

**BETWEEN LITERAL LESIONS AND LITERARY TROPES -  
A PROPOSAL FOR EXAMINING THE DISCOURSE OF  
HEALING  
IN SOME AFRICAN INDIGENOUS CHURCHES.**

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These studies represent original work by the author and have not otherwise been submitted in any form for any degree or diploma to any University. Where use has been made of the work of others, it is duly acknowledged in the text.

A handwritten signature in dark ink, appearing to read 'AJ Allan', written over a horizontal line.

Austin James Allan.

### Abstract

Approaches to indigenous healing in South Africa need to be situated in the broader health care system within which that healing occurs. To facilitate a viable recognition of that indigenous healing, this paper argues that categories need to be defined which allow for the cross-cultural comparison of different forms of healing.

One of these categories concerns the analytical approach which is used for explaining what happens during indigenous healing. By developing a proposal for analysing the discourse of healing in some African Indigenous Churches (AICs), what this paper purports to do is to lend recognition to the viable and important role which indigenous practitioners have in contributing to the general system of health care.

This proposed model is applied to specific examples of indigenous healing drawn from the AIC healers included in the fieldwork. The conclusion reached is that healing in these churches operates within a particular discourse. As cultural constructions these discourses create important sociosomatic links between the general meaning system in which a person lives and her physiological functioning. It is in the process of rhetorical movement, observable in healing transactions and which occurs across these discourses, that the powerful endogenous healing processes are activated, and a change in the patient's condition is affected. This change is affected along the sociosomatic linkage.

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## Chapter One

### WHITHER INDIGENOUS HEALING?

'Even among facts some are more equal than others'  
 Jacques Barzum [A stroll with William James] (30:34)

Dorothy Farrand in a paper entitled *An analysis of indigenous healing in suburban Johannesburg*, states that 'A change in attitude towards indigenous healers can only be truly achieved... if they are studied within (the) context of an indigenous, rather than Western scientific, world-view' (21:2). Situating this statement within the universalist versus culture-relativist debate she outlines the debate as follows. On the one hand, the universalists argue that there are universal, non-evaluative norms of mental health and abnormality which exist and which can be applied unequivocally to all societies (21:9). On the other hand, the relativists counter this by saying that there are no universal norms, that each culture is important in its own right and that a cultural system can only be understood by examining it within its own context and framework (21:11).

In analysing elements of indigenous healing in South Africa, Farrand expressly sides with the relativist position, arguing that, given the unique cultural context, it is only possible to do justice to indigenous healing practices by forsaking all Western universalist principles. Farrand's concern is to explicate meaning rather than trying to quantify and measure. As such her project raises important questions regarding some of the methodological issues governing research into indigenous healing practices.

Farrand's project serves as a useful introduction to some of the problems surrounding any enquiry into indigenous healing in South Africa. Indeed, by pitting the work of some of the scholars in the Social Sciences against their colleagues in the Biomedical establishment, what her work serves to do is to

problematise some of the more critical issues surrounding notions of health care and the appropriate forms of delivery of that health care. This, in the current context in South Africa, is an area of crucial concern, given the present government's concern to provide a health care system which is aimed, by and large, at primary care intervention (ANC, 1).

The inability on behalf of some of the Medical establishment to recognise the valuable role which indigenous practitioners play in delivering health care, stems from an implicit bias governing the orientation of health care workers. The nature of this bias was pointedly identified by Engel in his attempts to develop a Biopsychosocial model of health care and health seeking behaviour. In this model he developed the idea that the biological, psychological and social contexts of health care are equally important dimensions, with none having a *priori* superiority in understanding the nature of human behaviour in health and sickness. McHugh and Vallis, summarising Engel's ground-breaking paper on the subject, write the following:

The biomedical perspective is what governs a large proportion of medical practice. Known as the biomedical model, this perspective understands an individual's complaints and ailments as stemming from disordered biology. Consequently, interventions are guided by biological principles and mechanistic thinking based on "either/or" and single cause explanations. Although referred to as a model, it is more a *post hoc* heuristic which has become reified through the single-minded scientific pursuit of greater understanding and harnessing of the human biological processes (44:2).

After many years of thought concerning the relationship between health and disease, Engel has argued that the biomedical model should be recognised as having assumed the status of 'cultural imperative,' an imperative which fuses the folk and scientific models in such a way that the folk model is no longer considered to be valid. Accordingly, Engel maintains that the biomedical model no longer fulfils the basic requirements of a scientific model. This is because of



its refusal to consider, recognise and incorporate new ideas and concepts about the socio-cultural determinants of sickness. Engel writes that the biomedical model:

'...has now acquired the status of dogma. In science, a model is revised or abandoned when it fails to account adequately for all the data. A dogma, on the other hand, requires that discrepant data be forced to fit the model or be excluded. Biomedical dogma requires that all disease, including 'mental' disease, be conceptualised in terms of derangement of underlying physical mechanisms. This permits only two alternatives whereby behaviour and disease can be reconciled: the reductionist, which says that all behavioural phenomena of disease must be conceptualised in terms of physicochemical principles: and the exclusionist, which says that whatever is not capable of being so explained must be excluded from the category of disease' (in Fabrega, 20:132).

This is the point at which Farrand's project intersects the biomedical establishment's universalist position. She rejects the universalist notions and adopts instead a relativist position which argues that indigenous healing can only be understood from within its own cultural context. However, this approach is also problematic as there can be little doubt that it is possible to diagnose disease processes according to an international nosology or system of classification. While a problem certainly does arise when this nosology is indiscriminately applied, for room must be made for acknowledging the manner in which culture can shape illness behaviour (Kleinman 30:47), it is not possible to go so far as to say that there are no universal, world-wide diseases which can be identified regardless of culture.

The point to be developed in this paper is not one which sides unequivocally on the relativist side nor one which sides on the universalist side. Rather, a medium between the two is sought. It is *between* literal lesions and literary tropes that an understanding of indigenous healing practices is to be found. Thus, it is recognised that cultural factors do shape the expression of disease

processes, but these cultural factors must also be seen as playing a variable role. The context in which healing occurs must always be considered. Furthermore, cultural processes must also be seen as playing a significant role in bringing about healing.

By adopting such a compromise position the question is then raised of what principles to follow in conducting research projects? How is a realistic and fair appraisal of indigenous practices to be reached?

The methods involved in the Social Sciences for studying human behaviour, and in the study of religion in particular, offer a sensible framework for broaching the subject of indigenous healing practices. This framework is able to embrace both the universalist dictates of the Biomedical establishment as well as the relativist dictates of the Social Scientists. It is a two-phase approach.

The first goal is to achieve an empathic understanding of the practices being carried out. This is the relativist stage of the work. Not only does it involve the suspension of value judgements but it also requires an authentic appraisal of the subject's activities. The account rendered should be an 'existentially appropriatable' one. In other words, the practices of the indigenous healer concerned should be described in such a way that she, or her patient, would be able to recognise it as a true account of what occurred.

Only once this goal is achieved is it possible to move on to the second phase. This phase involves defining categories into which to put the observations from the first phase. These categories are then used to make comparisons between different systems of thought.

Translation is the essence of this type of research. The process has been described as follows:

In anthropological studies, description of indigenous categories of thought, modes of communication, and patterns of behaviour is at heart the translation from one cultural system into another. That translation is what the ethnographer spends her days doing - ie, getting it right from the native point of view. Having achieved a valid understanding of the local context in its own terms, the ethnographer then undertakes another type of translation into which she puts her findings into terms and categories appropriate for transcultural comparison (Kleinman, 30:28).

A problem which emerges here, however, is the validity of the proposed diagnostic categories for transcultural comparison. The validity of these categories needs to be brought into question because of the subtle influence which the Western, positivist framework exercises on interpretations put forward by researchers. For example, in psychiatry leeway is often given to the positivist bias of the biomedical framework (Kleinman, 30:17). Categories of thought which are meaningful to the subjects of research become things to be translated into the more correct understanding garnered by western science.

In such a context it is possible to dismiss indigenous healing as hocus-pocus or, worse - because it is apparently more objective - to take the view that indigenous healing is either an act in which certain psychologically induced sickness states are *reinterpreted* so as to enable the person to cope better, or as an act which has a placebo effect on the sick person. These views are indicative of the fact that medical knowledge fails to take cognisance of its own assumptions. The very discourse from within which medical practitioners operate is not recognised as a discourse as such but rather the 'objective' way of being in and viewing the world. It is not accepted that this sort of diagnosis 'is a semiotic act in which the patient's experienced symptoms are reinterpreted as signs of particular disease states' (Kleinman, 30:8).

One reason behind this skewed perception is that Western medicine, due to its strict empiricist training, suffers under a positivist bias such that it is believed that observations are direct representations of reality. Certainly the picture is more complex:

a word...is a sign that signifies a meaningful phenomenon. That phenomenon...exists in a world mediated by a cultural apparatus of language, values, taxonomies, notions of relevance, and rules for interpretation. Thus, observations of phenomena are judgements whose reliability can be determined by consistency of measurements but whose validity needs to be established by understanding the cultural context. Perception is theory driven (Kleinman, 30:11).

For these reasons the validation of diagnoses 'is not simply verification of the concepts used to explain observations. It is also verification of the meaning of the observations in a given social system (a village, an urban clinic, a research laboratory). That is to say, observation is inseparable from interpretation' (Kleinman, 30:12).

Although the cross-cultural perspective raises the issue of validity it does not resolve how it is to be decided. One particular theorist rejects the idea that validity is either a matter of pure subjectivity or one of complete relativity. This is because the disease and its experience also play a role in determining what diagnosis is valid (Kleinman 30:12). Instead he poses the question of what criteria to use in order to establish the validity of diagnostic categories applied cross-culturally. He offers a tentative answer to this question, saying that the process of assuring validity should involve:

a conceptual tacking back and forth between the psychiatrist's diagnostic system and its rules of classification, alternative taxonomies, his clinical experience and that of the patient, which includes the patient's interpretation. Validity is the negotiated outcome of this transforming interaction between concept and

experience in a particular context. Thus, validity can be regarded as a type of ethnographic understanding of the meaning of an observation in a local cultural field (Kleinman 30:12).

What this means is that in order for any observation about a particular form of healing to be 'existentially appropriable' it must be valid. This validity rests on an awareness of what the observation means in the particular cultural field from which the example was taken. So, following the empathic observation of any form of indigenous healing, the categories into which to put those observations must be defined. This process of defining categories involves translation. This translation is what must be guided by the notion of validity. The translation into the second phase's categories should be the final, not as in psychiatry the first, phase of the work (Kleinman, 30:28).

The building of this cross-cultural framework for comparison is an important step in the move towards understanding what the practice of healing actually entails. In this paper, through tracing the form which this framework should take, what is proposed is a model for analysing the nature of the practice of indigenous practitioners in some of the AICs.

The work of Arthur Kleinman has been seminal in terms of defining and orienting the nature of this enquiry into indigenous forms of healing. Working as a medical anthropologist in both the United States and in Mainland China, Kleinman has written much on the perplexing problem of how to facilitate the provision of health care services in cross-cultural contexts. His work has been chosen as a major reference point for this paper because of the similarities which present themselves in the context of the health care which is being provided by healers in the AICs. As in his experiences in Boston, USA, and in Mainland China, so here in South Africa, the problem of pluralistic world-views and competing notions about health care is endemic. If due recognition is to be afforded to the role which different practitioners play within the overall system

of health care then some sort of conceptual grounding for interpreting the experiences of others needs to be found. This is just what Kleinman provides.

He proposes a five point framework for the cross-cultural analysis of different healing discourses. However, before turning to this it is important to situate his work in the broader framework of health care activities which he proposes. This is crucial as many of his assumptions rest on points which he develops in this framework. Once this framework has been elucidated attention will then be paid to outlining the cross-cultural framework. From there it will be possible to turn to a consideration of what the actual processes are that are involved in healing.

### Health Care Systems

To arrive at the notion of Health Care Systems as sites of competing discourses about health care, and in order to explain the internal structure as well as the core clinical functions of Health Care Systems, Kleinman first articulates the notion that health care is a *system* that is social and cultural in origin, structure, function and significance (29:27). He articulates this notion by locating patients within the different types of reality which it is possible to distinguish.

An individual, Kleinman maintains, is comprised of interrelated psychological and biological processes. She moves within the context of a social world which is comprised of families, social networks, communities, institutions, and the systems of ideals, meanings, and power which they embody. Her interaction with this world, via what Kleinman calls symbolic reality - in order to bridge personal and social spaces - creates the social reality of which she is a part. She is both a product of and helps to shape the nature of this social reality. This interaction with and by social reality is grounded in the physical or non-human environment. The interaction with this environment is what constitutes physical reality (29:28).

Having positioned the individual in the midst of her social and cultural world, Kleinman moves on to contend that in all societies health care activities are more or less interrelated. As such, they need to be studied as socially organised responses to disease (sickness) that constitute a special cultural system. This cultural system he calls the Health Care System. Medicine is thus to be seen as a cultural system: 'a system of symbolic meanings anchored in particular arrangements of social institutions and patterns of interpersonal interactions' (Kleinman, 29:24). In other words, it is the health care system which integrates all the health-related components of society. These components include such things as the systems of belief regarding the causes of illness; rules governing the choice and evaluation of treatment; socially-legitimated statuses, roles, power relationships, interaction settings, and institutions (Kleinman, 29:24).

The health care system binds together the way people think about and respond to sickness. As a cultural system, with which individuals interact, it also serves to determine the way in which people react to sickness. This obviously influences both patients and healers - two basic components of such systems - for they are bound to the specific configurations of cultural meanings and social relationships which constitute the system as a whole. Sickness and the attempts made to heal sickness must also be viewed as part of the system of health care. This is because they are both articulated as culturally constituted experiences and activities.

What this means, for both patients and healers, and sickness and healing, is that as a cultural system the health care system is both the result of and the condition for the way in which people react to sickness in local social and cultural settings. It is an integral part of how people come to perceive, label, explain and treat sickness. This is because the health care system includes people's beliefs (largely tacit and unaware of the system as a whole) and patterns of behaviour. These are in turn governed by cultural rules which constitute the social worlds in which those individuals live (Kleinman, 29:24-7). Most of the

time this governing by cultural rules does not involve open prohibition but rather a conditioning by means of unconscious assimilation and influence.

A proviso which Kleinman makes at this point is to remind the reader that the 'health care system' is a *concept* not an entity. It is a conceptual model held by the researcher in order to come to understand how the actors in a particular social setting *think* about health care; what their beliefs are about sickness; and how they come to make decisions about how to respond to specific episodes of sickness and their expectations and evaluations of particular kinds of care (29:26). This fore-grounding is important as it means that Kleinman does not run the risk of trying to objectify reality. This is a model which he proposes for use in analysing how people respond, and are indeed determined in their response, to sickness.

In saying that health care systems are socially and culturally constructed, so it can be said that they constitute forms of social reality. The notion of *social reality* signifies the world of human interactions existing both outside the individual and between individuals. It is the transactional world in which everyday life is enacted, in which social roles are defined and performed, and in which people negotiate with each other in establishing status relationships under a system of cultural rules.

As Kleinman writes:

Social reality is constructed or created in the sense that certain meanings, social structural configurations, and behaviours are sanctioned (or legitimated) while others are not. The individual absorbs (internalises) social reality - as a system of symbolic meanings and norms governing his behaviour, his perception of the world, his communication with others, and his understanding of both the external, interpersonal environment he is situated in and his own internal, intrapsychic space - during the process of



socialisation (or enculturation). Socialisation takes place in the family, but also in other social groupings via education, occupation, rituals, play, and the general process of internalising norms from the world we live in (29:36).

This can be seen clearly in the manner in which traditional healers in South Africa have defined their status, especially amongst rural people. The roles of patient and healer are marked by a clear differentiation in status, with the healer often being held in a mixture of respect and fear. The respect is for the ability which they have to bring healing to the individual, and the fear is because of the perceived spiritual world of evil spirits and great power to which they have access.

What is of concern for this project is the manner in which social realities may differ because of family differences, differences in past experiences, differences in socio-economic status, class, education, occupation, religious affiliation and ethnicity. Furthermore, the fact that individuals differ - even in supposedly homogenous social worlds - in their conscious understanding and acceptance of social norms and in the degree to which they follow those norms in actual practice is also significant. This is so because differences in social reality affect the responses which are made to sickness. This response is articulate in the evaluation which is made of the effectiveness of the health care practices which are available and the choices which are made between such practices (Kleinman, 29:37-8)

The actual act of clinical practice (both traditional and modern) can thus be seen as occurring in and creating particular social worlds. Beliefs about sickness, the behaviours exhibited by sick persons, including their treatment expectations, and the ways in which sick persons are responded to by family and practitioners, these all constitute aspects of social reality. They, as is the health care system, are cultural constructions.

It is these health-related aspects of social reality (especially attitudes and norms concerning sickness, clinical relationships, and healing activities) which form *clinical reality*. Here: 'Social factors such as class, education, religious affiliation, ethnicity, occupation, and social network all influence the perception and use of health resources in the same locality and thereby influence the construction of distinctive clinical realities within the same health care system' (Kleinman, 29:39). In South Africa, it is possible to view the role which several cultural, historical, socioeconomic and political factors have had in shaping the types of clinical reality which are extant in the overall system of health care.

Kleinman proposes a model of more or less integrated *local* health care systems: composed of separate sectors, clinical relationships and roles. It is in this model that it is useful to remember the distinction which he makes between:

- (i) Psychological reality: the inner world of the individual;
- (ii) Biological reality: the physiological structure of organisms; and
- (iii) Physical reality: the material structures and spaces which form the non-human environment.

Further, there are two aspects of social reality to distinguish between:

- (i) the social and cultural world; this is what Kleinman refers to as social reality *per se*; and,
- (ii) a bridging reality that links the social and cultural world with psychological and biological reality. This is what Kleinman calls *symbolic reality*.

While *clinical reality* refers to the socially constituted contexts that influence illness and clinical care - a context consisting mainly of social and symbolic reality but which also relates to the psychobiological and physical realities - *symbolic reality* is what relates culture, as a system of symbolic meanings, norms and power, to illness and treatment.

The thesis developed is that the internalisation of symbolic reality plays a vital role in an individual's orientation to her own inner world. This symbolic reality enables the individual to make sense of her personal experience through shaping her personal identity in accordance with social and cultural norms. Unpacked, this means that symbolic meanings can influence an individual's basic psychological processes. These processes may include her attention, state of consciousness, perception, cognition, affect, memory and motivation. The implication of this, given the connection between psychological processes and physiological processes, is that symbolic reality, 'either directly or via its effect on psychological reality, connects the social environment with physiological processes' (Kleinman, 29:42).

This is the connection which Kleinman develops in his theory on how healing actually works. This will be considered in the next chapter. For the moment it suffices to say that:

...the clinical reality of health care systems is mediated by symbolic reality. Neither health care systems nor their clinical reality can be fully appreciated without examining how this biosocial bridge relates culture, as a system of symbolic meanings, norms, and power, to illness and treatment (Kleinman, 29:43).

