prostituting along Church Street.

While her alternative story showed signs of teenage day-dreaming, Emmanuelle thickened her alternative story by relanguaging her body in what she considered to be religious terms. She renamed herself as a moral, caring and spiritual person. She saw herself as a “moral agent” who would help her sisters to become independent of male acknowledgement and support. She started looking at herself as a person who, in future, would have access to “moral” choices in life, that might include a choice to consort with healthy male company.

Emmanuelle also found herself to be a caring person towards others, a characteristic she attached to the values she was exposed to during Bible study sessions. As a “moral, caring and spiritual” person, she gathered strength from concepts such as “respect” and “commitment” as features of a healthy relationship in which her body could explore its spiritual side.

*Alternative identity stories**Patient 1*

The patients are a white man and woman in their twenties and about to get married. The bride's parents are against the marriage and intend not to attend the wedding. The reason for this is that the bridegroom is highly trained, but as yet unemployed. The bride will have to provide for them both. The couple externalised the problem as "Parental stubbornness". The effects of the problem on their lives were anger and disgust with their parents. The problem was strengthened by the discourse that a man should be the breadwinner in a family. The couple deconstructed the problem discourse and re-identified themselves as two people equal in being soulmates to one another. They thickened the alternative story by identifying themselves not only as soulmates (*sielsgenote*), but as mates in faith (*geloofsgenote*). They intend to structure their wedding ceremony to reflect these values of equality and mutual enjoyment of one another.

Patient 2

The patient is a 26 year old Tsonga woman who worships at the Zion Christian Church. She had been raped by a man who pretended to offer her a contract for the National Arts Council. He said that the contract was in his flat, where he held a knife to her throat and raped her. After she reported the rape, the rapist started to threaten her. The patient is scared, angry, and suffers from nightmares. Her alternative story includes identifying herself as a person who learns wisdom easily and who will not be tricked by the rapist again. Also, she has placed herself now on a journey where she places respect for herself above everything else. Her alternative story is thickened by the belief that God will protect her, and that God has allowed this to happen only once to make her strong. She intends to undergo healing rituals in her church to strengthen her self respect and make her strong in the Lord.

Patient 3

The patient is a 70 year old Pedi woman, a pensioner who worships at the Lutheran Church. She looks after her two grandchildren. A month ago the oldest, a boy of 12, out of jealousy poisoned his brother of three with rat poison. The patient has lost her own son 12 years ago when he was stabbed to death at school. Now, again, the patient is angry and depressed. The patient's dominant identity is that of a (grand)mother who is the victim of child kil-

lings. However, her alternative story is that of a woman who deals with her sorrow in a strong way. Thickening her alternative story are stories of women in the Bible who lost children and became stronger because of that. Eva, for instance, also suffered from one of her children killing the other. Naomi had two sons and lost them both. This assists the patient in feeling that she is no longer alone in her sorrow, but shares an identity with Biblical women.

Patient 4

The patient is a 53 year old black South African Muslim woman who is self-employed. She cooks and sells home-made food on the street. She suffers from arthritis and high blood pressure, and is very depressed because of her financial situation. Her husband is a handyman who cannot provide for the family. Her dominant story is that of a person who is the victim of divinely initiated set-backs. This story is in the process of being shifted to an alternative story of agency in which she takes control over her life. The alternative story is thickened by her remembering that her husband was a gambler when they married, and that the gambling has stopped because of her prayers. The alternative story is thickened further by her realising that she has chosen to remain with the man God has given her, "although he is not bright". The patient keeps the door open to explore alternative ways of finding consolation in living according to God's will in future, ways that will enhance her self-image and undermine her seeing herself as trapped in a loveless marriage.

Patient 5

The patient is a white woman of 26 who worships at the Hatfield Baptist Church and is unemployed. She has been living with a man for nine years now, sacrificing study opportunities and a career. They have three children, but he does not intend marrying her, goes out at night and leaves her alone with the children. She has left him several times before, staying with her parents, but always goes back. She has externalised the problem ruling her life as "Pain". Strengthening the problem is the fact that there is nothing on the side of the relationship to keep it going. She is thickening her alternative story of self-worth with the memory that she was quite a rebel from the time she was twelve and affirming that it is time again to rebel against a relationship in which her value as a human person is taken away from her. She is developing an alternative identity as one who rebels against helplessness and the pain it brings. Also thickening her alternative story is attending a single

parent support group at the church to develop skills of coping outside an abusive relationship and grow into an identity of worthiness.

Patient 6

The patient is a 41 year old black South African woman who worships at the Unity Apostolic Church and is unemployed. Her brother died in a motor accident. We externalised the problem as “Feeling hopelessly sad”. “Feeling hopelessly sad” is affecting her heart and causes constant headaches. She is shifting to an alternative story of identifying herself not mainly as a bereaved person, but as a person committed to life through exercise, dressing as a person of worth, and eating well. She is thickening her alternative story by means of value she has learned from the church. The church tells her not to identify with people who cause her pain and humiliation. She is going to use this insight to say to “Feeling hopelessly sad” to go away: “You are not my type; go and stay with the neighbours.” She intends to expose herself to the healing practices of her church to help her in chasing away her problems, practices that may include exorcisms.

