Healing work: Intersections for decoloniality

Healing is often understood as a concept that applies to individuals, and is used mostly with reference to physical bodily wounds. Yet it is generally accepted that colonisation, which brought about transnational slavery and land theft, has left behind societies that are essentially wounded; stripped of the necessary resources for collective reliance and self-determination. In addition, coloniality, an ongoing principle that drives western-led modernity, gives rise to inequality that affects historically marginalised populations the most, globally. One global phenomenon that is indicative of rising inequality is that of the Prison-Industrial Complex, which is sustained by high unemployment rates and shrinking social welfare, forcing poor people into petty crime for survival. Prisons and ill-health, in South Africa and elsewhere in the world, go hand-in-hand.

Whilst occupational therapy has an indisputable and impressive track-record of enabling occupational engagement and participation for individuals and groups with impairments or disabilities, it has yet to demonstrate its impact on historically marginalised populations. An understanding of human occupation as a transactional experience (Dickie, Cutchin & Humphry, 2006), and the fact that human beings can impact their health through what they do in the world, suggest that occupational therapy does hold potential to contribute towards healing society. This contribution can be enhanced when occupational therapists work in decolonial ways with other professions, and in partnership with marginalized communities. In order to advance this work, gross economic inequality must be understood as an ongoing and de-humanizing consequence of colonialism, racism and a global capitalist neo-liberal agenda.

There also needs to be recognition that an approach to disability that is focussed solely on diagnosis, whilst useful in facilitating access for individuals to appropriate care, can also be limiting. Instead, disability needs to addressed simultaneously with the notion of debility, which Livingston (2005) describes as a condition which is marked by deep historical changes in society that strip communities of resources, and is reflected in how communities re-define meanings of aging and able-bodiedness, whilst no longer able to look after the frail amongst them. Approaching disability in ways that are divorced from debility as a historically situated concept embeds the atomizing and individualistic understanding of health, which is founded on colonial medicine. This understanding has been critiqued in occupational therapy literature, with Ubuntu as an ethic and philosophy being invoked by Ramugondo & Kronenberg (2015) in order to understand collective occupation, and human occupation being viewed as a potentially humanising or de-humanising practice (Kronenberg, Kathard, Laliberte-Rudman & Ramugondo, 2015).

Interestingly, the birth of our profession, occupational therapy, was triggered by debility, resulting from people migration in England in the late 1800s and the United States of America in the early 1900s. Occupational therapy became an important resource then, to assist largely destitute refugees
to integrate into society. People migration has become a global phenomenon, with societies becoming increasingly diverse. In helping people integrate into society, care needs to be taken not to abate coloniality through the civilising project.

Decoloniality is a useful term to think about mechanisms through which coloniality is sustained. Ndlovu-Gatsheni (2015) and others (Maldonado-Torres, 2007; Mignolo, 2012; Quijano, 2000) delineate the notion of coloniality along three concepts; coloniality of power, coloniality of knowledge, and coloniality of being. Occupational consciousness, a concept theorised from South Africa, stresses the need for (ex)-colonised people to be vigilant about the ways in which dominant practices are sustained through every day doing, with implications for personal and collective health (Ramugondo, 2015). Coloniality of doing, thus becomes a fourth concept through which to think about how coloniality is re-inscribed and sustained. Decoloniality of doing, therefore, shifts decolonisation from just being about discourse, but also reflexivity within every day doing.

In order to demonstrate praxis in decolonial work, four examples are offered in the main paper. These examples, while offering critique on how occupational therapy may have been co-opted in re-inscribing coloniality, also showcase conscientization at both individual and collective levels, towards healing.

References