Having thus explained the orientation towards health care and its positioning in society - as a system which is culturally constructed and which both forms and is formed by the people within the system - it is possible to move on to consider the internal structure which Kleinman maintains this cultural system exhibits.

**Inner Structure of the Health Care System.**

Kleinman asserts that the internal structure of health care systems are roughly the same cross-culturally although their content varies according to each system's social, cultural, and environmental circumstances. The local cultural system which is formed by any health care operation consists of three overlapping parts: the popular, professional and folk sectors (Kleinman, 29:50).

(i) Popular sector. This is the largest of the sectors and can be conceived as a matrix containing several levels: individual, family, social network and community beliefs and activities. 'It is the lay, non-professional, non-specialist, popular culture arena in which illness is first defined and health care activities initiated' (Kleinman, 29:50). People base their decisions about going to folk or professional practitioners on the modes of thinking and the value orientations of the popular culture. Following their treatment they return to this popular sector in order to evaluate it and to decide what to do next.

The popular culture serves as the point of intersection between the different sectors. The popular sector interacts with the other two sectors even though they are usually isolated from each other. As lay people activate their health care by deciding when and whom to consult, whether or not to comply with the prescribed treatment regimen, when to switch between treatment alternatives, whether the care they are receiving is effective, and whether they are satisfied with its quality; so it can be said that the popular sector serves as 'the chief source and the most immediate determinant of care' (Kleinman, 29:51). This counters the assumption that it is professionals who organise health care for lay people.

An important reminder is that the popular sector is not only concerned with sickness and care but also with 'health' and 'health maintenance' (Kleinman, 29:53).

(ii) Professional Sector. This is comprised of the organised healing professions, usually using modern scientific medicine. This sector has become so dominant in the health care system of many societies, that studies of health care often equate modern medicine with the entire system of health care. Concomitant with this are views such as: the biological aspects of medical problems are the 'real' ones (the psychosocial and cultural aspects are relatively unimportant); any health-related activities undertaken by members of the other sectors of the system are dangerous and should not be tolerated; and, the doctor's role is to 'tell' patients what to do and the patient's role is to comply for non-compliance is morally offensive (Kleinman, 29:57). According to Kleinman's model of health care systems as cultural constructs, what has to be realised is that the health care system is a great deal wider than the boundaries of the modern medical profession. This is a critical first step if the project of developing a cross-cultural framework for thinking of the cognitive and communicative structures found in the symbolic space of patient-practitioner relationships is to be successful.

(iii) Folk Sector. This consists of the non-professional, non-bureaucratic, and specialist orientation of folk healers. It is frequently classified into sacred and secular parts, but this distinction is often blurred in practice and the two overlap, e.g. *Izinyanga*, Diviners, *Izangoma* in African Traditional Religion; and the Prophets and Prayer Healers of the AIC.

These three sectors interact because patients move into and between them. The popular sector can be seen as forming an undifferentiated matrix which serves to link the more highly differentiated professional and folk sectors. The boundaries between the sectors serve as the entry and exit points for patients who follow the outworkings of their sicknesses through the complex structures of the health care system (Kleinman, 29:60). The function of the system taken as a whole is to

heal patients. This process of healing requires the interactive work of several core clinical functions of the health care system. Attention will now be turned to a brief consideration of these core functions.

### **Core Clinical Functions of Health Care Systems**

The core clinical functions of health care systems are summed up in the following five points:

- (1) The cultural construction of illness as psychosocial experience.
- (2) The use of systems of belief and values for choosing between health care alternatives and for evaluating treatment outcomes.
- (3) The cognitive and communicative processes used to cope with disease/illness, including perception, classification, labelling and explaining.
- (4) Healing activities *per se*, which include all types of therapeutic interventions, from drugs and surgery to psychotherapy, supportive care, and healing rituals.
- (5) The management of therapeutic outcomes, including cure, treatment failure, recurrence, chronic illness, impairment and even death (Kleinman and Sung, 32:8).

Healing is the sum of the activities of the entire system of health care. Thus, the system as a whole, not just the healer, heals. The first and the third functions are considered to be the most worthy of explanation given that they so pointedly situate the whole question of healing within particular cultural discourses.

The construction of the illness experience is the first of the health care functions. This is because sickness as a 'natural' phenomenon is set in a particular cultural form through the categories that are used to perceive, express, and value symptoms.

Attention is drawn here to the distinction which is to be made between disease and illness. Illness, on the one hand, refers to the patient's perception, experience, expression, and pattern of coping with symptoms. Disease, on the other hand, refers to the way practitioners recast illness in terms of their theoretical models of pathology (Kleinman, 30:7). What this means, usually, is that disease refers to a malfunctioning of physiological and/or psychological processes, while illness has to do with the manner in which this disease state is perceived. As Barodess maintains:

*Disease* is a biologic event, characterised by anatomic, physiologic or biochemical changes, or by some mixture of these. It is a disruption in the structure and/or function of a body part or system...(which), due to a variety of causes, may persist, advance or regress...and may or may not be clinically apparent.

*Illness* is a subjective experience consisting of an array of discomforts and psychosocial dislocations resulting from (the) interaction of a person with the environment. The environmental stimulus may be a disease, but frequently it is not (44:4).

Shweder, however, cautions against adopting this distinction as he maintains that it subtly introduces the perspective of the biomedical model as normative. He calls instead, for the use of the term sickness to denote the cultural activity of the perception, experience, expression, and the pattern of coping with symptoms. And he calls for the replacement of the term disease with the terms causal ontology or causal theodicy. This would replace the need for the disease nosology to be a biomedical one (61:312-3).

While it is easier to adopt only part of Shweder's recommendation and to speak of disease and sickness, which is the terminology used in this paper, the

usefulness of his injunction is recognised because of the reminder it serves to purposefully foreground any discussions about health care activities within a particular discourse. The purpose of developing this scheme for interpreting health care activities on a cross-cultural level is so that the reductionism of blind participation within a particular discourse can be avoided.

Kleinman also sounds the caution that, like the model of health care systems, disease and illness are explanatory concepts and not entities. It could be said that 'Disease and illness exist, then, as constructs in particular configurations of social reality' (Kleinman, 29:73). Such a view confirms the need to be conscious of the discourse from within which the health care system is being monitored.

When it comes to symptomatology a complex interrelationship between disease and sickness is noted (Kleinman, 29:73). Since sickness behaviour includes the perception, affective response to, cognising, and valuation of the symptoms of disease, along with their communication (verbal and non-verbal)<sup>1</sup>, it can be said that *all* symptoms are moulded by the sickness experience. Further, as sickness usually begins with the individual's attention to and perception of the early manifestations of disease, so it should be evident that personal and family beliefs and experiences, and through them cultural and societal systems, are powerful influences on these processes (Kleinman, 29:75). In other words, it is through labelling and other cognitive processes that it can be said that symptoms are socially constructed.

The cultural shaping of symptoms may be minimal and may produce sicknesses that look roughly the same cross-culturally. It is more often the case, though, that this core clinical process produces sicknesses that differ significantly in meaning and in which the quality of the experience may be different. There may even be occasions in which the patterning of symptoms produces 'culture-bound disorders'. This can possibly be interpreted, according to Kleinman, as



sicknesses associated with culturally unique patterns of meaning superimposed on diseases that are universal. However, the problem with this view is the implicit prioritisation which is given to the biomedical perspective.

The usefulness of Kleinman's distinction can be summed up by saying that without situating disease in the context of meaning, there is no basis for behavioural options, no guide for health-seeking behaviour or the application of specific therapy. 'Hence, the major mechanism by which culture affects the patient and (her) disorder is via the cultural construction of (sickness) categories and experiences' (Kleinman, 29:77).

Kleinman also tentatively explores two proposed mechanisms by which culture can pattern disease/sickness. It is useful to briefly mention these as they tie in with the manner in which he develops his model of how healing works. The first involves subjective interpretation, while the second suggests a direct effect upon the physiological substrate. The majority of Kleinman's work emphasises the former. In other words, the mechanism is one which involves cognitive appraisal.

Culture influences the cognitive appraisal of external stimuli; it helps determine whether they will be evaluated as stressful or not. It also influences the cognitive appraisal of bodily and emotional states, determining if they are to be labelled as (sickness) or not. It is at work in the labels themselves and the logic of their application. [This cognitive appraisal]...is the pathway from context to person and physiology, from symbolic stimulus to psychobiological response (Kleinman, 29:79).

The second mechanism, however, is one in which culture can directly affect the psychological and physiological processes in disease/sickness. The route followed is one which bypasses cognitive appraisal, goes via the symbolic systems and relationships established in early experience, and directly affects the mind and body. As such, it is outside of conscious experience, just as much of

a patient's sickness experience falls outside of her awareness (Kleinman, 29:79-80). This is the point which was developed earlier about how the symbolic bridge between clinical reality and physiological processes operates. As mentioned, a return will be made to this connection when Kleinman's proposed model of healing is examined.

From this important distinction between disease and illness Kleinman moves on to propose a conceptual model for studying the cognitive and communicative features of health care. This is the third core clinical function of health care systems. The model which Kleinman proposes is called the *explanatory model* framework. Explanatory models (EMs) are the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process. They attempt to offer explanations of sickness and treatment so as to guide the choices which are made between available therapies and therapists. They also seek to cast personal and social meaning on the experience of sickness. As the products of cultural construction in different settings, so EMs differ in analytic power, level of abstraction, logical articulation, metaphor and idiom. EMs are held by patients and practitioners in all health care systems.

To some extent EMs attempt to answer the following five questions in order to explain illness episodes:

- (1) etiology (why the sickness came about)
- (2) time and mode of onset of symptoms
- (3) pathophysiology (how the sickness works)
- (4) course of sickness (what to anticipate, including: degree of severity; and the type of sick role - acute, chronic, impaired)
- (5) treatment (Mechanic, 44:19).

Very rarely, though, do EMs exhibit the formalism which the above five divisions seem to imply. Rather, EMs are characterised by vagueness, a multiplicity of meanings, frequent changes, and a lack of sharp boundaries

between experiences and ideas. Thus, rather than displaying single causal connections, EMs may often involve symbolic connections - resulting in the transgression of logical principles of 'identity' and 'contradiction' (Kleinman, 29:107).

In other words, despite the fact that EMs draw upon general beliefs about sickness and health care, they must be seen as responses to particular sickness episodes. They are to be distinguished from the general beliefs about sickness and health care. As a consequence it is important to analyse them in their concrete setting (Kleinman, 29:106).

In these concrete settings it is usually found that patient and family EMs do not possess single referents but represent semantic networks that loosely link a variety of concepts and experiences. 'These semantic sickness networks draw upon beliefs about causality and significance to make available particular treatment options; they enable instrumental and symbolic therapies to be used together without concern about mixing or confusing concepts from very different sources' (Kleinman, 29:107)<sup>2</sup>.

In sum then:

EMs determine what is considered relevant clinical evidence and how that evidence is organised and interpreted to rationalise specific treatment approaches. Hence EMs are the main vehicle for the clinical construction of reality; they reveal the cultural specificity and historicity of socially produced clinical reality, regardless of whether it is based upon scientific medical knowledge' (Kleinman, 29:110).

Three important hypotheses emerge from employing the EM framework to health care systems:

1. Health care outcomes (compliance, satisfaction, etc) are *directly* related to the degree of cognitive disparity between patient and practitioner EMs and the effectiveness of clinical communication<sup>3</sup>. In other words, the closer the similarity in EM the better the outcome of the intervention is likely to be.
2. Folk practice - as compared with professional practice - involves fewer social and cultural differences between healer and patient and, as a consequence, health care outcomes may be better. Similarly, greater degrees of cultural heterogeneity will possibly worsen health care outcomes<sup>4</sup>.
3. Where the clinical explanation given to the patient does not correspond to the practitioner's theoretical explanatory model, but is closer to the popular explanations, the measures of explanatory effectiveness and health care outcome will be better (Kleinman, 29:114).

When applied to a cross-cultural context, especially one including the discourse of indigenous folk healing, it is important that the application of these three hypotheses follow the principles outlined below:

◆ it is essential to move beyond the attempt to apply 'universal' principles of psychological and physiological mechanisms of therapeutic action. All sickness experience is shaped within a particular discourse. The notion of universal underlying disease processes is also a cultural construct and needs to be applied with discrimination in cultural contexts which are different to the western biomedical framework.

◆ this moving beyond must involve the recognition of social and cultural processes in the shaping of disease into sickness behaviour. Healing can only be understood in an holistic context involving both the language of biology and that of psychosocial and cultural involvement.

◆ what needs to be recognised is that it is the *relationships* between different analytic levels (ie cultural, social, psychological, physiological) that are of special significance for understanding the healing process and for making cross-cultural comparisons.

Moving from here to consider the broader biopsychosocial model it can be noted that 'disease is construed as the embodiment of the symbolic network linking body, self and society'. In the biomedical model the disease may be an occluded coronary artery; in the biopsychosocial model it is a dynamic dialectic between cardiovascular processes (hypertension or coronary artery insufficiency), psychological states (panic or demoralisation), and environmental situations (a midlife crisis, a failing marriage, the death of a parent from the same disorder) (Kleinman, 31:6).

What has been done thus far in this chapter is to outline the broad framework of health care activities which Kleinman proposes. This notion of a health care system must be regarded as a crucial analytical tool if the project of developing a cross-cultural framework for thinking of the cognitive and communicative structures found in the symbolic space of patient-practitioner relationships is to be successful. The building of this cross-cultural framework for comparison is an important step in the move towards understanding what the practice of healing actually entails.

Kleinman proposes a five point framework for the cross-cultural analysis of different healing discourses. This framework provides an important basis from which a consideration can be made of the actual processes involved in healing.

The framework is given here in a very summary form as its main benefit stems from being fleshed out in a specific context of healing. This fleshing out will be done in subsequent chapters.

### Categories for comparing therapeutic relationships

(ex Kleinman, 26:307-8).

#### 1. *Institutional Setting.*

This means the specific location which a healing interaction has in a given health care system's sectors and subsectors.

#### 2. *Characteristics of the Interpersonal Interaction.*

- a. The Number of Participants.
- b. The Time Co-ordinates. This means whether the interaction is episodic or continuous, the expected average length of treatment, the amount of time spent in each transaction, the time spent in explaining or communicating.
- c. The Quality of the Relationship. This refers to whether the interaction is formal or informal with respect to etiquette, type of social role - primary, secondary, tertiary, emotional distance, restricted or elaborated communicative code, nature of transference and counter-transference; whether it is integrated or divorced from everyday life experiences and ongoing daily activities.
- d. The Attitudes of the Participants. This refers to the manner in which practitioners and patients view each other, especially if they hold mutually ambivalent views of each other.

3. *Idiom of Communication.*

- a. The Mode: whether it is psychological, mechanistic, somatic, psychosomatic, sociological, spiritual, moral, naturalistic, and so on.
- b. The Explanatory Models: whether they are shared, openly expressed, tacit or conflicting. Also, whether the EMs are drawn from single, unified belief systems or fragmented, pluralistic ones.

4. *Clinical Reality.*

- a. Sacred or Secular (indigenous or Western)
- b. Disease-oriented or sickness-oriented
- c. Symbolic or Instrumental Interventions
- d. Therapeutic Expectations: concerning etiquette, treatment style, therapeutic objectives, and whether these are shared or discrepant.
- e. Perceived Locus of Responsibility for Care: whether this lies with the individual patient, family, community, or practitioner.

5. *Therapeutic Stages and Mechanisms*

- a. Proposed structure of Healing: in this case the three-point model to be developed in chapter two.
- b. Mechanisms of Change: for example catharsis, insight, psychophysiological, social, or rhetorical.
- c. Adherence, Termination, Evaluations of Outcome: shared or divergent assessments of satisfaction, efficacy, cost-effectiveness.

What has been shown in this chapter is a breakdown of the manner in which healing practices should be subject to a two-phase appraisal. An empathic account of the actions involved should be followed by the translation of these practices into categories which would facilitate cross-cultural comparison. Having achieved that the goal which is being proposed in this paper is to create a model which can be utilised for understanding the mechanisms involved in that healing process. To arrive at this what will be done is to examine two existing models and, by holding them in concert, to extrapolate from them a new model which can be used to help understand examples of indigenous healing.



End Notes for Chapter One.

1. Problematic here is the notion that disease is primary, ie. that one has to have a recognisable disease state in order for the illness experience to develop. It has been shown that illness states can occur in the absence of disease.
2. This is significant in the AIC given their eclectic heritage, drawing on both traditional religious perspectives as well as more modern Christian influences. The influences, with regard to health care, stemming from these two sources could well be significant.
3. Reducing the amount of cognitive disparity between different EM's means recognising the validity of constructing other realities in different forms. Effective communication in this sense involves stepping down from one's own perspective and trying to integrate the two. This is the second part of the project this paper is aimed at - describing categories for cross-cultural analysis.
4. This is where the AICs provide such an invaluable service. Their populations are in a state of rapid flux, with vastly different and alien influences impinging on their daily lives. By stepping in and catering to the needs created by this state of affairs the AIC foster both tremendous appeal and are particularly effective in their healing ministries.

## Chapter Two

**BETWEEN LITERAL LESIONS AND LITERARY TROPES: ✓**  
**DEVELOPING A MODEL FOR UNDERSTANDING**  
**INDIGENOUS HEALING.**

Emerging from the rationale governing the previous chapter it should be evident that the purpose of this investigation into faith healing is to analyse what the discourse of healing implies. Health care systems, as it has been shown, differ substantially depending on the cultural context in which they are situated. Diagnosis as such has to be seen as a semiotic act, it is an act of interpretation performed by the healer in which the patient's complaints or symptoms are cast into a mould of meaning which the healer feels she is best able to deal with. In other words the illness experience is reconfigured into a particular disease nosology or classification. Shweder's reminder is pertinent as this disease nosology need not be a biomedical one. Indeed it is probably better to call this process one of reconfiguration or interpretation into a particular causal ontology or theodicy rather than a disease nosology, given the ambiguity invoked by the term disease. Healing in this context centres largely on the question of what it is that constitutes 'health'. The curing of disease, the naming of a particular illness experience as a precursor to the onset of well-being, the shaping of particular idiomatic symptoms into an experience of suffering and their effective removal or at least in some cases their being come to terms with, are all options which emerge when trying to uncover what it is that healing actually is or achieves.

A reminder at this juncture of the five basic functions of Health Care Systems may clarify things as it helps to focus the question on what is involved in healing.

These five functions are:

1. The cultural construction of illness from disease;
2. The use of systems of belief and values for choosing between health care alternatives and evaluating treatment outcomes;
3. The cognitive and communicative processes used to cope with disease/illness, including perception, classification, labelling, and explaining;
4. Therapeutic activities *per se*;
5. The management of a range of potential health care outcomes: cure, chronic illness, impairment, and even death.