Patient 7

The patient is a 76 year old black South African woman, a pensioner who worships at the Methodist Church. Last month she lost both her daughter (through Aids) and her husband (through a heart attack). The problem has been externalised as “Loneliness”. “Loneliness” is made stronger by the cultural prescription that she has to stay in her house, dressed in black, for a year after her husband’s death. The effect of the problem on her life is a deep depression and feelings of loss and sadness. During counseling she has moved her dominant story of “Why should I still live?” to the alternative story of someone who has always found comfort in being a follower of God. The alternative story is thickened by going to church and attending the meetings of the *manyanos* (women’s groups in the Methodist church), thereby softening the cultural imperative that a widow may not leave her house. Also, she is inspired by sermons at the church that emphasise the blessedness of life on earth, such as one specific sermon that proclaimed that Jerusalem was not a place in heaven, but here on earth.

Patient 8

The patient is a 45 year old black South African woman who worships at the Presbyterian church and is unemployed in spite of two nursing degrees. Her

husband divorced her after their house had been broken into and everything stolen. Her husband said that she had “bewitched” him and that she was bad luck. Recently, also, the patient herself had been hi-jacked. We externalised the problem as “Maybe I am a witch”. The problem caused much anxiety in the patient. We shifted the discourse “Bad luck is always caused by a witch” to “I can take control over my life, also over the bad luck.” As a means of thickening her alternative story, we considered arranging a discussion with the pastor of her church so that she would be cared for in the faith community and find the opportunity to define her Christian identity in terms of her “cultural fears”. The patient expressed her need to be cared for spiritually as a scared person who is anxious about bad luck that might come her way. The pastor turned out to be an extremely caring person. Also, as a pastor he arranges for troubled people to be taken up in support groups as well as in activity groups – such as choirs and groups going out to do home visitations to the sick.

Patient 9

The patient is a 67 year old white Afrikaans speaking man who wants to be a woman. He worships at the New Apostolic Church and is a pensioner with limited funds. The patient dresses in women’s clothes since the government is no longer funding sex-change operations. The patient’s alternative story is moving towards accepting himself as a gorgeous person. He has, indeed, promised to teach me to be as sexy and gorgeous as he is as a woman, a promise he has kept in subsequent sessions. Thickening his alternative story is his ongoing efforts to find acceptance at church, and to meet male friends at church who will enjoy his company within his new identity.

Journeying with stories: Charles’s sexual identity joins his religious identity

Charles worships at the International Christian Church, but is presently unemployed and lives at a mission. It is his 31st birthday.

Charles’s brother has raped him since he was eight. Charles does not have a father and his mother drank herself to death. He stayed with his aunt till he was nineteen, when the family forced him to join the defence force. Here he found his feet, but also found out that he was gay.

Charles cannot love a woman, but hates himself when he has sex with a man. Also, at the mission where he lives, he is forced to repent his gay identity and mend his ways.

We externalised the problem as “I must choose between being gay and being a Christian”. The problem had severe effects on Charles’s life. He wanted to commit suicide because he knew no other way of escaping the problem. He had asked God to change him, but this was to no avail.

The religious discourses supporting the problem focus on the sinfulness of a gay identity. We deconstructed these discourses towards God’s care for all people. Charles then re-storied his life as one in which God had cared for him and gave him answers.

Charles thickened his alternative story by identifying and reinforcing the Christian values that had ruled his life, such as honesty, true and loyal friendship, and trust.

These are the things that characterise him as a Christian, and him being gay does not make him less honest, less of a friend, and less trustful. Being gay, above all, does not make him less of a Christian. As a Christian and as a gay person he has a lot of love to give to his fellow Christians.

Alternative otherness stories

Patient 1

The patient (55) is from the Anglican Church and has suffered enormous losses. Several of her close family members have been killed or injured in accidents and violent attacks, and her husband has lost his job. We externalised “Life is unfair” as the problem causing her depression, neck pains, stress, oversensitivity, insomnia and loss of appetite. The patient is a nurse and we explored her healing career as an alternative story to the unfairness with which life has taken her family members from her. She strengthened her alternative story by looking at God as the One who has given her the skills to become a self-healer amidst her unfair circumstances.

Patient 2

The patient is 41 years old and belongs to the African Methodist Episcopal (AME) Church. She is unemployed. Her husband, a taxi driver, was shot dead a year ago. The patient externalised the problem as “God has forsaken me”. The effects of the problem on her life are sleeplessness, and feeling powerless. The discourse supporting the problem is that God’s attitude towards the believer can directly be related to bad or good things happening

to the believer. The patient has moved towards an alternative story by identifying herself as a “trier”, that is, as a person who tries to make the best of her life. Also, she is a nice person to be with. In this she experiences God to be on her side. She strengthens her alternative story by listening to gospel music and allowing the music to bring her in touch with God’s supportive and loving side. She furthermore strengthens her alternative story by praying, that is, by asking God, whom she now experiences as good-willed, to take her hand through difficult times.