Healing is the sum of the activities of the entire system of health care. It is through these activities that social and cultural factors become major determinants of healing. But healing efficacy is not a straightforward resultant of these processes. It is determined by expectations, which are in turn tied to the beliefs and values of different sectors of Health Care Systems, and these expectations, therefore, may be discrepant. For this reason healing is viewed differently across cultures and in different sectors of health care (Kleinman and Sung, 32:8). It is here that the crucial role of religious orientation may be recognised; the diverse elements of each person's faith orientation adding to the overall expectations placed on the health care system.

In this chapter two models of healing which take the impact of that faith orientation into consideration will be considered. By contrasting these two models it will be possible to arrive at a single heuristic tool for understanding healing practices as they occur in some AICs.

**Kleinman's Four Stage Model.**

The first of the two models of healing is that proposed by Kleinman. The model forms a neat continuation of the health care system framework which was examined in the previous chapter. By developing the notion of the symbolic bridge between social/cultural reality and psychobiological reality, which Kleinman maintains is largely responsible for the cultural patterning of sickness states, he is able to arrive at a framework for interpreting the mechanisms of healing which gives due recognition to the cultural context in which that healing occurs.

Kleinman maintains that in each of the realities created by different religious orientations the manner in which healing happens is the same. 'It seems to be,' he writes, 'the dialectical structure of healing that is invariant' (Kleinman, 30:136). It is in the precise breakdown of this structure that Kleinman is able to explain *how* healing occurs. This *how* rests in Shweder's observation that the model is an holistic, dialectical, interactionist view of the interrelationships between mind, body, society, culture and nature (Shweder, 61:313). This nature of Kleinman's model of healing becomes clear when unpacking each of the four stages involved.

**Stage 1: Symbolic Bridge**

In stage one of his model Kleinman postulates the existence of a symbolic bridge between personal experience, social relations, and cultural meanings (30:131). This means the presence of a sociosomatic linkage which is the first stage of symbolic healing. It is by expanding on this idea of a sociosomatic linkage that Kleinman is able to avoid the traditional problems inherent in mind-body dualism. Granted that we are recognising the pragmatic distinction of mind and

body in reality but not explicating this division on a formal level so interactionism - which is a key concept for Kleinman - is a valid hypothesis.

Kleinman's explanation of how healing works rests, very briefly, on the notion of an hierarchical structure, consisting of linked systems, which enables communication between cultural symbols, on the one side, and bodily processes, on the other. This hierarchical structure forms what he calls a functional continuum of communication systems. Mind and body are not unrelated entities but, rather, fall along the same continuum, performing different functions.

Unpacking this idea of a sociosomatic linkage reveals that the *experiences* of an individual in society (eg, serious loss, physical suffering, political discrimination) are *signs* whose meanings are bound up with a group's master symbols (for eg the body/self as broken machine, the crucified Christ, Israel in bondage in Egypt, ancestral wrath, bewitchment). Those symbols aggregate and form symbolic clusters or what Kleinman would call 'the deep cultural grammar governing how the person orients himself to the world around him and to his inner world' (30:132). These clusters, or the cultural grammar, are found in the central myths (eg the Good News, Freedom Charter, battle between the forces of good and evil, Jesus as Healer, God as a loving and caring Father) that authorise the values of the group and that serve as a type of genetic code or template for the personal myths of the individual. These values, meanings and symbols are translated into lived experience through a 'hierarchy of linked systems running from cultural symbols to social relations and on to self and bodily processes' (Kleinman, 30:132).

The biopsychocultural basis for healing lies in this hierarchical structure: this hierarchy of linked systems 'underwrites the "upward" assimilation of personal experience into cultural meanings' (i.e. the naming of an experience so as to give it substantive meaning), 'and the "downward" particularisation of those

meanings into bodily processes via the cognition and affect of a particular person in a particular context' (Kleinman, 30:132) (i.e. the symbolic restoration/transformation of the patient's sickness state).

Kleinman justifies the elaboration of this notion of a symbolic bridge by drawing upon the work of Sebeok (1986) in order to suggest that, through evolutionary development, these systems are linked by means of the development of codes for connecting at cellular, psychological and behavioural levels<sup>5</sup>. According to Kleinman: genetic code, the neurotransmitter code, the code of endocrine hormones, and codes communicating meanings in social relations and cultural symbol systems - all lie along a functional continuum and so, as communication systems, are meaningfully interrelated. This notion of a functional continuum allows Kleinman to postulate that, in human systems, biological codes and codes of perception and behaviour are made, through the processes of socialisation, 'to relate, resonate, and even transact' (30:132).

These notions of relating, resonating and transacting need explication in order to avoid unnecessary confusion. Kleinman is not suggesting that there are direct causal links/connections between these different systems. Rather, he is saying that it is possible to see their meaningful interaction in terms of relating to each other along the same continuum. An experience may effect more than just one system and so the systems can be seen as resonating, but it may also cause one system to impinge directly on another thus bringing about transaction between the systems. The stress should be on the notion of *meaningful* interrelation, and not so much on the idea of direct causal effect. As the relation between mind and body is as perplexing as ever Kleinman's suggestion is that there is a lot more room for interpretation as to what goes on between these two extremes if the idea of a functional communication continuum is adopted. Thus, with *illness* being projected at different levels of the biopsychocultural hierarchy (see Engel, 19), so healing can be seen as a transformation of these 'recursive systems' (Kleinman, 30:132).

Kleinman gives as an example a Taiwanese healing ritual which may serve to re-moralise a depressed young housewife. It achieves this by mobilising her husband, in-laws, and parents to offer emotional and practical support. Furthermore it authorises her special status in the community and gives her time away from onerous duties in the home. This is because her symptoms are interpreted as evidence that the gods have chosen her as a spirit medium. The ritual itself elicits catharsis, trance, and a powerful feeling of faith and hope. These, in turn, recruit autonomic nervous system, neuroendocrine, and limbic system reactions that reverse the physiology of depression (Kleinman, 30:135) (The *uthwasa* state and the relevant healing rituals aimed at those who believe they are being called in such a way to be *izangoma* can be paralleled with this example).

So, the first stage of symbolic healing is the presence of the *sociosomatic linkage*. 'When lived experience in a shared community of meaning is not its source, initiation into a particular system of healing is' (Kleinman, 30:132). Sometimes this need to be initiated into a shared community of meaning only arises when the person gets sick. More often, however, it would seem that the person becomes sick within a particular understanding or framework and chooses a healer accordingly.

#### Stage 2: Activation of the Bridge.

This stage commences when this particular symbolic connection is activated for a particular person.

A patient seeks out a healer. The healer persuades the patient that the problem from which he is suffering can be redefined in terms of the authorising system of cultural meaning (Kleinman, 30:132).

Kleinman's research has highlighted the fact that in small-scale preliterate societies and in many developing societies as well, healer, patient, and family are usually in agreement about those core meanings (30:133). As it has already shown, the healing system itself, or the health care system, involves specific professional or institutional symbol systems in which the patients are socialised. Operating within this particular semiotic structure the healer interprets the patients' problem in the precise terms of their codes. But clearly more than just interpretation takes place. The healer also uses various rhetorical devices essential for social persuasion to convince the patient that the redefinition of the problem via the authorising meaning system is valid.

Kleinman maintains that this is a reciprocal movement. The healer affirms and the patient accepts; the healer elicits trust and belief, and the patient actively participates in the therapeutic ethos and commits himself to it, often passionately. The patient's experience comes to resonate with, or is conditioned by, the symbolic meanings of the healing system. Meaning is not attached to the experience so as to constitute a separate entity, rather it is constituted by the way in which the patient *attends* to her experience. Both the problem and the patient begin to be changed by the healer's redefinition of the situation. This redefinition is what is important. The patient is persuaded to recast her experience in the light of the symbolic system put forward by the healer and in which she is now attempting to participate. This changing of communicative codes, as Kleinman calls it, may either be noticeable with respect to its difference, or else it may just be a subtle refinement of the patient's views. Kleinman's examples include: the switch from a melancholic state with no plausible explanation to persuading the patient that she is suffering from possession by demons or from the effects of a childhood-based neurotic conflict; and, the change from experiencing bodily pain for no known reason to viewing the pain as stemming from an imbalance in *yin* and *yang* (30:133).



In other words, the discourse, in order for healing to be effective, should be a shared one between the patient and the healer. This point has been highlighted by the first stage of this model where introduction into the shared community of meaning is so important. This corresponds to the point which Kleinman makes about the convergence of explanatory models bringing about a greater degree of success in any therapeutic intervention. A patient operating within a similar discourse will be more easily persuaded to adapt certain features of her explanatory model because it will be seen as a refinement within the logic of the discourse which shapes her world view.

stage 3: **Mediating change.**

Having brought about a switch in communicative codes the healer now skilfully guides therapeutic change in the patient's emotional reactions (which means bodily processes as well as self-processes) 'through mediating symbols that are particularised from the general meaning system' (Kleinman, 30:133). These are the symbols manipulated in healing rituals.

By way of example, Kleinman refers to the psychotherapist's concrete clarifications and interpretations as *symbols* that are authorised, negotiated, and deeply felt in the psychotherapeutic sessions. But, it is not just the healer's rhetorical skill at work here:

The clinical reality of the healing interaction, constructed by the mutual expectations of the participants, contributes to the generalization of personal experience into therapeutic meaning system - eg, the reinterpretation and re-experiencing of menacing amorphous demoralisation as the specified anxiety of Oedipal conflict or the felt depression of blocked flow of energy - and the particularization of symbolic meaning into personal experience - e.g., from the family therapist's general idea of personal pathology representing hidden family conflicts to its concrete instantiation in an adolescent's experience of his overwhelming fear of parental divorce as the understandable and therefore treatable rage of delinquent acting out (Kleinman, 30:133).

This twin process of generalisation and particularisation is significant. The healing interaction allows the patient to switch communicative codes. In other words, she is able to change the perspective from which the problem was viewed and to thus look at it in a new light. The patient's problems are no longer mysterious or inexplicable. A safe context is created in which she can view her ailments; the bewildering universe is named and becomes subject to control. The patient generalises from her subjective experience in order to place her experiences in a context which is both manageable and understandable. This is what is meant by the *generalisation* of personal experience into the therapeutic meaning system.

Now, the particularisation of symbolic meaning into personal experience is both allied and complementary to the process of generalisation. By particularisation Kleinman can be understood to mean the process whereby the patient takes hold of particular symbols and directs her life around the associations which those symbols have (and this can be clarified or strengthened by the context from which those symbols are taken). Thus, the patient creates personal meaning through 'using' the symbol. 'Meaning' is seen to be taken from the general *Weltanschauung* and translated into personal, lived experience.

This is what the third stage is about: mediating symbols particularised from the general meaning system in order to affect change in the patient's emotional reactions. So, for example, the symbols of Jesus the Healer or God the Forgiver, are extracted from the general meaning system and made to feel personally applicable to the patient. This particularisation has a therapeutic effect inasmuch as it brings about feelings of relief; the unburdening of feelings of guilt; hope; and, expectancy of better things to come. Kleinman writes that: 'Altered meanings exert practical efficacy in the felt experience of the patient, e.g., remoralizing the demoralized, and in the social tensions of the patient's circle, e.g., reconciling angry family members' (30:134).

stage 4: **Confirming the transformation.**

Here the healer *confirms the transformation* of the particularised symbolic meaning - e.g., the patient having confessed and been forgiven her sins now is able to receive the blessings which God has in stall for her; or, the sick person, now understanding the illness from which she is suffering, and believing that God is able to heal her in her suffering, is prayed for to receive God's gift of healing.

This symbolic transformation activates the dialectic linking culture (symbolic code) and social relations, on the one side, and psychobiology (autonomic nervous system and neuroendocrine system) on the other, to foster a desired (hoped for, believed in) change in the patient's emotions, disordered physiology, and social ties (Kleinman, 30:133).

Two things deserve mention here: Firstly, healing achieves its efficacy through the transformation of experience. Kleinman writes that: in anthropological terms, the healing interaction fosters this transformation as a work of culture: the making over of psycho- physiological process into meaningful experience and the affirmation of success. And secondly, this transformation must be seen as being in accordance with the notion of illness being projected at different levels of the biopsychocultural hierarchy. For, meanings mediate change at different levels of the hierarchy in a far more complicated way than the simple parallelism between the symbolic world and body/self processes previously held to be the case by scholars of ritual such as Levi-Strauss and Douglas (Kleinman, 30:134). Indeed, the patient may not even be aware of the intricate meanings of the symbol system.

Rather, it may be his early conditioning to key cultural codes - sounds, smells, words, images - that are now physiologically effective even if only partially or wrongly understood, or his

placebo-like response to more general meanings of trust in the healer's competence and a conviction that the ritual, no matter what the details, will make one better - it may be these things that constitute efficacy (30:134).

These two possibilities were briefly outlined in chapter one. It is in holding to both possibilities that Kleinman's model grows in strength for it does not pose the question of whether catharsis or expectant faith or persuasion or restructured social relations is the *single* basis of healing. Rather, Kleinman holds that:

All are important, along with yet other processes of change - e.g., irony, paradox, modelling, insight - though none is determinative. It seems to be rather the dialectical structure of healing systems that is invariant. That structure creates a process of transformations that moves from cultural meanings to embodied experience, from the meanings of personal relationships to the relationships of personal meanings (30:136).

Kleinman makes sense of this process of transformations through postulating that all human communication systems exist along a functional continuum, a continuum which allows these different systems to relate, resonate and even transact.

At this juncture, having outlined Kleinman's model of symbolic healing, it will be useful to explore a distinction which Kleinman and Sung make between:

- (a)
  - i. acute self-limited diseases (i.e., serious sickness episodes with spontaneous remittance),
  - ii. non-life threatening, chronic diseases (i.e., sickness episodes with no apparent cure but which are not fatal),
  - iii. secondary somatic manifestation (i.e., relatively harmless sickness episodes), one the one hand, and
- (b) severe, acute diseases, on the other (i.e., those sickness episodes which are terminal if there is no effective intervention).

The conclusion they reach is that indigenous healers seem best able to deal with the first group. Indeed, for this group they must heal<sup>6</sup>. But, biomedical practitioners are best able to deal with the second group. This does not mean, however, that indigenous practitioners are totally ineffective against all severe, acute, and life threatening, chronic diseases. Their success, when it happens, may well be due to placebo effect or due to the direct effects of the medication they prescribe (32:8).

Pursuing this notion of placebo effect Kleinman writes that: 'the placebo effect can be reconfigured as the activation through the process of interpersonal communication of a powerful endogenous therapeutic system that is part of the psychophysiology of all individuals and the sociophysiology of relationships...the biology of optimism' (30:112).

This talk of psychophysiology and sociophysiology serves to reinforce what has been called Kleinman's 'recursive systemic approach' (Schweder, 61:313). Systemic is simple enough to understand, falling as it does within the system's-theory approach, and into which it is important to place Kleinman's efforts. Furthermore, the notion of a *recursive* systemic approach fits into this overall conception very neatly, for it implies a system built up of successive terms of series, much like Kleinman's hierarchical structure of communication systems running from genetic codes, on the one side, to cultural symbol systems, on the other - all lying along a continuum of meaningful interrelation.

What has been described is a fairly detailed account of the four-stage model of healing which Kleinman proposes. This model fits neatly into the framework for analysing indigenous healing which was outlined in chapter one. In this approach the importance of recognising the impact which culture has on the shaping of sickness states was stressed. By elucidating the nature of this impact Kleinman has developed an analysis of how cultural constructs can affect physiological response. The main mechanism through which this affect is felt is

Kleinman's postulated sociosomatic linkage - the functional continuum along which all human communication systems relate, resonate and even transact.

The nature of the operation of this sociosomatic linkage is not clear however. It is felt that the model proposed by Kleinman needs to be modified if it is to serve as a useful heuristic tool for analysing indigenous healing as practised in some AICs. In order to arrive at this modification a framework for approaching non-physical forms of healing, as proposed by Thomas J. Csordas, will now be given some consideration.

### Csordas' Three-stage Model

This is the second model for understanding healing which is to be considered in this chapter. Csordas developed his model through his work on the Catholic Pentecostal movement in the United States. His work is useful because it stresses the importance of situating a particular form of healing within the discourse which it creates. Csordas maintains that it is the rhetorical movement observable in healing transactions which brings about 'healing'. This is because the rhetorical movement acts as an exogenous catalyst to the endogenous healing processes. As such, by identifying the stages of this rhetorical movement, it is possible to understand the changes which occur along Kleinman's proposed functional continuum between cultural reality and physical reality. Once Csordas' ideas have been developed it will be possible to move on to a critique of both the models presented. Following this critique a new model for analysing indigenous healing will be proposed. This model will then be applied to case examples drawn from the fieldwork which was conducted for this study.

By way of introduction, Csordas maintains that within the Catholic Pentecostal movement it is possible to identify four types of healing;

(1) *Physical healing*: this is the most widely known and is associated, particularly in the United States, with popular evangelists such as Oral Roberts and Kathryn Kuhlman;

(2) *Spiritual healing*: this treats the soul injured by sin, it is regarded as occurring primarily within the sacrament of confession;

(3) *Healing of Memories*: this treats emotional hurts or scars which may linger from a person's past; and,

(4) *Deliverance*: this is healing in which the adverse effects of demons or evil spirits on a person's behaviour or personality are removed by the expulsion of the spirits judged to be responsible.

Of the four, according to Csordas, physical healing should be seen as a descriptive category, while the other three are etiological. In other words, physical healing is advocated for specific somatic symptoms and complaints, while the others are advocated when spiritual, psychological or demonic causes are discerned. Dismissing physical healing as less accessible to interpretation because of its poor elaboration as a form of ritual discourse, and discarding spiritual healing as a kind of 'consolation prize' for those who receive no relief from the other three, Csordas sets about elaborating on 'the two forms that generate the lion's share of Catholic Pentecostal discourse about illness and healing: the Healing of Memories and Deliverance' (16:336).

Csordas takes as a starting point for this enquiry the fundamental question of what it means to be a human being, whole and healthy or distressed and diseased. He argues that the category of the 'holy' may in its own way be fundamental to an understanding of health and health problems. He writes:

A complete account of religious healing *per se*, then, must not only examine the construction of clinical reality with respect to medical motives, but also the construction of sacred reality with respect to religious motives (16:334)<sup>7</sup>.

Accordingly, by supplementing the methods and issues of transcultural psychiatry with an awareness of the methods and issues of comparative religion, one can build upon the understanding of healing episodes generally by widening the range of meanings relevant to analysis. Such an approach is consistent with the call by Good and Good for a meaning-centred as opposed to a 'disease-centred' medical anthropology (in Marsella and White, 38:145). 'It embraces the hermeneutic method familiar to students of comparative religion, and is based upon the assumption that "medical idiomata provide interpretive frameworks used in the construction of personal and social realities" ' (Csordas, 16:334).

What does this mean? What is the hermeneutic method familiar to students of comparative religion? The project of comparative religion can be seen to be based on what could be called 'empathic identification through active ideation'. This means that by learning about the various concretizations of a religious tradition, one is put into a position where one can imagine oneself into 'role', so to speak, within that faith orientation. The meanings of expressions found in a religion's cumulative traditions are what are important. The bare facts and bald statements of belief are not enough. One has - in a manner of speaking - to enter into the skin of the other person and to try and make sense of their way of living their faith (see W.Cantwell Smith, 12). Formalised creeds and other forms of belief structures only form interpretive frameworks, ones used by



followers in the construction of personalised sacred realities. By learning about these frameworks one is halfway towards achieving the goal of sharing in the meaning-world of a person following a different faith tradition.

This whole project should ideally be based on the Foucauldian insight of recognising *differance* and not the self/other dichotomy. Implied in Foucault's phrase is a recognition of two things: firstly the *differential* value of all truth claims, an insight which is built, secondly, on the recognition of the *deferring* nature of all meaning. This translates into a refusal to get caught up in the notion that one particular set of claims are *revealed* and therefore constitutive of final, definitive Truth (Marshall, 40:174).

Csordas, then, seeks to enter empathically into the different worlds of meaning in the healing systems which he is analysing. His goal, within the context of approaching religious healing in a meaning-centred medical anthropology, is to construct an interpretation of the therapeutic process involved in religious healing. This interpretation, Csordas maintains, identifies processes or forms which can be seen in all types of religious healing.

Csordas begins this project by identifying what he sees as the common ground shared by religious, folk and conventional (biomedical) therapies.

To the extent that therapies are effective, there are certain elements common to all forms. It is widely agreed that a primary interpersonal aspect of treatment is the emotional support of the suffering individual and the reaffirmation of his worth in a community or society, while a primary intrapsychic result is the reorganisation of the person's taken-for-granted orientation to experience or 'assumptive world' (Frank 1973), or the affective and cognitive restructuring labelled 'mazeway resynthesis' by Wallace (Csordas, 16:334-5).

These two points, the interpersonal aspect and the intrapsychic result, deserve unpacking. Firstly, the interpersonal aspects of all therapies have been well documented. In our situation there are numerous examples of parallels being drawn between the role which psychotherapy and the role which traditional African healers, for example: *Izinyanga* or *Izangoma*, play in providing both this sort of emotional support and in reaffirming the worth of a particular person within their group or society [eg H.Ngubane (1985) and I. Mkhwanazi (1986)]. Secondly, those aspects intrinsic to all therapies are distinguishable from the intrapsychic *results* of therapies. What is meant by the reorganisation of 'assumptive worlds' or 'mazeway resynthesis' was hinted at at the beginning of this chapter. It refers to the task the healer has of reconfiguring or reshaping particular symptoms into a particular disease nosology or classification. This act of interpretation effects the patient in that she is persuaded to share/adopt that particular framework of meaning and to make it her own.

Frank (1974, 24), postulated that this switch of communicative codes is brought about by the power of 'persuasion' which the therapist, ritual or psychological, has over her subject/patient.

Two views compete for currency as to how these effects of intrapsychic change are achieved. The first emphasises 'exogenous' processes, focusing on the impact on the person of the therapeutic technique or environment. This is what Frank means by persuasion. The second emphasises 'endogenous' processes such as sleep and rest, search for insight, dreaming, dissociation, or acute psychotic episode, which can have possible positive 'therapeutic' outcome. The focus is, accordingly, on the role of the person's response to his own suffering. Prince (1980), 'accounts for the effects of the exogenous processes by arguing that various forms of psychotherapy, whether associated with the consulting room, with shrines, with cults, or with shamans, are in fact techniques for

facilitating or manipulating the endogenous processes' (16:335). So, in other words, the exogenous factors help shape the influence which the endogenous processes have.

This view provides the point of departure for Csordas. His thesis is that *the*:

exogenous factor that provides the specific form of effectivity of ritual healing is constituted by distinctly definable rhetorical devices that 'persuade' the patient to attend to his intrapsychic and interpersonal environment in a new and coherent way. This rhetoric of transformation is central to the hermeneutic problem posed by ethnopsychiatric research (16:335).

This problem can be formulated in the following way: looking at healing cross-culturally, especially at very different therapeutic environments, why is it that a common degree of success is enjoyed by all? What is it that brings about or facilitates healing? Why is it that 'relief of discomfort...occurs promptly and to the same degree, on the average, regardless of the form of therapy or amount of therapeutic contact' (Frank, 24:155)? Csordas' contention is that there is a commonly identifiable rhetoric which works in all contexts of healing. This is the rhetoric of transformation.

Csordas gets to this point by a skilful analytical manoeuvre: by emphasising the importance of endogenous processes he steers away from the commonly held view that the locus of therapeutic effectiveness lies in the *transference* activated by the dyadic patient-therapist interaction. Transference, as an exogenous process, is generally thought to be the crucial element in all ritual healing. However, by drawing upon examples from both his and Prince's work, Csordas shows how healing experiences can occur in the *absence* of a ritual therapist, thus demonstrating that a more adequate site of interpretation needs to be found. Csordas is not saying that the role of the ritual therapist is extraneous. Rather, he maintains that the exogenous process of transference does not on its own give an adequate explanation of therapeutic effectiveness. Further, simply identifying

the endogenous factors involved does not provide an adequate locus of interpretation, 'for it must be asked how the processes are activated in therapy, and why different endogenous processes are prevalent in different settings' (Csordas, 16:345). In other words, the hermeneutic problem raised by ethnopsychiatric research still presents itself for resolution: considering that different therapeutic interventions have similar effectiveness, what is it that governs healing at these different sites?

In answering these questions Csordas comes up with the trump of his argument:

...the locus of therapeutic efficacy is in the particular forms and meanings, i.e., the discourse<sup>8</sup>, through which the endogenous processes are activated and expressed. Recognising this role of discourse resolves the paradox posed by the activation of endogenous processes in the absence of a healer. As suggested by Foucault, discourse is a semiautonomous process which can be contributed to or tapped by those conversant with its conventions. Carried forward by its own structure of implications, discourse itself embodies the therapeutic efficacy and mystical power of the divine 'other' (16:346).

Discourses about health, health care procedures and healing are situated at very varying sites. The point Csordas makes is that despite these different readings of health care procedures a commonality in terms of understanding *healing* can be arrived at. This he proposes in the following form: 'Understanding the specific nature of this efficacy [of different healing practices] requires the construction of a hermeneutic of the cultural rhetoric at work in the discourse of healing' (16:346).

Now rhetoric has already been read as encompassing all those elements which persuade one about the validity or relevance of a particular viewpoint or discourse (16:368). Rhetoric lies at the 'cutting edge' of discourse and it is possible to recognise rhetoric as operating on both conscious and subconscious levels. To expand: it could be said that the influence of rhetoric makes itself

felt in the habitual ways people have of thinking about or viewing the world. Their *Weltanschauungen* are, typically, the products of a persuasive rhetoric operating together with the particular discourse in which they are situated. Moreover, this rhetoric serves to persuade people of the validity of a particular symbolic perspective and once it has done this the symbol itself then serves that function, in what could be called an abbreviated form of persuasion. In constructing a hermeneutic or interpretation of the way in which cultural rhetoric works in the discourse of healing Csordas argues that:

The notion of rhetoric, as against the notions of suggestion, support and nurturance, or placebo effect, contributes a recognition that healing is contingent upon a meaningful and convincing discourse that brings about a transformation of the phenomenological conditions under which the patient exists and experiences suffering or distress. It can be shown that this rhetoric redirects the supplicant's attention to new aspect(sic) of his actions and experiences, or persuades him to attend to accustomed features of action and experience from new perspectives (16:346).

This does not mean that Csordas rejects the notions of suggestion, etc. Rather, he is saying that the rhetoric of transformation is the exogenous factor which harnesses all the others - according to the discourse under observation- and which consequently activates the endogenous processes of healing<sup>9</sup>. The question could well be asked why it is that this rhetoric should serve to *redirect* the patient's attention? Two principles are important to remember:

- (i) the recognition that all illness realities are fundamentally semantic<sup>10</sup> (cf. Good and Good, 25); and
- (ii) the recognition that all clinical transactions are fundamentally hermeneutic or interpretive.

Unpacking these it becomes clear that no matter what the biological correlates or grounds of the experience of suffering may be:

'sickness becomes a human experience and an object of therapeutic attention as it is made meaningful...*All* illness realities are meaningfully constituted. Explanatory models and networks of meanings, grounded in medical subcultures, are employed in all medical systems to construct and interpret experience (Good and Good, 25:167)

The experience of sickness: the expression and recognition of symptoms, the effective coping with these symptoms, or the steps taken to deal with them; all these processes contribute towards a meaningful, albeit often bewildering, experience. Once coping with the phenomenological reality of symptoms becomes unbearable, steps to effectively combat the situation are sought. It is here that the redirection of the patient's attention is important. For *healing* is not only about righting disordered physiology, it also is about creating a new, meaningful world for the patient to live in.

Following on the second principle, that all clinical transactions are fundamentally hermeneutic or interpretive, it should be clear that 'all clinicians routinely engage in translating across medical subcultures or systems of medical meanings and interpreting patient's experiences' (Good and Good, 25:167). Thus, in the clinical interaction, a healer abstracts from a patient's complaints information considered relevant and interprets the complaints as resulting from a particular pathology. This reality is revealed to the patient and becomes the object of therapeutic efforts. The clinician can thus be seen as redirecting the patient's attention to a new ideological reality, one which, in order to bring about effective healing, has to be grasped and made real in the patient's life.

Csordas demonstrates this process clearly. By drawing on Schutz's work, which shows how the particular way people attend to their experiences constitutes the meaning of those experiences<sup>11</sup>, he is able to show how this redirection of

attention amounts to the creation of meaning for patients (16:346). To the degree that this new meaning is able to encompass the person's life experience, healing can be seen as creating for him a new reality or phenomenological world. It is in coming to inhabit this new, sacred world, that the patient is healed. Healing does not mean being restored to the state in which he existed prior to the onset of illness, it means being rhetorically 'moved' into a state dissimilar to both pre-illness and illness reality. Accordingly, it is Csordas' key interpretive task to show how this new reality is constituted as a transformation of both pre-illness and illness realities. By linking the rhetorical aspect of discourse with the endogenous healing processes, in that *rhetoric* becomes the chief (but not the only) exogenous factor responsible for activating endogenous factors in the service of healing, Csordas is suggesting that the transformation brought about by healing operates on multiple levels. 'The experience of healing,' Csordas writes, 'is an experience of totality'. This must be so insofar as 'endogenous processes take place on physiological and intrapsychic levels, and rhetoric acts on both the social level of persuasion and interpersonal influence, and the cultural level of meanings, symbols, and styles of argument' (Csordas, 16:346)<sup>12</sup>.

In this context the rhetoric of healing must accomplish three closely related tasks:

- (1) Predisposition - within the context of the primary community of reference, the supplicant must be persuaded that healing is possible, i.e., that the group's claims in this respect are coherent and legitimate;
- (2) Empowerment - the supplicant must be persuaded that the therapy is efficacious, i.e., that he is experiencing the healing effects of spiritual power, and;
- (3) Transformation - the supplicant must be persuaded to change, i.e., he must accept the cognitive/affective, behavioural transformation that constitutes healing within the religious system (Csordas, 16:348).

Taking each, Csordas amply details how Catholic Pentecostal healing fulfils these tasks. It will suffice for our purposes to briefly outline what is involved in each stage without going into the specifics of Csordas' examples.

**(1) Rhetoric of Predisposition:**

Prior to the tasks of empowerment and transformation, there is a degree of persuasiveness which has to be achieved which predisposes potential patients to the kind of experience that healing makes available. It is possible that two levels of persuasion are discernible at this stage. Firstly, healing could be esoteric in that it is only available to those who have already experienced at least a minimal degree of participation in the movement. Secondly, the healing could be exoteric in that it is oriented towards the health care needs of the general populace. In the context of the AICs it is possible to discern both of these strands, or more precisely, to cast the churches within the mould of this distinction. It can be shown that some prayer healers are more indigenous, in other words they closely resemble traditional *Izangoma / Izinyanga*, in this it could be said that they are more exoteric as the role of the traditional healer in African Traditional Religion is aimed at the general populace, anyone perceiving themselves to be in need of help is free to approach a traditional healer. There are, however, some prayer healers who view their healing role as being more aligned with Biblical precedents. They see themselves as recipients of a divinely ordained gift of healing and, in that their mission is to those who are members of a particular congregation of God's church, their role is a more esoteric one. For example the healing ministry of those involved in the Ukukhanya mission is expressly aimed at those who are willing to accept the precepts of the 'church'. This will be taken up in more detail in the next chapter.



Whether exoteric or esoteric 'the contextual rhetoric of therapeutic ritual creates a predisposition to be healed, and an awareness of a larger purpose for one's healing' (Csordas, 16:350). This predisposition to be healed can be ambiguous as at this stage there has not been any negotiation of different explanatory models, any translation of what particular symptoms may mean or any express help-seeking behaviour. However, it would be misleading to so clearly differentiate help-seeking behaviour from the actual expression of sickness; to distinguish so rigidly between the invocation of a particular causal ontology or theodicy to explain the change from good-health to ill-health and the actual experience of suffering itself. As has been noted above, the expression of suffering is the first step in the process of healing. The naming of an experience, albeit a naming in conflict with how the healer may express it, is integral to the therapeutic efforts aimed at coping and effectively dealing with that experience. But this naming is not an arbitrary or isolated experience. The very act of naming reveals the cultural factors at work shaping the perception and recognition of certain symptoms.

What then constitutes a predisposition to be healed? What are the factors governing, where such a choice is available, the choice of a particular form of therapy? What predisposes a patient to choose one particular form of healing system over another? Or, as is sometimes the case, what causes a patient to 'hedge their bets'? - to choose two forms of treatment concurrently? (for example, seeking the help of a faith healer in an AIC and also going to the local clinic to consult a western doctor).

To answer these questions requires the recognition of competing discourses on health care and help seeking. The patient does not and can not exist independently of such discourses as they are inextricably intertwined with other discourses which constitute the cultural fabric of the society in which that patient lives. Accordingly, the predisposition to be healed can be conceptualised as the decision to choose one form of health care (or two or three as the case may be)

over another. The reasons governing this choice may not be explicit but it can be hazarded that they are more than likely to have to do with either a basic agreement in world views, the reputation of the healer concerned, or 'faith' (faith in God, or something, for e.g. western medicine). This latter point would be inextricably tied to the basic agreement in world views - agreement for example about the efficacy of divine intervention, or about the effect of chemical intervention. It corresponds too with Kleinman's hypothesis that a convergence of explanatory models is likely to bring about a greater degree of therapeutic effectiveness.

Referring to his work with Catholic Pentecostals, Csordas demonstrates how the cultivation of a predisposition to be healed is recognised as being of the utmost importance. The term *expectant faith*, coined originally by Frank in his explanation of faith healing (Frank 24:79), is one which occupies an important place in the Catholic Pentecostal's self-definition/explanation. Csordas' argument is that 'whether it is implicitly recognised on an emic level or posited as an operational category on the etic<sup>13</sup> level, such expectant faith is constituted by a rhetoric specific to the context in which the healing occurs' (16:350). This rhetoric may be influenced by either the esoteric or the exoteric nature of the healing practice, and, progressively, the subordination of healing to the overarching discourse of the religious orientation. The impact of this rhetoric at this level '...is to lay the groundwork for the activation of the endogenous processes through which the main work of healing is achieved' (16:351). So the rhetoric of the particular healing discourse serves to both affect a patient's choice and to reinforce the correctness of that choice.

**(2) Rhetoric of Empowerment:**

Having made a choice about which claims are the most apposite or that the group's claims are indeed coherent and legitimate, the patient now stands to experience the efficacy of the believed in power. Accordingly Csordas considers here those aspects of ritual therapy which persuade the patient that she is experiencing the effects of divine power. Csordas maintains that the impact of the power rhetoric is a function of the way it is grounded in concrete experience. In other words, if the rhetoric of empowerment can be substantiated by felt experience then its impact is likely to increase accordingly. In this context two aspects of empowerment need to be considered: the role of somatic symbols and physiological process, and the interpretation of the spontaneous expression of endogenous processes (Csordas, 16:351).

Drawing on Mauss's notion of '*les techniques du corps*', in which the human body is simultaneously the primordial object of and tool for cultural action, Csordas affirms that the most immediate and concrete manner of persuading someone of the reality of divine power is to involve her body. 'Symbolically a microcosm, and physiologically the limit of human experience, the body recruited to the cause of symbolic healing invokes a powerful sense of totality, encompassing the whole person (Csordas, 16: 351).

Csordas refers to the 'laying on of hands', 'anointings' (the physical sensation of either tingling or constriction in the chest), and 'slaying/resting in the Spirit' (the physical experience of motor-dissociation when the person falls into a trance-like state, during which consciousness of external events may or may not be claimed), as examples of the Catholic Pentecostal *techniques du corps*. These elements of empowerment viz. laying on hands, anointing, and resting in the spirit, are considered in the case studies of healing in the AIC given below.

Moving from the *techniques du corps*, the second important aspect of empowerment, Csordas claims, is the meaning attributed to 'spontaneity'.

While praying for healing, memories of previous events and visual imagery can either be intentionally evoked or else they emerge spontaneously from the preconscious. These memories and visual images are endogenous processes.

The rhetoric of empowerment, aiming to convince the patient that she is experiencing the effects of spiritual power, establishes these endogenous processes as indicators of the manifestation of miraculous power in two ways:

Firstly, 'Spontaneity is believed to be a qualitative effect of experiencing the Baptism of the Holy Spirit'<sup>14</sup> (Csordas, 16:354). This Baptism in the Spirit is believed to be an undeserved gift from God in which one is infused with the power of God. 'For the (patient) in healing, the spontaneous insight, visual image, memory, or pronouncement of a demon's name is motivated or oriented as a manifestation of divine power; it is not a human achievement, but a spontaneous gift from God to one of His faithful (Csordas, 16:354). Thus, due to the cultural rhetoric, the endogenous process is experienced as a manifestation of the holy.

Secondly, 'the spontaneous activation of endogenous processes is given concrete rhetorical form by defining its results as the fruits of discrete, named "spiritual gifts"' (Csordas, 16:354). These gifts may appear in both the healer and/or the patient. Among these gifts are: a 'Word of Knowledge' - facts about the patient's life previously unknown to the healer, or visions experienced by the healer revealing the sources of the patient's distress; 'Prophecy' - direct messages from God to the patient, expressing counsel, encouragement or exhortation; a 'Word of Wisdom' - a statement of advice to the patient experienced spontaneously as a directive from God, this is regarded as being divinely inspired because it is considered as being beyond what the healer could have arrived at by herself; and 'Discernment' - an intuitive sense of the presence of evil or a spiritually enhanced kind of good judgement for guiding the

proceedings and getting at the root of the patient's problem. Very often encompassing these gifts is the gift of Healing *per se*. This is thought of as a divine enhancement of the 'ordinary' powers of prayer (Csordas, 16:355).