Patient 3

The patient is a 48 year old black woman, a nurse who worships at the Roman Catholic Church. Her boyfriend always picks quarrels with her and then disappears for a week or two, coming back with cards and flowers. She believes he does this to make time for himself to visit another woman. When she confronted him and refused to take him back, he burnt down her house. We have externalised “depression” as the problem making her life miserable. “Depression” is strengthened by the discourse that God has forsaken her. We confronted “Depression” with her own situation as nurse, where she helps to heal other people and where she has learnt about the grace of God for the injured and the hurt. She strengthened her alternative story in which she restored herself as healer and self-healer, with stories of God’s interaction with people as Healer. The patient furthermore finds immense healing in participating in the sacraments of the church, especially Holy Communion. In their parish, also, the priest prays over the oil every Sunday and anoints those who are in need of healing by putting oil on their foreheads with his thumb.

Patient 4

The patient is 39 years old, a black woman who worships at the Universal Church. She is unemployed. Three months ago her baby died of a heart problem. The baby was only one month old. This is the third child she has lost. One died of diarrhoea and the other also of a heart problem. The problem was externalised as “Bad news knocks at my door”. The problem was made stronger by the priest who said, when he heard about the baby’s death, “It was time”. The effects of the problem were that she found it hard to breathe, and that she became very anxious when somebody knocked at the door, fearing bad news.

The patient shifted the religious discourse of “Everything happens according to God’s plan” to “God uses his power in favour of people” and “We may talk to God about untimely things that have happened.” In her alter-

native story she restoried herself as someone who can heal herself of her fears with God's help. She thickens her story by talking to wise people about overcoming fear and dealing with bad news. She will also participate with her congregation in "driving out the devil of fear" from her heart.

Patient 5

The patient is a 23 year old woman from Cameroon who worships at the Pentecostal Revival Centre and is unemployed. She lost her baby three weeks ago. The baby suffered from Down's Syndrome, as well as heart and lung problems. The baby was five months old. The patient suffers from depression and a pain in the chest. The patient's dominant story is that of a person who has been robbed by God of her baby. Her alternative story honours God as the one who is taking care of her in her loss. The alternative story is thickened by the patient allowing the church to take care of her through the personal friendships of other women who have suffered losses, and the rituals of healing performed in the church itself. The patient intends to undergo healing at her church through prayer and the laying on of hands the following Sunday.

Patient 6

The patient is a 47 year old Tswana woman who worships at the Ethiopian Catholic Church in Zion and is unemployed. Her only son (22) was stabbed to death ten days ago at the snooker table in a bar. He sustained 41 knife wounds. The patient's alternative story is taking her away from being the bereaved mother to being a mother with pleasant memories of her deceased son. The patient is moving towards a thickened alternative story by praying for strength and acceptance, and by remembering the times that God supported and sustained her through difficult times. She intends to go to a Christian *sangoma* who will reveal to her who killed her son and why. She will then make amends to heal herself and her situation.

Patient 7

The patient is a 39 year old black South African woman who worships at a Zionist church and has a "piece job" at a scrap yard. Her baby died two months ago. The baby was one year and one month old. The problem's name is "Sadness". "Sadness" has stolen all the power from the patient's body. She is tired, with pains in her neck and constant headaches. The patient's alternative story focuses on restoring her power by concentrating on what does

make her strong, such as being a mother to her other children and being a pillar to the extended family. Her alternative story is thickened with a powerfully positive God talk, such as “He who walks with God, walks with sticks.” She furthermore finds healing in the prophet of her church interpreting her dreams, interpretations that include her in the community of the faithful and heal her relationship with God and the ancestors.

Patient 8

The patient is a 39 year old South African man who worships at the Anglican Church. He was demoted from work after he fell into a deep depression when his wife left him. He started hearing voices and he could not sleep. We have externalised the problem as “Not in control of my life”. This problem made him drink Jix two weeks ago in a suicide attempt. Apart from making lifestyle changes and inviting people into his life, the patient is renaming himself as the one who can take control over his life. Thickening the alternative story is a strongly positive experience of God as the one who is giving him the gift of life, and is helping him to take control.

Patient 9

The patient is a 35 year old white Afrikaans speaking woman who worships at the Dutch Reformed Church Moreleta Park and is employed in a middle income job. She tried to commit suicide after her divorce because of financial and emotional problems. She is concerned that, after the suicide attempt, her eight year old son will be taken away from her because she will be considered “unstable”. Her alternative story includes inviting significant people into her life who would make her strong against her fear of losing her child. This includes family members, but also church members. However, because of her concept of “honour and shame”, the patient resists thickening her alternative story by inviting the pastor(s) of the said congregation to act as caregivers towards her.

Journeying with stories: Tebatso has a good relationship with her deceased son

Tebatso is a 43 year old black South African woman who worships at the Methodist Church. She lost her job while mourning the death of her son, her only child, who was killed by two school boys. They killed him with a cork opener out of jealousy because he was wearing a new shirt. Now, four years

after his death, his court case is due, but has again been postponed for three months. Tebatso has very few support systems. She has lost her job. She finds consolation in the women's group in the church, but one of the women in the group has verbally abused her, telling her that, because she could not get over her son's death after four years, she is not a Christian. She put up a tombstone for her son on his grave on his birthday, but she did this with the last of her money, her ex-husband's family refusing to give money or to attend the ceremony.

Tebatso's alternative story is that of a mother who insists on being taken seriously as a mother although she has lost her only child. Also, she insists on taking her relationship as mother with her deceased son seriously. Theirs will be a relationship of "hello" and not goodbye. To thicken her alternative story, Tebatso has written letters to her son, as well as to the two boys who killed him, giving them clarity on what their relationship in future should be like. She has informed her son by letter that they will forthwith communicate in dreams, and that she has built him a tombstone to give him a house here on earth. She is happy that he has come home now. Also, she has taken soil from his grave in which she has planted a flower to remind her of him and to have him near to her bed.

Summary of findings

Profile of research population

The aim of this chapter was to describe the fourth leg of the MEET process, that is, thickening the patient's alternative story. Within the parameters of this study, the focus was on **religious practices** as thickening actions and discourses.

The profile of the 40 patients discussed in this chapter vis-à-vis the five variables that have earlier been identified as of therapeutic significance – race, gender, employment, age and religion – is as follows:

- *Race:* More than half of these patients, that is 26, are black. There are eleven white patients, two Indian patients and one Coloured patient..
- *Gender:* A vast majority of patients (32) are women. Eight of the patients are men, amongst them one patient who wants to be a woman.

- *(Un)employment:* More than half of the patients (23) are unemployed. Of those employed, six fall within the middle income group, five are half-employed, and one is self-employed. There are also three pensioners and two students in this group of patients. In this group, as in the previous groups, the patients, then, are generally very poor with grave financial problems.
- *Age:* This group is, on average, older than the previous groups described in previous chapters. Half of the patients (20) are over 40 years of age. Of these two are over 70, one is in her sixties, 10 are in their fifties, and seven in their forties. Of those under forty, nine are in their thirties, five are in their twenties, and six are teenagers.
- *Religion:* In this group there are two Muslims. A majority (29) belong to mainline churches, seven to Pentecostal churches, eight to born-again churches, and four to Zionist churches.

In summary, the patients here (as in the previous groups discussed in Chapters 3 and 4) are very poor, with more than half of them unemployed. Most of them are committed Christians, with half of them attending mainline churches.

Religious healing practices and the thickening of alternative stories of faith

Township spiritualities offer a variety of healing practices, and often combine them. Township spiritualities, as defined by this study, combine four types of healing, namely

- Diaconal healing – as traditionally practiced in mainline churches
- Ritual healing – as practiced in the (African initiated) born-again churches,
- Faith healing – as traditionally practiced in the Pentecostal churches, and
- African traditional healing – as traditionally practiced in pre-Christian African cultures.³²⁸

This study, furthermore, points to healthy religious discourses as ways of thickening alternative stories. Empowering God talk is an example of healthy religious discoursing that thickens the alternative story.

³²⁸ Othusitse Morekwa, *The interchange, exchange and appropriation of traditional healing, modern medicine and Christian healing in Africa today* (Unpublished MTh dissertation. Pretoria: Unisa), p 152.

Also, therapeutic documentation and ceremonies used and performed during counseling are considered here as ways of thickening the patient's alternative story of faith.

The ways in which patients have chosen to thicken their alternatives stories within the healing practices available in and outside their churches will now be described.

Thickening practices of diaconal healing (vis-à-vis the mainline churches)

- Diakonia

Traditionally, mainline churches understand diakonia “in terms of lowly service, rendered humbly to those in physical and material need.”³²⁹ However, few of the mainline churches in Atteridgeville have the financial capacity to render this type of “healing” to their members since so many of them are unemployed and dismally poor. The Roman Catholic Church does render these diaconal services through food packages and Aids hospices, thereby becoming the fastest growing church in the townships. While mainline Protestant churches in South Africa (Reformed, Methodist and Anglican) have lost 26,2% of their membership (1.750.920 members) during the past five years (from 2001 to 2006), the Roman Catholic Church in South Africa, which has a 95% black membership, has grown with 16% (366.872 members) during the same time.

The only patients, then, who were able to refer to the “diaconal healing” from the side of their churches, were patients from the Roman Catholic Church, and white patients who were “*nouveau* poor”, that is, those who have suddenly fallen into poverty after the death of a breadwinner, such as the patient from the Hervormde Kerk whose pastor was unaware that the family was suffering financially until he was contacted in this regard.

However, there were also patients who found that supporting others in a “diaconal” role, strengthened them against their own feelings of unfulfilment and thickened their alternative story (such as the woman in the mission who felt fulfilled through supporting her husband and other needy people at the mission).

Women patients who have been forced into prostitution, women who have been raped, and women who are suffering from HIV and Aids, too, found that acting diaconally towards other thickened their alternative story of human worth and respect.

³²⁹ Boettcher, Reinhard (ed), *The diaconal ministry in the mission of the church*. Switzerland: Lutheran World Federation, 2006, p 14.

- Word and sacraments

Mainline churches, of course, also offer other forms of “healing” to their members. The Protestant churches focus on the preaching of the Word as a confirmation of salvation, and thus as a way of “healing” the believer, and the Roman Catholic Church present the sacraments (esp baptism, the Eucharist, Confirmation and anointing) as ways of communicating God’s grace and therefore of “healing” the believer. The Roman Catholic Church in the townships has indigenised and taken Christianity back from the West, thus incorporating traditional healing into their sacramental ministries.