Many of these gifts appear in similar forms in healing sessions in the AIC and care must be taken not to impose alien frameworks of interpretation on them. But by drawing parallels with the Catholic Pentecostal movement it is possible to help unearth the rhetoric at work within these healing movements. Reading the 'text' of healing in the AIC demands a special frame of reference, especially one which is made as open or transparent as possible. It is for this reason that employing Csordas' framework of looking for the rhetoric involved in persuading patients about the validity of the discourse of faith healing is useful. This is because the framework implies both a relativeness and a universality about healing transactions. Such a framework dovetails this paper's project of describing and then analysing some examples of healing drawn from AIC practice. Later on consideration will be given to these elements which Csordas identifies as they emerge in AIC healing interactions. For the moment it suffices to say that the effect of this 'battery of spiritual techniques', as Csordas calls them, is that it allows the healer to:

participate mystically in the inner life of the (patient), and allows the (patient) to participate in the endogenous processes experienced by the healer. This mutual participation is not the result of interpenetration of minds - it is the phenomenological component of co-participation in the social project of generating a discourse that is convincing, a rhetoric that creates the concrete experience of divine power (16:355).

This summation points to several important issues. The first is the reminder that the healing ritual is a two-way process. The healer, in the process of translating the semantic illness codes put before her by her patient, also gets fully involved in the holistic experience of healing. The healer emotively participates in redirecting the patient's attention towards a new created meaning.

The second point is linked to the first; it is that the process of rhetorical movement is a joint one - and not simply a process in which one party tells the other how to move into their position. This co-participation is significant because it must serve to strengthen the rhetorical experience of divine power. The patient can sense that the healer is also experiencing the effect of that power and so this reinforces her experience of it. The third and last point is that being exposed to the gifts of God, especially when the healer is a recipient of them too, must serve to reinforce the conviction that the discourse is valid.

### (3) Rhetoric of Transformation:

Csordas considers the rhetorical movement of transformation to be complete when the suppliant is persuaded to change basic cognitive, affective, and behavioural patterns. Indeed, the process of movement and change must be seen as concurrent features of the same phenomenon - healing. The rhetoric of transformation is meant to redirect the patient's attention to her action and experience in order to achieve 'the construction of a self that is healthy, whole, and holy' (Csordas, 16:356). This is achieved by the manner in which the rhetoric of transformation directs the patient's attention to, and brings her experience to participate in, a field of symbols, motives, and meanings that constitute her religious milieu. In this she must be persuaded to change so as to accept the transformation that constitutes healing within the religious system.

This process can be seen in the two forms of healing which Csordas cites: the Healing of Memories and Deliverance. In detailing these examples it is possible to see how the rhetoric of the religious orientation of the patient serves to define the patient's understanding of her own selfhood. This understanding influences what the patient obtains from the healing interaction.

Briefly put, the Healing of Memories can be described as a process of healing emotionally disturbing experiences in a patient's life by getting her:

- (i) to visualise the presence of Jesus in each moment of her life, especially the really difficult and hurtful ones, and
- (ii) to consciously forgive all those who may have been responsible for that traumatic episode, including herself - thus displacing any untoward self-feelings, for example feelings of guilt and responsibility.

Through the dual act of remembering one's life events as though they were played out along a trajectory which lead clearly from birth to the present, and at the same time inserting divinity into those moments, a tremendously powerful rhetorical figure is created. The image of Jesus 'walked through' the patient's entire life trajectory, in order to demonstrate concretely that '*He was always really there*' (Csordas, 16:356), serves to reinforce the transformation occurring in the patient's life. This is so because two things are happening:

- (a) divine presence is being read into a person's life; and so,
- (b) a new life (or new past) is being constructed for her - *in the present*.  
New meaning is being created for the patient and, by coming to accept it, she is coming to participate in the experience it entails.

As stated above:

To the degree that this new meaning is able to encompass the person's life experience, healing can be seen as creating for him a new reality or phenomenological world. It is in coming to inhabit this new, sacred world, that the patient is healed. Healing does not mean being restored to the state in which he existed prior to the onset of illness, it means being rhetorically 'moved' into a state dissimilar to both pre-illness and illness reality.

How is this movement brought about? It is important to recognise the two-fold role of the patient in the Healing of Memories. Firstly, she has the role of active ideation, she has to insert Christ into all the moments of her life, experiencing (albeit in her mind) that presence in the present, and feeling the wholeness and restoration which Christ is believed to bring to all those who suffer and who call on Him for help. And secondly, she has to actively commit herself to forgiving all those responsible for her hurt. This act of forgiveness serves as an overt commitment to changing her mind. Those things from the past which were so disturbing can no longer be held onto and used as an excuse for her lack of well-being.

The second example Csordas draws on is Deliverance. This may be described as the active expulsion of evil spirits or demons believed to be responsible for adverse effects on a person's behaviour or personality.

The transformation wrought here occurs during two main processes: first there is the 'naming of spirits', a process of active participation on behalf of the patient during which the rhetorical impact can be noted on three levels. Psychologically, naming the spirit responsible for the condition has the impact of making the patient acknowledge that she is suffering from problems, thus opening herself up to subsequent interpretation and counselling by the healer. On the spiritual or ritual level, the naming gets the demon out in the open where it can be cast out using a relatively simple ritual formula. It is important that the demon be commanded by name to depart in the name of Jesus, hence this naming is very important. On the cultural level, naming serves to acknowledge the part played by demons as concrete spiritual entities. By naming a demon to be responsible for a particular problem the believer's spiritual reality is confirmed, her experience is made to resonate with the religious milieu - with the symbols, motives and meanings which constitute the semantic network in which she lives, the network which provides the orientation for the outworking of her faith (cf. Cantwell Smith, 12)<sup>15</sup>.



The second process involved in Deliverance is the actual casting out of demons or evil influences. The transformation brought about by the casting out occurs mainly on the cultural level. The process is complicated and Csordas, in his exposition, relies heavily on Fernandez's work on ritual healing in the Bwiti cult. The exposition runs as follows: the demon is perceived as a metaphor of self. Now, on the level of cultural discourse, the self is represented as an 'inchoate pronoun' - a simple I or me which lacks distinct qualities. The metaphor (evil spirit) is predicated onto this inchoate pronoun giving it a particular cultural value or significance. In other words, the metaphor is symbolically 'moved' along a qualitative continuum in such a way that the inchoate pronoun acquires direction and form until, finally, the self - as pronoun - acquires the qualities defined by the metaphors characteristic of the end of the continuum where it has come to rest.

So, in casting 'out' negative metaphors of self, the process is reversed and the qualities acquired by the self are those which mark the opposite end of the spectrum of Catholic demonology, the so called negative vocabulary of motives. Thus, for example, a demon such as Hate is juxtaposed on a qualitative continuum to a motive such as Love. 'The success of this process on the cultural level persuades the individual to accept the new self-definition as the means for orienting (her) actions in daily life' (Csordas, 16:357).

In sum, Csordas writes:

...in deliverance negative metaphors of self drawn from a variety of domains are transformed into positive motives, fundamentally altering the way supplicants attend to their own patterns of cognition, affect and behaviour. In the Healing of Memories, the supplicant's past is transformed by redirecting (her) attention toward various actions and experiences in such a way as to perceive the role of Jesus in leading (her) to the present, thereby removing the negative residue of emotionally damaging experiences (Csordas, 16:357).

Csordas maintains that these two rituals exhibit a complementarity in harnessing the endogenous healing processes. In the Healing of Memories, on the one hand, with its activation of memory/insight and vision/visualisation, all the action takes place within the person. But in Deliverance, on the other hand, which activates externalisation, the action occurs between the individual and forces which are perceived to originate outside her self. Moreover, in the Healing of Memories the goal is forgiveness and reconciliation with one's past. It involves reinterpreting the whole of a person's life as a fulfilment of God's plan, one which led the person to her present relationship with Jesus within the charismatic movement. In Deliverance, though, the attitude is one of active, authoritative grappling with and expulsion of evil influences (Csordas, 16:359). Thus, taken together, these two rituals can be seen as offering a balanced approach to healing that deals with both internal, intrapsychic factors and with external, social environmental factors that contribute to emotional distress.

Succinctly put, the goal of this framework provided by Csordas is to generate interpretations of religious healing based on the premise that "disease" and the "holy" are categories on the same phenomenological level, pertaining to ultimate issues of life and death, activating endogenous processes...and generating fields of interpretive discourse the intersection of which is discourse about illness' (Csordas, 16:364). This framework is in accordance with the critique of empiricism that challenges the definition of meaning as a "relationship between language and a reality that lies outside language," and posits instead that the "meaning of medical discourse is constituted in relationship to socially constructed illness realities" (Csordas, 16:365). Thus, what is put forward is a non-empiricist concept of meaning. This holds that meaning does not *attach* itself to an experience but, rather, is constituted by the way in which a subject *attends* to her experiences (Csordas, 16: 365).

So, taking into consideration the premise that it is "coherent networks of symbols through which experience realities are constructed" (16:365), the rhetorical approach put forward by Csordas can contribute to the analysis of faith healing in at least two ways:

First, it can show how networks of symbols accomplish their task as they are taken up and put to use in discourse. Second, it can show that the principal concern is not the meaning attached to symbols themselves, but the way in which they redirect the attention of participants in discourse, and thereby create new meaning for their actions and experiences <sup>16</sup>(Csordas, 16:366).

A third point should be added to the effect that Csordas' approach helps to identify the importance of recognising the work which endogenous and exogenous processes have in effecting healing. However, recognising the importance of these processes leads to a difficulty when asking how this model of faith healing, which pointedly absents itself from commenting on physical healing, can be included in or allied to a model which is inclusive of physical healing. Any model of healing inevitably has to answer the question of whether or not the process actually works. The answer expected is not just a simple yes or no, but what is requisite is an explanation of *how* such healing can be understood to work.

Having outlined Csordas' three point model of rhetoric, it is necessary to turn to a critique of both the models which have been presented in this chapter. What will emerge out of this is the usefulness of conflating the two models into a single approach which can be used for analysing healing practices in the AICs.

Critique of Kleinman and Csordas.

The strengths and weaknesses in each of the above models need to be held in concert as often the strength of the one model is the weakness of the other. Indeed, this complementing forms the basis for uniting the two into a single heuristic tool for approaching the question of healing in the AIC.

Kleinman's model of symbolic healing has the following strengths:

- (1) The link which he identifies between bodily processes and cultural ones is very important. The mind-body duality has always prevented such an analysis. Now that Kleinman has set out an holistic approach which repairs this breach, the way is opened up for an awareness of the recursive nature of all human communication, be it biological, emotional or symbolic.
- (2) His model recognises the fact that healing is the sum of all the activities of the health care system, and not just an isolated visit to a practitioner. Healing, as opposed to curing, makes sense only when viewed within the cultural context in which it occurs. A consequence of this is the possibility of more effective cross-cultural therapeutic intervention based on the acquisition and implementation of knowledge about the cultural grammar of a particular person.
- (3) A further strength lies in the recognition that being involved in a particular discourse involves a lot more than simply thinking about things in a particular manner. The cultural symbols regarded as important in a discourse play a role in determining what things are admitted to experience and, thus, how illness itself is shaped.

Some of the weaknesses, however, include the following three points:

(1) Although it does not emerge directly, lurking in Kleinman's argument is a prioritisation of the biomedical perspective which is a remnant of his distinction between disease and illness. However, if Shweder's modifications are followed and sickness and its accompanying causal ontologies are conceived as lying along a functional continuum, with a pragmatic recognition of the reality of disease states, then this difficulty can be overcome.

(2) It seems as though Kleinman stresses the importance of the presence of a ritual therapist in order for healing to take place. All of his examples point towards the formation of such a dyadic relationship. Indeed, the stage of activating the sociosomatic linkage is achieved by a patient actively seeking out a healer (Kleinman, 30:132). This stress is problematic because it means that one would be unable to explain how healing can occur in the absence of such a ritual therapist. What would seem preferable, therefore, is to affirm the existence of such a dyadic relationship but to qualify it. The relationship is between the patient and the healing discourse with which they choose to engage. A ritual therapist, while important in terms of bringing about certain exogenous processes, is not indispensable. What is important is the overarching discourse which they represent, and which the rhetorical movement involved in healing seeks to align the patient with.

(3) What is not clear in Kleinman's model is how the sociosomatic linkage is actually activated, or what processes operate along it. Thus, while Kleinman's explanation of the process of generalisation and particularisation is particularly good, where his model grows tenuous is in his fourth stage of confirmation. Not much effort is made to explain how transformations can be wrought along the sociosomatic bridge. Detailed medical research is not what is sought by this particular critique. Rather, it is felt that an attempt must be made to unpack the processes involved in this transformation which is being 'confirmed'. By

borrowing Csordas' distinction between exogenous and endogenous processes, with the rhetoric of healing acting as the chief exogenous factor which facilitates and harnesses the other exogenous and endogenous factors, it is possible to arrive at a clearer understanding of what the fourth stage of confirmation involves. This is because of the seminal position which the sociosomatic bridge occupies in the whole framework of Kleinman's model.

The strengths of Csordas' model lie in the following three points:

(1) His manner of situating the issue of healing within the notion of different discourses shows the inescapable subjectivity of all experience. This is a sobering reminder given the usual tendency when confronted with issues of health care - and healing in particular - to retreat into an essentialist position which favours a biased appraisal of the situation. By situating oneself within a particular discourse, indeed by consciously teasing out the implications of the discourse from within which an individual is viewing the world, it is possible to give a more fair account of the processes involved in a discourse which is alien. It is possible to then not become stuck with the idea of an underlying reality on top of which all different manifestations of sickness and health care treatments are aberrations.

The danger of this view is that it would possibly be viewed by Catholic Pentecostals, in Csordas' case, as implying that healing is of human rather than divine origin. This is, unfortunately, an unavoidable residue of any act of interpretation. While every attempt must be made to render the account of the healing transaction in as appropriatable a form as possible, invariably what happens when translating it into terms which would facilitate comparison is that the individual concerned feels that an injustice has been committed <sup>17</sup>.

- (2) Csordas' model of the manner in which rhetoric functions is particularly good at explaining Kleinman's twin processes of generalisation and particularisation.
- (3) The notion of discourse as a semi-autonomous process helps to separate the act of healing from the dyadic patient-practitioner relationship, thus giving it a wider, more autonomous scope.
- (4) By employing the distinction between endogenous and exogenous processes, and by situating the notion of rhetoric at the helm of the exogenous processes, Csordas performs an extremely useful analytic manoeuvre. This is because it is possible to keep hold of the other exogenous processes. These are able to find their place according to the type of healing under analysis.
- (5) By situating healing within particular discourses, with rhetoric functioning within those discourses in a similar fashion, it is possible to move the appraisal of faith healing beyond the essentialist-relativist debate. Each discourse is indeed different and needs to be recognised as such, but there is an identifiable similarity in the function which rhetoric plays within each discourse. It is, therefore, no longer a question of literal versus symbolic healing. The two are brought together along the same continuum. *Differance* is the order of the day, not a correct versus incorrect method of healing. So it is that healing takes place on the continuum which stretches between literary tropes and literal lesions.

Some of the weaknesses though in Csordas' model are found in the following points:

- (1) It is difficult to apply Csordas' model because of the manner in which he has absented physical healing from the realm of his enquiries.

(2) Csordas' weak link is in actually explaining *how* rhetorical processes (exogenous) actually activate/facilitate the functioning of the endogenous processes. He offers no conceptual framework for analysing how this process could take place.

(3) Following on this, his attempt to steer his enquiry away from so-called physical healing is problematic because:

(a) emotions also involve physiological response, so Csordas' delimitation is an arbitrary one, and

(b) Csordas fails to take into account, or to tease out the implications of, the very discourse from within which he is operating. His insistence that he is not looking at the question of physical healing reinforces the duality between mind and body, and is a false and misleading compartmentalisation.

(4) Csordas' accounts of the rhetoric of predisposition point the way to recognising the influence which culture has on the very shaping of symptoms. What needs to be explored further in this area is the influence of the individual's primary community of reference on her illness perception and presentation. It is not sufficient to just point out whether the healer/healing activity is of exoteric or esoteric origin.

What emerges from this brief critique is a growing awareness of the need to amalgamate the two models into a single heuristic tool. Both have points which complement the other. Both have strengths which compensate for the other's weaknesses. What will be done then in the next section is to outline what form this new proposed model will take.



**Proposed model for analysing indigenous healing**

It is proposed that Kleinman's and Csordas' models can be brought together to form the following model of healing. This new model consists of the following three points:

1. The presence of a symbolic bridge linking mind and body: the sociosomatic linkage;
2. The activation of that bridge; and
3. The process of Rhetorical Movement. This involves three distinct phases:
  - (i) the rhetoric of predisposition,
  - (ii) the rhetoric of empowerment, and
  - (iii) the rhetoric of transformation.

What this model recognises is that to be healed means to be moved into a state different to both illness and pre-illness reality. The 'cure' of a patient's sickness may well form part of this movement but it is not essential. Sickness has to be construed as a fundamentally semantic reality (cf Good and Good, 25).

Healing is thus about the right ordering of that semantic reality in order to allow the patient to cope.

In unpacking this three point framework for interpretation what emerges are the following points.

1. **The Sociosomatic linkage.**

(a) Individuals operate within particular meaning systems. These varying discourses are marked by *differance*. The experience of the world, from within these frameworks, is a subjective one. It is in the construction of these frameworks that it is possible to identify the existence of a sociosomatic bridge. This is because of the manner in which individuals inhabit constructed frameworks of meaning, and the functional continuum running between mind and body, is an inherent part of the construction of that very framework of meaning.

(b) When people become sick they do so within that self-same context. Explanatory models are invoked to help people to understand the nature and meaning of the sickness. In other words, causal ontologies are constructed in order to make sense of the bewildering disruption of the 'natural' order that is sickness.

(c) This sickness may find its etiology more on the physiological side of the scale, or more on the sociological/spiritual. Whichever side, the *experience* of sickness is still one which is largely interpretive.

(d) An appropriate response is sought to the sickness. The appropriateness of this response is determined by the general meaning system in which that individual lives. In other words her *Weltanschauung* will predicate what the appropriate response is.

(e) More than this, her general meaning system will, in part, have determined the very nature and experience of the sickness episode (Cf Kleinman, 29, 30).

- (f) The sociosomatic bridge can, therefore, be seen as serving two functions:
- (i) it helps establish the nature of the symptoms as well as helping to determine which symptoms are considered significant; 'It configures the illness response' (Kleinman 29:26); and
  - (ii), it establishes the most appropriate help-seeking behaviour.