Quite a few patients mentioned preaching or participating in the sacraments as ways of thickening their alternative stories:

- Roman Catholic patients often referred to participation in Holy Communion as a healing experience when they had suffered grave losses (such as the man who lost his business and his wife) or were dealing with difficult personal relationships (such as the woman whose boyfriend had burnt down her house).
- Protestant patients referred to sermons that they found inspiring and healing³³⁰ because role models for handling loss and sadness have been provided during these sermons (such as the women who lost babies found healing in learning about women in the Bible who have suffered, and dealt with, similar losses).
- Patients from a variety of churches found healing in renaming themselves according to what they believed were Biblical values enhancing healing (such as the woman who was accused by her husband of witchcraft, but started renaming herself as a citizen of God’s kingdom).
- A patient also found healing in attending a support group at her church for single parents where she is regaining a sense of self-worth.

Patients from the mainline churches also mentioned the following as healing activities that thickened their stories:

- participation in women’s groups, especially the (Methodist) *manyanos*, and
- singing in the church choir.

³³⁰ Pioneering work on communication in sermons has been done by Hennie Pieterse. See his article on a sermon by Desmond Tutu, “Hoe kom God aan die woord in die prediking? ‘n Vaste vertrouwe op God se beloftes is teologies noodsaaklik”, in *Practical Theology in South Africa* 20.2 (2005) pp 110-128. This information should be used for therapeutic purposes, that is, to help thicken the alternative stories of patients.

To the Western reader these thickening practices may sound insignificant. However, attending services in the townships convinced me as a researcher (and counselor) how important these activities are as thickening practices to the bereaved and traumatised believer. For several women patients these were the only means of healing to which they had access (such as the woman who lost her only son in gang related violence at school and found consolation only in attending the meetings of the manyanos).

Thickening practices of ritual healing (vis-à-vis the African independent born-again churches)

Gumede (in Morekwa)³³¹ has found that 80% of local black patients consult a traditional healer before they visit a medical doctor at a clinic or hospital. Christians in Atteridgeville, too, visit traditional healers (*sangomas*), but I have observed the tendency here to visit Christian healers whose healing includes traditional African rituals.

I have visited several healing rituals in Atteridgeville, some by *sangomas*, but most by Christian healers. I have tried to visit healers from a variety of Christian backgrounds (Zionist/Apostolic, born-again, etc) and from different socio-economic contexts (squatter camps, as well as middle class and upper middle class areas in Atteridgeville). I have described the rituals involved in these healing practices in an article “Women healers in Atteridgeville: research method and findings”³³² I shall refer here to two of the ritualistic processes of healing:

- (1) The Prophet Sarah Maema of the St Petro Apostolic Church in Jeffsville, the oldest squatter camp in Atteridgeville, conducts healing through the following process:
 - *Prophecy*: The Prophet prophesises what the believer’s illness is and what causes it after having received a word of discernment from the verses where the Bible has fallen open.
 - *External purification*: The believer is told to wash him- or herself in a bath behind a partition that has been blessed by a stick and in which ashes (*sewasho se nhlamhla*) have been strewn.

³³¹ MV Gumede, “Healers modern and traditional” in GC Oosthuizen ea (eds), *Afro-Christian religion and healing in Southern Africa* (Lewinston, Queenston, Lampeter: Edwin Mellen), quotes in Morekwa, p 89.

³³² *Studia Historiae Ecclesiasticae* 30.1 (2004), pp 205-221.

- *Internal purification*: The believer gets down on his or her knees and starts to drink five litres of warm water mixed with Joko tea and white stones (*lejwe la mokoti*) until he or she starts vomiting.
 - *Restoration*: The believer is told to go home and pray three times during the night at 21:00, 00:00 and 03:00. He or she must then go home to his or her birthplace and offer a sacrifice to the ancestors.
- (2) Bishop Mashudu “Thandi” Ngwenya of the Bethal Apostolic Church in South Africa calls herself a “Christian *sangoma*” and a faith healer (*inyanga*). She started healing people in 1989 after she had seen herself in a vision prophesying and healing people. Her church, consisting of 200 people, is situated in a house in an affluent part of Atteridgeville.
- *Prophecy*: Thandi uses both the Bible and the throwing of bones to reveal a believer’s problem. Before she throws the bones, she burns other substances and places a glass of water, a burning candle and other beads on a small mat. She then prays a short prayer, throws the bones on the mat and discloses the problem to the believer. She also uses cards to prophesy. She furthermore sees her patients in visions and dreams in which God and her ancestors show her the solution to their problems.
 - *Cure*: Apart from purification practices and sacrificing to the ancestors to heal people who are suffering from dreaded diseases and infertility, Thandi also helps people to recover goods or cars that have been stolen. Her trademark is birds’ nests (*balusi*) which she finds in the river. They help people to recover their stolen properties. She also uses a mirror which reveals the person who has stolen from the believer or who has bewitched him or her.

Patients from a variety of churches referred to ritual healing as a thickening practice:

- Many patients expressed their intent to visit a Christian *sangoma* or report to their church’s healing rituals as part of thickening their alternative story (such as the woman’s whose adopted baby was taken away from her whose alternative story empowered her as a person who could make choices about her life, and who now chooses to rejoin a church).

- Also, patients recovering from childhood abuse found that the purification rituals of the churches/Christian *sangomas* thickened their alternative stories of the goodness of the body.
- A patient who was raped, found healing and the rediscovery of self-respect in the healing rituals of her church.
- A patient who had lost her child and suffered from nightmares, found thickening to her healing by having the prophet of her church explain her dreams to her.
- Some of the patients, too, found going to church to have their problem (“demon”) exorcised to be a practice thickening their alternative story (such as the woman who, after the loss of her brother, went to the church to have the demon of depression exorcised). Patients also experienced fear as a something that can be driven out.
- However, there were also patients who did not want exorcisms, because of the fact that they did not consider their alternative sexualities as “demons” to be driven out (such as gay patients, and one who dressed as a woman because he could not afford a sex change operation).
- Some patients also chose to follow a path of thickening their alternative story spiritually outside of the church (such as the woman who related her depression to her uncommitted boyfriend, and now thickens her alternative story of personal strength by searching for the nearness of a committed God.)

Thickening practices of faith healing/divine healing (vis-à-vis the African Pentecostal churches)

Allan Anderson³³³ points to the following features of (African) Pentecostal healing:

- Healing (salvation) presupposes lifestyle changes. “In Pentecostal evangelistic meetings people are encouraged to bring their cigarettes, their fighting sticks and knives, their traditional charms, their *muti* (traditional medicines), and even their church badges to the ‘altar’ to be burned or otherwise destroyed... The ‘saved’ are expected to separate themselves ‘from old friends that deceive and mislead people’”.
- Faith healing (sometimes preferably referred to as “divine healing”) in the more classically orientated Pentecostal churches is conducted

³³³ Allan Anderson, *Tumelo*, pp 65-93.

through prayer, the laying on of hands and anointing with oil. Classical Pentecostal churches reject the use of symbolic objects in the healing process.

Many patients, then, reported that they have seen people emotionally and physically healed after they had been prayed for and anointed with the laying on of hands in the church. One of these patients considered undergoing this type of healing with her husband to thicken her alternative story after her husband's devastating life style caused them great financial problems.

Other patients from Pentecostal churches found in the healing practices of their church a second chance on life (such as the person who was suffering from alcohol poisoning and was HIV positive who was hoping for a new life from the healing practices of his church to thicken his alternative story of being alcohol free for seven months).

Finally, it has to be noted here again that no person, from any church, who was considering an abortion, ever allowed any religion talk, or any suggestions to undergo religious healing practices into the conversation.

Thickening practices of therapeutic documentation and ceremonies

- Therapeutic documentation

Therapeutic documentation to thicken the alternative stories of patients included mainly

- photographs of the deceased
- letters to family members, deceased children, or to God (such as the woman who lost her three day old baby).
- sometimes patients brought pot plants with them to follow-up sessions. They had gathered sand from the grave of a diseased and plant a flower in them to say hello to their beloved deceased every day.

- Ceremonies

- Certificates were given to patients who achieved the goals of an alternative story.
- One couple, whose parents wanted to boycott their wedding, intended to enrich their wedding ceremony with symbols of their equality, respect and fun with and for one another.

Thickening practices of alternative religious discoursing

Patients also thickened their new, hopefilled stories by discoursing on God and faith in alternative ways. Some of these thickening discourses were:

- God has placed me back in control of my relationship
- God makes me strong to make my own choices.
- God gives, God takes, and then God makes things better
- God is near me although my boyfriend remains uncommitted.
- God has made my body for singing and dancing and not for abuse.
- God has made me a worthy human being in spite of me having been raped.
- A real man of the church shows respect towards women.
- God is always there when I am in need.
- God has given me a chance on life and I do not want to spoil it.
- God has given me skills to develop myself into a self-healer amidst difficult circumstances.
- Gospel music brings me into touch with God's loving and supportive side.
- God is a healer who sometimes works through a Christian *sangoma*.
- God is my fancy car who will drive me through a crisis.

Conclusion

In a fascinating article, "Churches moving beyond denominationalism: A new united church in Africa",³³⁴ Maake Masango points to the variety of churches in Africa that are nevertheless bound together by certain "cultural" norms. One of these, I would say, is the acknowledgement amongst Africans that healing is holistic. To this I want to add the insight of Jacques PJ Theron³³⁵ that the Biblical imagery of illness, including that of demon possession, helps us in understanding how, for us in Africa, "body and soul" are holistically engaged in the healing process.

In this chapter, then, even more than in the others, religious concepts and practices of healing have been described as part of a narrative counseling process, as they have been appropriated by patients who live (mainly) by the convictions of township spiritualities.

³³⁴ Maake J Masango, "Churches moving beyond denominationalism: A new united church in Africa", in *Ecumenical Review* 53.3 (2001), pp 404-408.

³³⁵ Jacques PJ Theron, "The ministry of deliverance from evil forces: The need for academic reflection in Pentecostal churches in Africa", in *Practical Theology in South Africa* 21.3 (2006), pp 191-206.