## 2. Activation of the sociosomatic bridge.

- (a) The sociosomatic bridge is purposefully activated as the patient seeks to find an effective response to her sickness.
- (b) This response would seem to take one of two predominant forms. Either the patient seeks out a healer or she grapples personally with the healing discourse. In the case of the latter, the patient engages with her general meaning system in order to find a way of coming to terms with or seeking a solution to her problem. Here she might seek to make the belief in God as the great healer a reality in her own life by personally seeking healing from the deity. Or, in the case of the former, she would seek out a healer who will facilitate that process. Whichever of the two, the function of the rhetoric of healing is similar. It is to get the patient to be moved into a state dissimilar to both illness and pre-illness. Having activated the symbolic bridge, either by seeking out a healer or by grappling with the discourse within which she finds herself, the patient is now carried along by the process of rhetorical movement.

### 3. Rhetorical Movement.

#### 3. (i) Rhetoric of predisposition.

(a) Here the function of the rhetoric is to persuade the patient that healing is possible. The patient has to be predisposed to the healing act. In other words, Csordas' *rhetoric of predisposition* comes into play. A degree of expectancy has to be aroused. The patient has to be persuaded that either the group's claims in this regard are both coherent (not necessarily rational) and legitimate, or, in the case of her grappling personally with the healing discourse, that her own beliefs are coherent and legitimate.

(b) Following Csordas, it is possible that two levels of persuasion are discernible at this stage. Firstly, healing could be esoteric in that it is only available to those who have already experienced at least a minimal degree of participation in the movement. Secondly, the healing could be exoteric in that it is oriented towards the health care needs of the general populace. Whether exoteric or esoteric 'the contextual rhetoric of therapeutic *ritual* creates a predisposition to be healed, and an awareness of a larger purpose for one's healing' (Csordas, 16:350).

(c) Csordas argues strongly for including the notion of expectant faith in the context of the rhetoric of predisposition. The rhetoric of predisposition which nurtures this expectant faith is influenced by either the esoteric or the exoteric nature of the healing practice, and, progressively, the subordination of healing to the overarching discourse of the religious orientation. What this means is that the rhetoric functioning at this point has to reinforce the correctness of the patient's choice. This will be achieved by the degree of congruence between the patient's beliefs and the nature of the symptoms which she is presenting.

### 3. (ii) Rhetoric of empowerment.

(a) Following the above the *rhetoric of empowerment* comes into action. The movement of this rhetoric can be seen in what Kleinman calls the twin processes of generalisation and particularisation. The overall effect which is desired is for the patient to experience the efficacy of the believed-in power. Accordingly, the impact of the rhetoric of empowerment [depends on the manner in which it is grounded in concrete experience] is a function of the way it is grounded in concrete experience. As has already been detailed, Csordas maintains that two aspects of empowerment need consideration: the role of somatic symbols and physiological process; and the interpretation of the spontaneous expression of endogenous processes. It is possible to combine the approaches of Kleinman and Csordas and to see the role which physiological process and somatic symbols have in the process of generalisation, on the one hand, and the role which the spontaneous expression of endogenous processes has in the role of particularisation, on the other.

(b) In the therapeutic setting the process of generalisation works through the healer trying to bring about a switch in communicative codes. This is more than just an interpretive act of what is wrong with the patient. The healer also tries to convince the patient that the redefinition via the authorising system is valid. It is a reciprocal movement: 'The healer affirms and the patient accepts; the healer elicits trust and belief, and the patient actively participates in the therapeutic ethos and commits herself to it, often passionately. The patient's experience comes to resonate with, or is conditioned by, the symbolic meanings of the healing system' (see 34, above). This is achieved largely by the manner in which felt experience substantiates the claims of the healer. Here the role of elements of empowerment, of the somatic symbols and physiological processes, such as laying on hands, anointing, and resting in the spirit need consideration. In other words, what happens here is that the healer manages to persuade the patient to view herself within the context of a wider, more embracing reality, one in which the patient's present experience of sickness makes sense, although it is by no means desirable. What the patient is in actual fact doing is drawing

it is by no means desirable. What the patient is in actual fact doing is drawing connections with the framework of meaning proposed by the healer and casting her experience in the light of it. Accordingly, the problem and the patient begin to be changed by the healer's redefinition of the situation.

(c) It is now that the process of particularisation comes into effect. This stage is about mediating symbols particularised from the general meaning system. It is the process whereby the healer now mediates change in the patient's emotional reactions by mediating symbols particularised from the general meaning system. The patient takes hold of these particular symbols and directs her life around the associations which they have. So, for example, the symbols of Jesus the Healer or God the Forgiver, are extracted from the general meaning system and made to feel personally applicable to the patient. Another example would be the healer extracting from the general idea of ancestral displeasure causing sickness and particularising it in the patient's experience by saying that the patient is sick because she had neglected to propitiate her ancestors. This particularisation has a therapeutic effect inasmuch as it brings about feelings of relief; the unburdening of feelings of guilt; hope; and, expectancy of better things to come.

Here the interpretation of the spontaneous expression of endogenous processes is important. The healer, especially in the AICs, usually receives in a vision a diagnosis of the patient's problems. This diagnosis invariably includes an account of the cause of the problem too. The healer is believed to have accessed the spiritual realm and been able to uncover information hidden to ordinary mortals. So, by accessing the general meaning system, the healer has been able to draw upon particular symbolic meanings which are then made to feel personally applicable to the patient. This changes the meaning which the patient ascribes to her experience. This change in meaning exerts practical efficacy in the felt experience of the patient. She is empowered by the experience and feels capable of being healed.

3. (iii) Rhetoric of transformation.

(a) The final rhetorical movement is that of the *rhetoric of transformation*. It is meant to redirect the patient's attention to her action and experience in order to achieve 'the construction of a self that is healthy, whole, and holy' (Csordas, 16:356). This is achieved by the manner in which the rhetoric of transformation directs the patient's attention to, and brings her experience to participate in, a field of symbols, motives, and meanings that constitute her religious milieu. What happens is that the healer *confirms the transformation* of the particularised symbolic meaning - e.g., the patient having confessed and been forgiven her sins now is able to receive the blessings which God has in store for her; or, the sick person, now understanding the illness from which she is suffering, and believing that God is able to heal her in her suffering, is prayed for to receive God's gift of healing.

(b) What this symbolic transformation achieves is the activation of 'the dialectic linking culture (symbolic code) and social relations, on the one side, and psychobiology (autonomic nervous system and neuroendocrine system), on the other, to foster a desired (hoped for, believed in) *change* in the patient's emotions, disordered physiology, and social ties' (Kleinman, 30:133). In other words, the exogenous rhetoric of transformation fosters the unleashing of the endogenous healing processes. This is what takes place during the entire rhetorical movement which constitutes the change that is healing. The patient is 'moved' into a state dissimilar to both sickness and pre-sickness reality.

(c) The overall effect of the rhetorical movement is to activate the endogenous processes which bring about healing. Even if the patient is not cured of her sickness she has at least been able to recast it into a new light. This possibly makes the experience less bewildering and so she is able to deal with her

perceived symptoms in a more integrative fashion. The whole point about employing Kleinman's mind-body continuum proposal is that this would possibly explain how healing is actually brought about. The rhetorical movement of the third stage acts as the chief exogenous factor which facilitates the outworking of the endogenous healing processes along the mind-body continuum. This allows room for the interpretation of seemingly miraculous cures of sicknesses.

Biomedical intervention may well be the most effective form of intervention for say a streptococcal infection, but this does not mean that it is impossible for a faith healer to heal a patient presenting similar symptoms.

In conclusion, the model which is proposed is one which takes seriously the contention that it is important to avoid the traditional mind-body dualism inherent in Western thinking. What is seen as preferable is to adopt the idea of an interactive, recursive sociosomatic linkage, a functional continuum of communication systems. Healing is about the purposeful activation of that linkage in a manner which best affirms the sick person's position within that hierarchy. A useful distinction is drawn between exogenous and endogenous processes. This is not meant to reinforce the mind-body duality but rather serves as a pragmatic recognition of the different functions played by different communication systems.

What is postulated in the model is that the *chief* exogenous factor which facilitates the practical outworking of the endogenous healing processes along the sociosomatic continuum is *rhetoric*. It is proposed that a process of rhetorical movement can be identified in any healing interaction. This movement can be subdivided into three stages: the rhetoric of predisposition, the rhetoric of empowerment, and the rhetoric of transformation. The effect of this movement is to bring about change along the sociosomatic continuum. This is what constitutes healing. For healing is about being moved into a state dissimilar to both pre-sickness and sickness realities.



What has been achieved in this chapter is to arrive at a new model for interpreting indigenous healing transactions as they may transpire in AICs. This has been done by contrasting the models proposed by Arthur Kleinman and Thomas Csordas, respectively, and then seeking ways in which to amalgamate them. In the chapters which follow this new three-point model will be applied to examples of healing drawn from three representative AICs. Before this is done, however, attention will be given to completing the task of achieving an understanding of the general practices occurring in AICs. Following this, by drawing on the work of the three case studies, Kleinman's five categories for making cross-cultural comparisons will be fleshed out. After that it will be possible to turn in more detail to the case studies and to analyse examples of healing drawn from them to see if the proposed model has any applicability, generally, to healing in the AIC.

End Notes for Chapter Two

5. This notion ties up well with the organic manner of interaction suggested in New Paradigm thinking, especially the ideas about an holographic paradigm put forward by Capra, Smith and others (cf Capra, *et al.*, 13).
6. Kleinman writes: 'healing is only possible because the relationship authentically particularises personal experience in symbols that are culturally and practically relevant' (RP 137), to this extent indigenous healers must heal.
7. Two things are worth commenting on here. The first is the manner in which to apprehend this concept of the 'holy'. Granted Csordas is basing his work on the Catholic Pentecostal movement, but in order to extrapolate from that and to apply his thinking into other contexts, it is necessary to try and broaden the understanding of the 'holy' which he employs here. To this end it would seem best to apply a Smithian understanding of religious practice, one in which the common *faith* strivings present in all people are recognised, but differentiated from the particular *cumulative traditions* (beliefs, philosophies, cultural appendages) which go with these strivings. In this sense it is possible to use the concept of the 'holy'. The second thing concerns the division between clinical and sacred reality. Very often no such division exists, or can be seen to exist. This is especially true in the traditional African cosmology where the religious universe is part and parcel of the 'ordinary' universe. So, division along these lines would be considered spurious. This is relevant when it comes to examining the manner in which suffering is given expression (i.e. the forms which the disease may be expressed in) for the form of suffering determines the form of intervention and consequently the outcomes in terms of the healing of the condition.
8. Drawing here on Csordas' clarification of the meaning of discourse the following can be said. Defined simply discourse can be stated to be simply linguistic performance in contrast with competence, or *parole* in contrast with *langue* (see Marshall 1992), though, according to Ricoeur, it does include non-linguistic semiotic modes and forms of communication. Drawing on Foucault, Csordas states that in its strongest formulation, 'the structure of discourse is the locus of the very conditions of possibility of knowledge [Foucault: *The Order of Things; The Archaeology of Knowledge and the Discourse on Language*]' (Csordas 16:368).
9. This distinction between endogenous and exogenous processes and the links between them is analogous to Kleinman's interactive hierarchy the sociosomatic link crucial to healing. Obviously it is just this link which is critical to the success of the thesis developed in this paper.
10. Realities are indeed semantic as they are constructed phenomena and have to do with a person's making of meaning in the world. For more on this refer to Marshall's elucidation on some of Foucault's work (1992).

11. 'It is best to summarise Schutz's approach to meaning in his own terms:

It is misleading to say that experiences have meaning. Meaning does not lie in the experience. Rather, those experiences are meaningful which are grasped reflectively. The meaning is the way in which the ego regards its experience... [A] meaning is not really attached to an action. If we say it is, we should understand that statement as a metaphorical way of saying that we direct our attention upon our experiences in such a way as to constitute out of them a unified action.

The meaning is merely the special way in which the subject attends to his lived experience; it is this which elevates the experience into an action. It is incorrect, then, to regard meaning as if it were some kind of predicate which could be 'attached' to an action (in Csordas 13:368).

12. A consequence of this holistic view of healing is that no single discourse, eg, western biomedical discourse, or Catholic Pentecostal, or Ayurvedic, or Astrological, etc., can claim healing as being solely its domain. In support of this view is the contention that western biomedicine is very good on finding *cures* for disease states but not so good on *healing* people in their specific cultural, religious, or social situations.

13. These two terms first gained currency as a result of the efforts of researchers working in cross-cultural contexts. On the one hand the need was recognised to document principles which are valid in all cultures and to establish theoretical frameworks which one could use to compare human behaviour in various cultures. This is the *etic* goal.

On the other hand, another goal of cross-cultural research is to document valid principles of behaviour within any one culture. Here attention is given to what the people themselves consider to be important. This is a form of *emic* analysis.

Put more succinctly etics have cross-cultural validity while emics are culture-specific (Brislin, 9:83-86).

14. The powerful feeling of being indwelt by the Holy Spirit. This feeling of indwelling may be so overwhelming that the person may lose consciousness.

15. Of course this particular logic presents the difficulty of being self-serving and thus incapable of contradiction. Doubt is tied up within the framework of meaning in the movement, a demonically inspired opposite to faith/unconditional belief.

16. Indeed, this is the value of symbols. Bourdillon writes: '...it is important to realise that meaning is a human activity. It is not so much symbols that mean something in themselves, as that people mean something when they use symbols' (Bourdillon 8:348).

- 17 In our church there is no science about healing. There is no knowledge; we do not know, we do not understand...what we are doing. We cannot explain it. We believe that anyone can lay hands on a sick person who is a

Christian, and that person would get healed, provided the person laying hands has enough faith in God, faith in Jesus Christ. The whole idea of healing comes from the teachings of Jesus Christ: "Go ye into all the world and preach the Gospel, lay hands on the sick, if they believe, they will get healed!" When people start to explain these faith healings and so on scientifically, I do not believe it; it is impossible. We do it blindly. It is a matter of faith. - John Galilee Shembe (quoted by Becken in Pillay, 53:16)

### Chapter Three

An attempt has been made in the previous two chapters to outline the far from homogenous approaches to healing. This has been done to provide a sense of legitimacy, urgency and purpose to the project of analysing faith healing as it is practised in a few African Independent Churches in South Africa today.

Biomedical discourse, it has been shown, no longer enjoys the unbridled power it used to. A return to the other sectors of the Health Care System is necessary in order both to grant indigenous practitioners a sense of legitimacy and to make professional practitioners more aware of the fundamental cultural constraints which pertain in any clinical interactive setting. It is not suggested that, by providing a model which takes seriously the premise that indigenous practitioners heal successfully, the biomedical model need therefore be abandoned. Rather, if more effective health care services are to be rendered, especially at the primary level, then a degree of co-operation is required between these two disparate sectors of the Health Care System.

The overall contribution which both make to health care must be stressed because it is too easy to naively dismiss one or other sector as being inadequate, inefficient, offensive or harmful. It is suggested that in trying to develop a model of *how* faith healing works, it is essential to take the religious outlooks and values of the recipients of that form of health care seriously. Indeed, these views and beliefs need to be acknowledged and worked into a method of understanding *healing*. Healing centres on a fundamental criterion: the provision and making of meaning. Healing rests, ultimately, on the patient being able to enter into a discourse geared towards the creation of a self that is whole and healthy (howsoever that self may be conceived).

The African Independent Churches in this country are marked by a diversity of practices and outlooks as disparate as those found anywhere else in Africa. Coupled with this is the reluctance by pre-eminent scholars in the field to seek

to classify these churches (personal correspondence: G.C. Oosthuizen, 55). In the course of field research three kinds of healer were settled upon whose practices, in this author's opinion, give a fair representation of the whole gamut of African Independent Church healing practices. The point of the research at this stage has not been to provide 'hard' quantifiable data which would undoubtedly establish the veracity of this new 'model'. Rather it is an attempt to tease out certain issues in the field. What needs to be seen is how a methodological shift embracing traditional and popular healing practices, observable in other countries in their approach to health care issues (for example Zimbabwe and Mainland China), could be applied to a specific health care sector here in South Africa.

Following the example put forward by Kleinman, of using specific categories for comparing clinical interactions cross-culturally, an attempt will be made to describe a general interactive setting applicable to the patient-healer relationship observable in indigenous church practices. In order to do this it is first necessary to situate the work of the AICs within some broad considerations. Following this the case studies will be detailed and examples of clinical interactions will be provided in order to apply the model proposed in the previous chapter. Once this has been done, the information gathered from the case studies will be placed into the categories for cross cultural analysis which were outlined in chapter one.

**Healing in the African Indigenous Churches: some general considerations.**

Perhaps the most striking feature about healers in the AICs is their strong affinity to a sense of history. This emerges chiefly in two forms: either through the strongly discernible influence of healing rituals from African Traditional Religion, or through the tenacious adherence to biblical precedents. In the latter, the past, represented by practices drawn from African Traditional Religion, is strongly rejected and faith in God alone as the source of all healing is encouraged.

Although most AICs would be best situated along a continuum defined by these two positions it is not uncommon to find good examples on either end of the spectrum. What occurs more often, however, is that one finds a puzzling mixture of both - disparate and often contradictory elements are held side by side without any sense of unease (This accords well with Kleinman's contention that Explanatory Models, those notions about an episode of sickness and its treatment, are invoked for specific sickness episodes and that they are derived from but not totally dependent on the General Meaning System. Disparate elements can then be invoked in order to cope with a specific illness episode) (Kleinman, 29:109).

In order to situate the work of the AIC movement within its broader context it is important to pick up on and trace the influence of African Traditional Religion on AICs. This will be done through exploring the nature of the African ontology which the AICs have inherited. Several strands will be elucidated, for example, the convergence of the concepts of *uMoya* and the Holy Spirit; how this convergence has allowed the concept of holism to be maintained; and following from this, why healing plays such an important role in the AICs. Attention will then be given to examining briefly what the causes of sickness are considered to be. This leads to the work of several authors who have sought to categorise the types of illness which are treated in the AICs. Finally, the actual

practice of healing will be considered. Here two things will be done: firstly, a proposal for distinguishing between two different forms of therapeutic setting will be elucidated, and secondly, the procedures involved in these two settings will be briefly described.

Mbiti's views on traditional African religion stand as follows. For the African, religion is an ontological phenomenon, one pertaining to the question of existence or being. This means that religion is not so much about adherence to a particular creed as it is about a way of being in the world. 'The individual is immersed in a religious participation which starts before birth and continues after his death' (Mbiti, 42:15). The whole of existence is a religious phenomenon and human beings are deeply religious beings living in a religious universe.

Expressing this ontology in an extremely anthropocentric form, Mbiti writes: '...God is the Originator and Sustainer of man; the Spirits explain the destiny of man; Man is the centre of this ontology; the Animals, Plants and natural phenomena and objects constitute the environment in which man lives, provide the means of existence and, if need be, man establishes a mystical relationship with them' (Mbiti, 42:16). In addition to this there is a force/energy/power which infuses the whole universe. God is the ultimate sustainer and controller of this force, and the spirits have access to some of it. Significantly, a few human beings also have the knowledge and ability to tap into and use this power too. They usually fulfil the role of sacred practitioners: e.g.; medicine-men, witches, priests and rainmakers (and *Izinyanga*, *Izangoma* and *Abathakathi*).

Given the strong cross-pollination of ideas between African Traditional Religion and Christianity, it is possible to see how this numinous power, the quality *par excellence* that is in every thing and every person, has become associated with the Holy Spirit (Oosthuizen and Hexham, 56:176). Thus it is that *uMoya* and the Holy Spirit have become interchangeable terms. Reacting to the western



philosophical ideology of the compartmentalisation of life, an ideology which has gained rapid ground through nuclear family patterns, urbanisation and social change, the African philosophy of a synthesised holism has had to draw on the concept of the Holy Spirit in order to shore itself up against further erosion (Becken, in Pillay, 58:9). The role which the AICs play in furthering this tradition must not be underestimated. As Masamba ma Mpolo writes: 'The restoration of broken relationships, the re-establishment of social equilibrium, the re-vitalisation of individual identity within the context of the renewed community, are all major means and dynamic ends underlying traditional therapies and healing processes' (41:25).

Thus we can say with Becken that the symbolic context, the overall framework of the general meaning system, within which the AICs are situated is more of an African than a Christian origin (58:14). This grounding in the traditional notion of the numinous, *uMoya*, which has only subsequently been recast in the mould of Christian terminology opens the way for an understanding of the need to return to that sense of holism. For this holism is what healing is all about (Berglund, 3:82). As Bührmann writes: "Healing means to 'make whole' and healthy. It implies that what was previously whole had become fragmented and had subsequently been restored to its previous wholeness and that signifies health" (in Pillay, 58:16). Healing, according to Oosthuizen, is an opening up for the person of the way to self-fulfilment. Physical healing is linked to social healing, in other words, the restoration of disturbed relationships, which implies those relationships which destroy socio-economic well-being (51:16).

The fact that within the context of acculturation, urbanisation and massive macro-economic change, the AICs have continued this healing tradition is probably, as Oosthuizen maintains, their most significant draw-card. "If one has to reduce the African Indigenous Churches to one common denominator, the most outstanding phenomenon is healing - psychic, spiritual, physical and social

- thus 'Healing Churches' could be the most appropriate designation" (quoted by Becken, in Pillay, 58:16).

The importance of healing is further stressed because of the ideas, stemming from the African ontology of being, regarding the mystical causation of illness. 'While a member is ill, the community is at risk' (Kiernan, 28: 94). This is because an ill person has come within the influence of outside malevolent forces. She is to be 'shored up, strengthened and bound more tightly into the community of the saved' (Kiernan, 28:95). The ill person has somehow or the other stepped into the ambit of the influence of these forces. Thus, for the healer, 'the concern is with the re-aggregation of wayward or afflicted individuals' (Kiernan, 28: 95). Two suggested sources of these outside forces are: (i) witchcraft, and (ii) ancestral influences. Both are responsible for causing illness but: 'Witchcraft attacks without moral considerations, while ancestors in general attack what is undesirable, wicked and evil' (Oosthuizen, 51:xxiv).

This distinction between good and evil forces ties in well with the notion that illness is most often caused by misfortune. Misfortune is not always due to the presence of evil, but is most often due to the lack of good. It is a state experienced when good fortune is deflected. The thing responsible for deflecting good fortune may not in itself be bad. Moral considerations may well play a role in what the person is experiencing. The fruits of misfortune manifest themselves in a variety of forms, ranging from physical complaints to difficulty in gaining employment (Mrs M.:74). The act of healing in cases like this is aimed at removing the obstacle which is preventing the patient from receiving good fortune.

This consideration of the mystical causes of illness dovetails with Edwards' project of categorising the types of illness treated in African Indigenous churches, for type cannot be divorced from cause. Edwards attempts her

categorisation by drawing on the distinction suggested by J. Orley, in which various constructs are used to classify the sickness states. Her classification system reads as follows. Sickness may be:

- (1) caused by the patient's sin/not caused by the patient's sin;
- (2) sent/non-sent;
- (3) strong/weak;
- (4) traditional/non-traditional.(i.e. Ukufa KwaBantu)

In a paper entitled 'Healing and Transculturation' (Edwards, 18), Edwards outlines what these categories stand for (the following section is indebted to her work in this regard).

- (1) Caused/ not caused.

Sin must be seen as a disruption of harmony. A sinner breaks the harmony between herself and God and between herself and her milieu (family, society or physical environment). 'Illness and misfortune are thus construed as both the outcome and the evidence of sin and their purpose is to cause the sinner to turn back to God' (18:183). For example, a member of an AIC, called the Ukukhanya Mission, told the story of how he had refused the request to move back to the Mission in order to open up a trading store in the area. As a result of this disobedience in what would have been a valuable service to the community and not just those at the Mission, he was afflicted with a painful condition in his left leg. He claims to have even been struck by lightening when, after having spent a weekend at the Mission, he attempted to return home. When he finally relented of his desire to establish himself away from the community, he was healed of his mysterious malady. His trading store is now operating profitably in the area and he provides a valuable source of financial security to the mission community (this example is drawn from the field

research, a more comprehensive account of this particular church will be given below). In other cases, however, the cause of the patient's sickness is not attributed to any sin on her part. The presence of such a disruption in the community then requires another explanation. This necessitates the move to the second category suggested by Edwards.

(2) Sent/ non-sent

Sent illnesses appear to have their origin in one of three sources:

- (i) either in witchcraft or sorcery,
- (ii) in the ancestors, or
- (iii) in the agency of God. These sicknesses are deliberately caused.

In the case of witchcraft or sorcery, for example, someone jealous of the patient may have obtained *muti* (harmful medicine) from a herbalist and placed it somewhere where its influence would produce the desired harm. Edwards describes the following example:

"He had been working on the mines on the Reef," explained Mr N. "One of his fellow workers was a Bhaca from Mount Frere. He was jealous of the young man and they were always quarrelling about work. The Bhaca put poison in the young man's shoes. The poison went up from his feet to his waist and he was paralysed" (18:183).

The ancestors usually send sickness because they have been unduly neglected or forgotten. It is not uncommon for an individual to experience a myriad of minor physical complaints and to attribute them to disgruntled ancestors (Lartey, 34:40).

God is also considered to be a source of sickness. Sicknesses believed to be sent by God are thought to serve the purpose of bringing people into a closer relationship with Him. Referring to her understanding of Daniel's vision in Daniel 10, Mrs D., an *umthandazi* interviewed during the field research, maintains that: 'God uses a certain way to bring you nearer to Him to talk to Him. Through sicknesses God can get hold of you, make you weak and then He'll talk to you. Thereafter He'll touch you with His own hand and give you His power and wake you up. Then you'll walk in the way that He wants you to' (Mrs D.:72).

Non-sent sicknesses are picked up by chance:

They can be subdivided into (a) illnesses caused by viruses and bacteria which are accidentally picked up ('flying sicknesses'), like colds and 'flu, and also such ailments as upset stomach caused by eating food on which flies have been walking; and (b) illnesses caused by accidental contamination with the invisible tracks of evil agencies (*imikhondo*). In this way 'bad spirits' may inadvertently enter the body by being swallowed or trodden upon. I visited the 21 year old daughter of a member of Mrs N's congregation and was told that four years previously she had accidentally put her foot on the hot path (*umkhondo*) where the *umamlambo* (sorcerer's snake/familiar) had passed through. Now her limbs are misshapen, her back hunched and her mind confused (Edwards, 18:183).

### (3) Strong / weak

The ease with which a sickness can be healed is what differentiates strong and weak sicknesses. According to Edwards' source, the category of strong sicknesses includes tuberculosis, paralysis, epilepsy, and all sicknesses caused by evil spirits. Weak sicknesses, in contrast, include skin troubles, cancerous tumours, headache and diarrhoea. According to this classification sicknesses

resulting from sin are also considered to be weak. They are fairly easily healed once the patient has confessed and asked for forgiveness.

(4) Traditional / non-traditional

Although Edwards refers in this category to either Xhosa or non-Xhosa sickness, it can be understood that she is referring to what is otherwise known as a culture-specific or non-culture-specific sickness. According to Oosthuizen, there are numerous instances of *Ukufa KwaBantu* (African sicknesses). They are usually related to:

1. Spirit possession (*ufufunyane, izizwe, indiki*)
2. Sorcery (*umhayizo, uvalo, igondo*)
3. Poisoning (*idliso*)
4. Pollution (*umnyama*)
5. Environmental hazards (*umeqo, ibulawo*)
6. Ancestral displeasure (*abaphansi basifulatele*)
7. Disregard of cultural norms (*ukudlula*) (for a more detailed explication of these categories cf. Oosthuizen, 51: 86-7)

These *Ukufa KwaBantu* are not easily treatable, if at all, by Western medicine. Non-culture-specific sicknesses, however, are treatable by either a Western doctor or by a traditional healer.

Following this project of categorising the types of sickness dealt with by healers in the AICs, attention must now be turned to an analysis of the actual practice of healing. West maintains that although the importance of the healing ministry in the AICs is uniformly asserted, the methods which are practised to achieve this end are widely divergent (67: 92). He makes the distinction between indirect and direct healing. For indirect healing it is not necessary for the

healer(s) to be aware of the specific complaints of individual patients. The patients are healed through the power of the Holy Spirit, *uMoya*, acting through the agency of the healers, and often the church congregation as a whole. Direct healing, though, occurs when the healer is specifically aware of the patient's complaints, and prescribes specific cures for them.

West suggests a second grid to place on top of this first which distinguishes indirect from direct healing. It is possible, he suggests, to identify three forms of healing:

- (a) healing during church services
- (b) healing by immersion
- (c) and healing through consultation with a prophet.

Although there is evidence to suggest that both direct and indirect forms of healing happen during church services, West does acknowledge that indirect healing is far more common during the services than direct healing (67:92). While West's distinctions are useful, it is felt that a more lucid analysis can be made by adapting them.

What is proposed is to subsume the 'healing by immersion' category into the 'healing during church services' category. Thus a distinction can be drawn between what can be called individual-based healing, on the one hand, and congregational-based healing, on the other. The former refers to the *direct* healing of one-on-one patient healer interactions. The latter occurs during church services where *indirect* healing is most prevalent. The differences in treatment procedures may seem to be at the greatest variance when analysing them according to this distinction. This does not mean, however, that what is actually happening is very different. This will be shown below when the proposed framework for interpreting what is happening in the interaction is applied.

To conclude this section on general considerations of healing in the AICs it will be helpful to very briefly juxtapose the therapeutic process of individual-based and congregation-based healing. Following Oosthuizen's analysis of the interaction between a prophet and a patient, the first step which can be identified in individual-based, 'direct' healing is diagnosis (Oosthuizen and Hexham, 56:174-5). Edwards maintains that this diagnosis forms two stages.

The first is that of identification of symptoms. This may take place, firstly, through the healer 'seeing' in a vision what it is that is wrong with the patient, or, secondly, the healer may actually come to feel in her own body the symptoms which the patient is experiencing. A third method is for the healer to directly intuit what is wrong. 'Here the healer experiences (herself) as being in harmony with the source of knowledge and healing, and in touch with the patient at a very deep level' (18:184).

The second stage of diagnosis is the identification of the cause of the illness. Here numerous EMs may be employed. Usually a dual etiology is invoked. A 'naturalistic' diagnosis is paralleled with an explanation of the cause in super-empirical terms, 'referring either to moral misdemeanours (or sins) of the patient, or more normally to witchcraft' (18:184). Oosthuizen writes that 'prediction,' or seeing in a vision what illness or discomfort plagues a person, 'has holistic implications because it includes diagnosis of all the negative forces which affect a person's whole life, such as mal-relationships and evil forces; it also implies seeing what is going to happen to a person in the future, as well as what has already happened' (56: 174).

The second step involved in individual-based intervention is when the healer sees in a vision what sort of medicine ought to be used. This may vary widely, from just prayer and holy water to a specific kind of purification *muti*. Oosthuizen maintains that at this point there is usually some sort of consultation with the patient in order to verify the nature of the problem. The fieldwork



conducted for this study demonstrated that this may well take the form of the healer suggesting what she has seen in her vision and the patient assenting to this interpretation.

The third step is then the 'treatment' of the problem. This may include singing and dancing around the patient, very often accompanied by hand-clapping. This is considered effective in terms of harnessing the power of *uMoya* in order to facilitate healing. Also, the laying on of hands is often an important element. The patient will invariably be prayed for and then given specific instructions about how to use the *muti* prescribed or about what ritual procedures to follow.

In the context of these healing transactions Oosthuizen also draws attention to the importance of certain symbols which serve as constant reminders of the pervasive numinosity which is being harnessed in order to bring about healing. *Impepho* (incense) and/or candles may be burnt. These symbolise the presence of metaphysical beings. Special vestments may also be worn by the healer. Here the symbolism of the colours worn is what is salient (for more on the importance of colour symbolism cf. Kiernan, 27). Special cords and amulets may be used and, finally, staves may be used by the prophets in healing in order to ward off evil forces (Oosthuizen and Hexham, 56:174-5). More attention will be given to these symbols as and when they appear in the case studies.

Turning now to congregation-based healing a fairly different picture of a therapeutic interaction emerges. However, what will become clear when the framework for analysis is applied is that although the content of these interactions may be fairly disparate, the processes involved are similar.

The first step here is the establishment of a therapeutic ethos of expectation. The first part of the service usually consists of worship, prayer, singing, confessions and testimonies. The congregants gather together in the name of one higher than themselves. They seek to acknowledge God's greatness and to

call upon Him to be present among them so that they may receive some of His power to effect change in their lives.

The worship is a yielding to the Spirit whose presence is invoked by prayer, singing, clapping, swaying and dancing. Individual confessions contribute to group catharsis and testimonies focus the congregation's attention on blessings experienced in the situations of everyday life (18:185).

The second step usually involves Bible reading and preaching. This can be interpreted as serving a reminder of the great deeds which God is capable of doing for those whom He loves.

The third step is when the patients actually present themselves for healing. As the healer (or healers) begin to pray for healing so they start to lay hands on the patients. 'This laying on of hands bears little resemblance to the equivalent procedure in a Western church, and the general effect is more like that of giving the patient a vigorous massage. The patient is pummelled, pounded and thumped on the head, shoulders, stomach, back, legs and arms, with special attention to the afflicted parts' (18:186). The patients participate passively in this process, subjecting themselves willingly to the vigorous physical manipulation. During this time of laying on hands those praying for the patients may pray aloud, in tongues or normally. After this the patients who have been prayed for may be given prayed-over (holy) water to drink. 'The water symbolises the cleansing and new life in the Spirit in which the patient is participating' (18:187).

The fourth step may, as Edwards points out, involve a sort of rounding off of the therapeutic process. Several different variations emerge here. Sometimes the healer and other members of the congregation dance around the patient in a circle. 'The circle is an important symbol...it stands for harmony and wholeness, and symbolises for all present the bringing of wholeness through healing' (18:188). In other situations a special time of concluding prayer is held

when the congregants are led in thanking God for the gift of His healing. The mood here is fairly upbeat and a sense of fulfilment is felt.

With these considerations serving as a general introduction to the question of healing in the AIC attention will now be turned to specific case studies which were studied during the course of the fieldwork. These case studies will each be introduced in a general fashion and then a specific example of a healing interaction will be given. This example will then be analysed according to the model proposed in the previous chapter.

## Chapter Four

The order of case studies presented will follow the order outlined by the continuum proposed above. In other words, the first example will be of a healing practice, ostensibly oriented towards the AIC, which is very closely inspired by indigenous healing practices. The second will be of a healing practice, confirmed and validated by the AIC, which manages to blend traditional practices with Christian ones, but with more of a weighting towards the Christian practice. The third example is of a healing practice which strictly rejects any influences from either traditional practices or from Western medicine. In this case, one's faith in God alone is to be the source of healing.

### Case Study 1: Mrs M.; Sobantu Village, Pietermaritzburg.

#### **Background:**

Mrs M. plays an interesting role in that she is a prayer healer-cum-*Isangoma*. This is an unusual blend of the traditional healer's role with that of the Christian prayer healer (or *Umthandazi*). In traditional African society there were, typically, three types of sacred specialists: *Inyanga* (herbalist), *Isangoma* (diviner), and *Abathakathi* (witch). The role of the *Isangoma* was to maintain contact with the shades and to discern their will (Berglund, 4:307). Mrs M.'s role is thus to maintain this contact with the ancestors while at the same time fulfilling her Christian duties. She wears this dual mantle quite comfortably and sees no difficulty in reconciling her Christian beliefs with her calling from the ancestors.

Brought up in a Christian family she attended a mission school where, early on, she started developing eye problems. In addition to this she also experienced strange dreams and visions. She would often see herself flying and things flying about in the church too. She sometimes even had these visions when she was

praying. On completing standard 9 she applied for a position at a nursing college. She was accepted for training but after a year fell pregnant and so had to give it up. After giving birth she continued her nursing training at Edendale Hospital in Pietermaritzburg, where she worked for seven years after completing her studies.

In 1971 she was forced to resign her post because she had been blamed for the death of a child who had been under her care. She was aware even then that she was being called to be an *Isangoma* but did not want to heed this call. As a result her dreams and visions continued and she also experienced other illnesses. One of these, the inexplicable swelling of her leg, still ails her to this day.

After the birth of her last child she fell terribly ill. During this time of sickness she had a vision of an *Isangoma* dressed in black and white standing next to her. A voice told her that she was the *Isangoma*, and also added: 'this is where you should go: to *shezi ka Mathakane*'. Mrs M. went to the this diviner who had been revealed to her and was treated by her over a period of six months. Her family, aware that she was being called to be a sangoma, wanted her to undertake the training to be an *Isangoma* at the same time as her treatment, but she refused. After being treated Mrs M. returned home where, despite being a member of the Anglican church, she joined the Zionist church in order to receive prayer. It was in this context that she discovered that she had a gift of healing and so she also joined in praying for the sick. Hearing of this the local Anglican priest encouraged her to renew her commitment to the Anglican church and to use her gifts there. During this time of active prayer healing she still rejected the ancestral call to be a Sangoma. She maintained her resistance until the end of 1992 when, finally, she went for divination. She now operates a healing ministry from her home in Sobantu Village where she practices as an *Umthandazi-cum-Isangoma*.

It is possible, in this brief biography, to see the typical stages of an ancestral calling to divination which Berglund outlines (4:136-154). These include: the dreams and visions, the experience of sickness (*uthwasa*), the treatment by a diviner, and the eventual period of initiation and training. What makes Mrs M.'s case more interesting though is the unusual admixture of Christian beliefs and the gifts from the Holy Spirit. She was a Christian, and a Christian endowed with healing gifts at that, before she went for divination. Some would debate therefore whether she could rightly be classified as either an *Umthandazi*/prophet or as an *Isangoma*.