It has been described how patients, after they had deconstructed religious discourses that held them captive in depression and desperation, and after they had restored their lives in terms of health and faith, are thickening their alternative stories by means of the healing practices offered by the churches in the township. Through diaconal healing, ritual healing and faith healing – and especially through a combination of these types of healing, blended with African traditional insights in healing – patients are growing in finding health in the context of township spiritualities.

Summary and validation

Journeying with narrative pastoral counseling in the context of township spiritualities

On Wednesday mornings I locked my office at Unisa and drove to the township. I journeyed from a place of tested knowledge to a place where I knew nothing for sure. I journeyed from a place where I could compete in skills of interpretation to a place where I was equal amongst the powerless. I journeyed from a place where I taught the theory of faith communities in crisis – to a place where I was taught the lived faces of healing.

On Wednesdays I worked as a counselor at the Family Medicine Clinic in Kalafong Hospital in Atteridgeville. I had done that for seven years, listening to people whose voices have been stolen by poverty and hopelessness, relanguaging stories of despair into stories of worth with people considered more or less worthless by politics and social standing .

How can I profile the people I have met on this journey? This study describes the journeys of the first 270 of more or less a thousands patients who crossed my path. One can give a statistical view of these patients, as I have done in the study. Most were black, some were white, coloured or Indian. Most were women, but men too disclosed their pain here. A third of these 270 patients had attempted suicide at least once in the month before they came for counseling. Some had attempted this more than once. A third of the research population, too, although not the same third, had lost a close family member to death in the month before they came for counseling. Some have lost even more than one in the duration of only one month.

What all (except the few patients who visited me at home) had in common was that they were desperately poor. They had come to the hospital for free primary health care. And they were all referred for counseling because they were physically ill, not because of organic failure or viral infections, but because they had been made ill by other people. Actually, they had been sickened by the discourses of society that empowered people to hurt other people and deprive them of their dignity. Religious discourses played no small role in this degradation and hurt.

The patients had one other thing in common: their faith. All of them (with insignificant exceptions) belonged to a church (or a mosque or a temple). And although their religions and denominations practiced healing in different ways, they all believed in the spiritual faces of healing. Because all the patients with a few exceptions were Christians, this study focused on religious discourses within Christianity.

It is for this, for counteracting the despair, for outfoxing the effects of the losses on the lives of the patients, for restoring human dignity and respect to those who were downtrodden, that a narrative pastoral counseling practice was conducted at the hospital.

It was not me who ran this practice. It was the patients. A narrative pastoral counseling practice became an almost “natural” part of their healing. “Narrative” suited them fine, since all of them excelled in telling their life stories; they excelled in externalising problems as they had been externalising evil as demons and evil spirits; they excelled in restorying their lives as people with an amazing optimism; and they excelled in thickening their alternative stories with the healing practices of their churches. The MEET process (Mapping, Externalising, Empowering and Thickening) flowed smoothly from the indigenous knowledge of people who lived by the wisdom of township spiritualities.

Township spiritualities presented themselves to me while I was doing research on the healing practices of churches in Atteridgeville. Of the 102 congregations/churches interviewed in Atteridgeville, a third were mainline and the others “born-again” in some form or other, be it Pentecostal or Zionist/Apostolic. All the churches in Atteridgeville offer some form of healing; actually, it is impossible for any church to survive here without reaching out to the desperate needs of people caught in poverty, fear and despair. During the research mentioned, township spiritualities showed their faces as a mixture of diaconal healing, ritual healing, faith healing, traditional African practices, and local interpretations of human rights. In township spiritualities, as was said in the study, Africa has taken Christianity back from the West. How township spiritualities affected the patients’ health was revealed during counseling, and is one of the main themes of this study. And that is why the counseling practice conducted here is not only narrative, but pastoral too: it maps the religious needs of the patients; it externalises the harm done by religious discourses; it empowers the patients through their own indigenous spiritual knowledge; and it reconstructs alternative stories of faith, thickened by the healing practices of the churches in the township.

The patients, then, established a narrative pastoral counseling practice at Kalafong. They did not do this by being statistics, but by being real life people who had suffered losses and were experiencing deep pain. It was an honour for me that they shared their stories with me. Because of them, I could enter into a process of growth, growing through their indigenous knowledge of healing. Sometimes through landscape of action questions, sometimes spontaneously, they shared with me their fears about God as they were made to know Him, their doubts in dogmatic truths, and the pain they were experiencing because of the hardness of cultural and religious practices.

They also shared their willingness, their hope – and their wisdom – in rescoping the religious discourses that harmed them, and in re-facing them as healing ones.

In doing so, they enabled me to reach the first aim of this study, that is, “to describe the faces of religious discourses in a township setting”. They furthermore placed me in a position to validate the first part of the hypothesis of this study, that “the faces of religious discourses can be identified and described through the insights of social construction theory in an exploration of the spaces between harmful and healing discourses”.

Of course the words “discourse” and “social construction theory” have never been used during a counseling session in all of these seven years. It became one of my personal aims not to use a sentence in counseling that consisted of more than eight words. This was not because I thought the patients were not clever. On the contrary, people are not poor because they lack intelligence, but because they lack opportunity. It was the patients who taught me to use short sentences, in which I expressed myself clearly and honestly. They taught me this right from the beginning, whenever I went on a theoretical or symbolical journey, losing touch with the concrete reality of their pain. This was how they directed me to show respect for their own ability to express their needs and their pain – clearly and honestly.

It was from the patient’s problem-saturated stories that I was able to identify the four faces of the religious discourses that made patients ill. Patients became ill when they were disempowered in hierarchies of gender and class (through harmful power discourses); they became ill when their bodies were alienated from them through dogmatic intervention (that is, through harmful body discourses); they became ill when their religious identity was placed into conflict with the other identities in which they had to function (harmful identity discourses); and they became ill when they were disappointed in what they believed to be the supernatural power of religion to heal them (harmful otherness discourses).

What were the ugliest faces of religious discourses that the patients disclosed in counseling? Religious discourses, I would say, showed their ugliest faces when they presented cheap ways of explaining losses; when they robbed people of their worthiness as women and children; when they validated any form of physical or verbal abuse in the name of marriage; and when they sided with culture to steal people’s basic human needs from them, such as to mourn a still-born child, or to start life again after being widowed.

And what did the patients externalise as the problems holding them captive in misery? If I have to summarise the problems trapping the patients in desperation, I would do so by using the three L’s: Losses, Loneliness and Lack of money. These three problems drove a third of the patients to attempt

suicide and captured the rest in depression, headaches, ulcers and even the paralysis of parts of their body. The patients sharing these feelings with me enabled me to reach the second aim of this study, that is, “to understand the effects of these discourses on believers’ thinking and doing”.

To what extent were the patients able to restore their lives amidst ongoing poverty, inequality between the genders, unemployment and lack of opportunities to change the future? I trust that this study, in describing the stories of patients, was able to give a glimpse of the healing patients experienced by shifting the discourses that held them captive. They themselves testified to this healing. Of course they did not use the words “shifting discourses” but rather pointed to the results of the counseling. Counseling made them feel happy, alive, without pain and strong enough to face the future.

How, then, did the patients find relief through deconstructing discourses when their circumstances seldom changed? Against power discourses that humiliated them on the grounds of gender or class, the patients found self-worth in restorying themselves as people who were equal in the eyes of God and worthy of society’s respect. Against body discourses, patients found the strength to combat cultural and dogmatic interventions that stole their right from them to make decisions about their own bodies (such as in the case of abortion, adoption or having sex). Against identity discourses that prescribed to them Old Testamental fundamentalist identities, patients found freedom in restorying themselves in Christian identities that acknowledged human agency and worth. Against harmful otherness discourses, patients found relief in restorying God as benign and supportive. They found further relief in repositioning themselves vis-à-vis supernatural external influences on their lives, such as demons, evil spirits, sangomas and ancestors.

Of course, narrative counseling is never about restorying and re-scoping only. Much was done to change the circumstances that fed the discourses which impacted harmfully on the patient’s life. Significant others were invited into the counseling process, letters were written to employers, pastors were called to help, and life-style changes were suggested, to name but a few.

Patients reporting better health after counseling validate the second part of the hypothesis of this study, namely that “the process of deconstruction can be of therapeutic significance; by means of narrative counseling the effects of harmful religious discourses on the health of the patient can be minimized, and those of healing discourses maximized”.

Finally, of course, the following question is of the utmost relevance to this study: What are the main characteristics of the narrative pastoral coun-

seling practice that was conducted at the hospital amidst township spiritualities?

This study describes a narrative pastoral counseling practice that negotiates healing between binaries that, when kept in opposition, keep patients from experiencing holistic healing. Some of these binaries are Western medicine versus supernatural healing; Western versus African; dogma and culture versus the needs of lived experience; happiness versus suicide; God as patriarch versus God as empowerment; and the patient as passive victim to harmful religious discourses on the one hand, and the patient as agent in his/her own healing on the other.

This study furthermore describes a narrative pastoral counseling practice that respects the indigenous knowledge of patients as it is embodied in township spiritualities. Township spiritualities were never considered to be a binary opposing counseling, but as an integral part of the healing process.

Ultimately, the narrative pastoral counseling practice described in this study aims at situating patients in a *community of care* in which the hospital, faith communities, extended families and society at large act as caring role-players to enhance the health of each individual. This narrative pastoral counseling practice also aims at contributing to a new *community of discourse* in which religion will flourish in healing discourses that belong to everybody, in which case this study would have started with the words: "Religion belongs to everybody. Therefore, it is extremely healing."

With a narrative pastoral counseling practice having been established thus, the final part of the hypothesis of this study has been validated, namely that "a pastoral counseling practice can be constructed based on the narrative deconstruction and reconstruction of religious discourses as social discourses ...". Also, the third and final aim of the study has hereby been reached, that is, "to present a pastoral counseling practice, based on the insights of narrative counseling, within township concepts of illness and healing."

However, with the hypothesis validated and the aims reached, this is not the end of the journey. The journey will continue as long as people are being made ill in the name of religion. Therefore the search for the healing faces of religion will also continue, as they have been explored in this study with the help of 270 patients.

A word of thanks, then, sincere thanks, to the patients who have co-journeyed with me in this search for healing – for the healing that only religion can bring.

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