Those like Mrs M., who became diviners after they were initiated as prophets, are described by some prophets as: 'Not having enough faith.....their ancestors succeeded in pulling them out of the church and they then qualified as diviners' (in Oosthuizen and Hexham, 56:185). But this view is certainly disputed by others who maintain that it is possible to have both Christian diviners and diviners who are Christians. The difference is as follows: 'Christian diviners are those who have been Christians and subsequently took the diviner's course; the others have been traditional diviners but repented their sins and accepted Christianity' (in Oosthuizen and Hexham, 56:184).

Fitting into the former category of Christian diviners Mrs M. certainly presents herself as an example of the complex syncretism found on one end of the spectrum of indigenised Christianity. Her healing sessions are always started with prayers directed both to God and to her and her patient's ancestors. Both sides work together although, Mrs M. believes, it is ultimately from God that all power is divined. 'I have a great belief in God for I find that when I don't pray I cannot heal anybody' (75).

This strong syncretism is most clearly identifiable in Mrs M.'s healing practices. While prayer is obviously the most important element of healing, she also uses a whole variety of other elements common to traditional diviners. These include

the use of water for drinking or steaming, the burning of *impepho* and different coloured candles, the sacrifice of white and black chickens, the rolling out of multi-coloured woollen cords, and a whole variety of different substances used to make *muti*.

Mrs M.'s place for healing is in the corner of one of the bedrooms in her house. In this room a sanctified area is demarcated by a goat's skin, several candles and burning *impepho*. Kneeling in front of this, with a patient sitting or kneeling at her side, Mrs M. begins her healing sessions by inviting both God and the ancestors of her family to be present. After this her diagnosis is given and she then prescribes various forms of treatment for the patient. Four examples of possible treatment include: laying on of hands; praying for a glass of water which she holds on top of her bible and then makes the patient drink; mixing up/concocting an appropriate *muti* which is to be used by the patient either as an emetic or inhaled by steaming. She does admit that in some cases she recognises certain illnesses as being more appropriate for Western medical intervention. In such circumstances she would perform a ritual for the patient, in order to make them doubly protected, and then encourage them to visit a doctor.

Mrs M.'s patients seem to cover a whole cross-spectrum of urbanised African society, ranging from well-educated young people, to older more rural folk. Predominantly it seems her clientele are women. She charges no set fee for her services but requires that the patients offer whatever they feel the treatment to have been worth or whatever they can afford.

Mrs M. cuts an interesting figure in the folk sector of the overall health care system as she is able to implement the different forms of knowledge which she has derived from her experience in nursing, prayer-healing and now, more recently, following her training as a diviner, her divination skills. All these

seem to meld into an holistic attempt to come to terms with or to overpower the cosmological forces which are invoked to explain suffering and distress.

### Healing Interaction

The patient, in her mid-fifties, had been to this sangoma on previous occasions. This was because she had fallen and been partially stricken by a stroke. It affected her left leg and foot. As a result of the stroke she is not able to work. She was given a lift by a family member to the *Isangoma's* house. The *Isangoma* had explained to her that the stroke was caused by her walking over muti which had been put on the street ('*umego*'). The treatment which she had been given included drinking holy water and massaging her body in order to relieve the pain in her leg. At present she feels much better and is able to walk unlike just after the stroke. She had returned on this occasion to the *Isangoma* because she had been experiencing more distress. The interaction with the healer took the following form.

[Gathering together in the *Isangoma's* lounge those present sang the following words to a song]

We are praising you Lord  
There is no one who is like unto you  
We approach you with joy  
In all things you are strong  
You rule throughout the heavens.

[The *Isangoma* opened the healing session with the following words of prayer]



In the name of the Father and the Son and the Holy Spirit  
God almighty,  
In the name of the lord Jesus Christ  
You, creator of all and the judge of all,  
We thank you because you are good  
and we thank you that you are still keeping us up to this point.  
We lift up your name and we praise you  
please be with us as we start this service  
Work, God of wonders, in our midst.

I'm inviting the spirit of Manzimela (and of Shezi and Ngomede and Ndlovu)  
to come and be with us here in this house.

[the *Isangoma* moves through into the consulting room. The patient, with some support because of the difficulty she has walking, also moves through into the room. The *Isangoma* kneels and light the four candles demarcating the sacred corner in her room. She also lights some *impepho*. Holding a special stick she opens the session by praying to her ancestors].

We are praying in the name of the ancestors of Manzimela...  
(some words of praise: those who, when they were married the earth shook)  
Come and be with us here in this house.

[while kneeling and praying she keeps her hand on a one-litre bottle of water]  
We are praying in the name of the ancestors of Gumede ...  
(praise)

We are praying in the name of the ancestors of Ndlovu...  
(praise: those who, when there is a moon, are still there on Monday)  
We are praying in the name of Dube Ngonyabe ...  
(praise: those who can see even when they crawl on their tummy - who can see everything)

Here, your child has come,  
She has come into the *Kraal* (within the perimeters of your home/area of jurisdiction)

[passing the patient the bottle which the patient holds, resting it on her knee]

She's coming to ask for help.  
I'm pleading that you be the one who will help her  
in all the problems and sickness she is suffering  
I ask that it be you who should go and help her.

I ask the ancestors of Ngcobo  
and also the ancestors of Ngwanyane  
to come together to help me to reveal to this patient  
what the problem is from which she is suffering.  
I ask that your work should be ahead of me  
and that I should be little  
(You be the leaders and I'll be the one through whom you lead)

[takes back the bottle of water; asks that a bible be fetched]

[taking the bottle and the bible together in her hands]

In the name of the Father and the Son and the Holy Spirit  
the Father of Jesus Christ,  
the creator of all people, and the judge of all  
Before your face Lord,  
Here I come and ask power from you  
Be like that lake (of Bethesda)  
Be the river of health,  
be the life giving spring

Four 101

shine like the sun

God the creator of all mankind and the world.

God I want *You* to work,

not me, but you.

By all power to the name of Jesus

Amen.

[praying over the woman, laying on hands and then touching her with the bible]

In the name of the Father and the Son and the Holy Spirit

You, the owner of all the powers

You, who do these things before all people

You, God, who is willing

meet with me and be with me in all things

God of holiness

Upon this body let it be you who heal

Shine like the sun on this body

You who know everything which is happening in this body

You God, you who know everything

Your rays should work like the sun,

scorching out this sickness.

[picking up the bandaged leg]

I don't have any understanding

it's you who should work

Through all power in Jesus' name.

[Goes back and kneels in front of candles: addressing the woman]

When I was praying for you I heard that sometimes you suffer from a heavy, oppressive headache. While this headache is strong then you feel dizziness which spreads into your left ear so that you can't hear. You feel like you can pull it so that you can hear. You also feel this heaviness on your shoulders which runs down your back and you feel like your back has been broken. This same thing (the pain) goes down into your legs especially on your left hand side, and you feel like sitting down and you feel like you should press/rub/massage your leg. All these pains are related to your ancestors and they're also from these other people who are actually causing this sickness. The ancestors want you to be something so they've allowed you to get sick so that you can come back here and find out that it's them trying to tell you something. You must strive to be what they want you to be. Your ancestors are revealing to me things which are hindrances - when they reveal these things you must accept them. You must accept the things your mother has revealed to me. The mother who has begotten you - you must take her work (an *Isangoma*) and continue it.

Do you agree with all I've said?

[Patient answers affirmatively]

[The *Isangoma* then takes the coke bottle and then rummages around amidst her packet for things which she then puts inside the bottle. Finally, she starts striking some matches, dropping each one into the bottle once it has lit. She does this three times. Then, holding up the bottle, she prays]

As I said before

God who is almighty and powerful

put your power in this lake

I'm asking from You who have mercy and love

let this water be the water of miracles

let it be the water of healing.

And whatever may be contrary to healing (with regard to the contents of bottle)

whatever is contrary to healing in this lake  
let it be cursed  
in the name of Jesus Christ  
Amen.

[she passes the patient the bottle]  
[session finished with this particular patient].

**Analysis:**

This is an example of individual-based, direct healing. The division, suggested by Edwards, into the stages of diagnosis, vision about treatment, verification and actual treatment of the problem are clearly evident. However, the exact ordering of these stages differs slightly from that suggested by Edwards (18). In this example the verification of the problem occurs before the healer 'sees' what treatment to prescribe for the patient. This ordering accords better with the proposed model for analysing the stages involved in the healing interaction.

These stages are: the presence of a sociosomatic linkage, the activation of that linkage, and the process of rhetorical movement. The sociosomatic linkage in this example serves as a very good illustration of the strong syncretism which exists between traditional African beliefs and Christian beliefs. The patient has clearly come from within a general meaning system where notions of ancestral displeasure and the causes of misfortune stemming from evil influences exist as possible explanatory models for sickness. Allied to this are Christian beliefs about the power of God, or *uMoya*, to heal.

This syncretism deserves unpacking because of the manner in which it functions as the very 'cultural grammar' on which the intervention depends. Mrs M. is a Christian diviner. She has successfully joined the two worlds. Her healing

practice relies on the power of God, without whom, she believes, it would be impossible to heal anyone. But she also recognises the place, role and power which the ancestors have. Her cosmology is one marked by God as the supreme power in the universe. Below Him, however, there are the competing forces of good and evil. The ancestors usually work for the good of people, while there are evil forces - usually in the form of witches, sorcerers or these specialist's familiars - which attempt to undo this good. The ancestors stand as the intermediaries of God, with Jesus being recognised as the greatest of the ancestors. As such the ancestors have the power to bring about sickness and healing. They are able to do things which accord with the will of God.

Mrs M.'s views on the causes of sickness complement this structure very neatly. They are summed up neatly by Edwards' proposals which were outlined in the general considerations above. These proposals are, briefly, that sickness is: (1) caused/not-caused by the patient's sin; (2) sent/non-sent; (3) strong/weak; and (4) traditional/non-traditional. In the sent/non-sent category Mrs M. would be likely to differentiate between those sicknesses sent either by witches, ancestors or by God. Moreover, she recognises that God can get the ancestors to act on His behalf. Thus, sicknesses traditionally seen as being sent by the ancestors are still viewed as such but now an additional level of interpretation is incorporated of why it was that God allowed it to happen. The treatment of sicknesses caused by ancestors or by evil spirits would follow the same format as for a traditional *Isangoma*, but what is different is that Mrs M. recognises that without praying to God she would not be able to affect a change: 'I have a great belief in God for I find that when I don't pray I cannot heal anybody' (72).

As a result of Mrs M.'s syncretism there is a rich blending of symbols which are considered to be potent. Mrs M.'s manner of dressing for healing rituals is significant. She wears a long white robe over her normal clothes. This distinguishes her from her patients, cloaking her in an aura of the sacred. The

stick which she carries and which she starts off the healing session holding is a possible remnant of the stave which the traditional *Isangoma* used to ward off evil forces. The different coloured candles and the impepho which she burns signify the presence of metaphysical forces which will be salient in the healing process. The impepho is a carry-over from the practice of the *Izangoma* while the candles can be seen as a Christian influence. The colour of the candles is also significant although the ones Mrs M. used in this session were only white. The goat's skin which was strung up in the corner of Mrs M.'s prayer room also has a significance attached to it which stems from the traditional practices of *Izangoma*.

Mrs M. uses water as part of the healing process. This she either gives for drinking, steaming or to be used as an emetic. The similarity between it and the Christian use of holy water is noteworthy. In certain circumstances Mrs M. would also prescribe the slaughtering of chickens. Finally, the most prominent form of treatment which Mrs M. offers is to mix up a certain concoction of muti. Many plastic shopping bags stand in the corner of her prayer room and after diagnosing the patient's problem she makes quite a show of rummaging through these bags for the correct form of muti which is being 'revealed' to her. When she has fished out several odds and ends, ranging from pieces of bark to quantities of washing powder, she places them inside an iron mortar and spends several minutes pounding the substances into a powder. When complete, she funnels this onto a piece of paper and carefully folds it, giving it to the patient with strict instructions of how it is to be used.

This then is the general meaning system in which the healer operates and also in which her clientele move. The second stage of the healing interaction is the actual activation of the symbolic bridge. This activation occurs when the patient seeks out a healer. What is interesting, is the patient's actual choice of healer. It can be assumed that this choice was determined, in part, by the reputation

which Mrs M. has managed to achieve for herself and by the degree of networking available to the patient.

That the patient chose to consult a healer instead of grappling with her own beliefs about the power of God to heal her, reveals some interesting ideas about the nature of her Christian faith. These ideas include the notion that there are sacred specialists who are best able to deal with the disruption of the natural order. Sickness is such a disruption and its cause may lie in some ominous metaphysical intervention. Thus in order to return to the sense of holism which undergirds the African view of life it is necessary for the patient to seek help from a specialist in these matters. If the patient holds both Christian and traditional religious ideas, she would look to a healer who would represent something from her past associations as well as integrating her new Christian beliefs. Mrs M. cuts such a figure. Her healing ministry is an important adaptation or Christianisation of the role of the traditional *Isangoma*. She is a Christian diviner. Both worlds are accessed by her ministry in a manner which does not set them up in opposition but sees the one as a logical continuation of the other.

Another interesting fact which the nature of this patient's response reveals is her need to explore this challenge to her faith, for what else can sickness be, in a communal context. The individualism inherent in the notion of a person praying directly to God for healing is not a part of this patient's 'cultural grammar'.

She feels the need to affirm herself within the context of a community of believers, even though she may only access that community indirectly through a healer. The patterning of this individual's sickness response has surely been constituted in part by this need. She is given social support in that she requires the services and time of a family member or friend in order to take her to the healer. The action of the healer helps to legitimate her sickness role, and thus the care-givers of the patient are also called upon to help sustain the environment in which healing is possible. The symbolic bridge does not, therefore, cease to function following the interaction with the healer. To the



contrary, it is legitimated by the healer's intervention and it helps to provide the framework in which the problem can be rectified.

The third stage of the interaction is that of the rhetorical movement. In this interaction it is clearly delineated into its three stages. In terms of the rhetoric of predisposition it can be said that the approach is by and large an exoteric one. There are no restrictions on who can consult the healer. The function of the rhetoric at this point is to reinforce the correctness of the patient's choice of healer. She has to be persuaded that the healer's claims are both coherent and legitimate. A degree of expectant faith is to be instilled in the patient. Considering the specific choice which the patient made to come to this healer the opening time of socialising with other patients must serve to reinforce the correctness of the patient's choice. As this was not the first visit made by this patient so it is possible that she may have known some of the other patients present. This time of interaction would have afforded the opportunity to exchange stories about the effectiveness of the healer's interventions in other's lives. Also, the patient had clearly benefited from her previous visits and so she would now be expectantly awaiting the beginning of the proceedings.

Mrs M. started the formal proceedings by leaving the room to go and put on a special white garment which she wore for the duration of the afternoon. Returning, she stood in the corner of the lounge to lead those gathered there in prayer. She started the session by leading everyone in a song of praise which expressed the desire to approach all-powerful ruler of the heavens. This song served to establish the sacred terrain in which the people were now moving. An atmosphere of worshipful expectation was created. Mrs M.'s words of invocation to the Godhead, and the manner in which, during her prayers, she managed to invoke a whole range of potent Christian symbols would have served as an important source of resonance for those seeking healing from God. By joining this with prayers to the ancestors to help guide and direct the proceedings, Mrs M. managed to make both world-views comfortably cohere.

This sense of unity between the two, stemming from the idea of both forces occupying their special places in the overall ontology of being, must have served to reinforce the correctness of the patient's choice of healer. For how could the intervention fail if both spiritual forces have been invoked? Moreover the words of the prayer reinforce the dependency which all humans are thought to have on God. He is the sustainer of all that there is in the universe and nothing is possible without His knowledge or His permission. The ancestors, accordingly, find their role within the space created by this too.

This dual action on Mrs M.'s part, of invoking both God and the ancestors to be present, is reinforced when she moves through to her healing room with the patient and spends a great deal of time praying to the ancestors. By calling on each by name she is reinforcing the importance, stressed in African culture, of remembering the ancestors. Furthermore, by calling on both her ancestors and those of the patient she is setting herself up as a possible repository of hidden knowledge. This can only serve to reinforce her power in the patient's eyes. Within this context the patient is made to feel that this is indeed the correct place to have come with her problem as everything which she holds onto in terms of belief is being called upon to help her. The expectancy which this must create in her cannot be underestimated.

The switch from the rhetoric of predisposition into the rhetoric of empowerment is a subtle one, and there is a degree of overlap between the two. Mrs M. opens the prayer session holding a special stick. This could have overtones from the special staves which diviners used to carry and which served to ward off evil forces. By using it Mrs M. is signifying that the interaction is to be marked by an absence of such evil so that the causes of the problem from which the patient is suffering can be correctly diagnosed. By using this important symbol Mrs M. is starting to blur the distinction between making the patient feel predisposed to healing and making the patient feel as though she is actually experiencing the effects of divine power. Furthermore, while praying to the

ancestors Mrs M. keeps her hand resting on a one litre bottle of water. As this is not the first visit of the patient to the healer, so the connection had already been established in the patient's mind about the efficacy of holy water. Indeed, it was probably in a similar container that Mrs M. last gave the patient some holy water to use as part of her treatment. This combination of prayer and efficacious symbols must serve to convince the patient of the effectiveness of the power she is starting to experience. When she mentions in her prayers that the patient has come within the perimeters of the ancestor's kraal or dwelling place, and reinforces that by passing the patient the bottle of water, the patient must already be starting to project herself and the problem from which she is suffering into the framework of meaning which the healer inhabits. She is not only being convinced of the coherence of the healer's claims, because they so clearly coincide with her own beliefs, but she is also being invited to participate in the experience of that power too. The patient, through her associations with holy water, is made to feel as though she is experiencing the effect of the power in which she believes.

The rhetorical movement of empowerment occurs in two stages. Firstly through the process of generalisation and secondly through the process of particularisation. The effects of Mrs M.'s prayers are to get the patient to start casting her experience in the light of Mrs M.'s framework of meaning. This is what the process of generalisation is about. If there is a fair degree of congruence between the healer's and the patient's outlooks, then the task Mrs M. would have would be to make the patient refine her views so that the two coincided. Mrs M expressly invites the ancestors to be the ones who will help the patient at this point. She asks that they be clear in revealing to her the problem from which the patient is suffering. The effect of this is to help the patient view her experience in the light of a system which recognises the power which the ancestors have to cause or allow sickness to afflict the patient.

The next step she makes is to consolidate this by also calling upon the power of God to help in the healing. By taking back the bottle of water and asking that a bible be fetched, Mrs M. makes it very pointed that she is now also calling on the power of God to be with them in helping to sort out the problem. Praying with both the bible and the bottle of water in her hands, Mrs M successfully amalgamates both worlds. God is invoked. The power of the water is Christianised, it is given added potency, and Mrs M draws upon the notion of God's omnipotence by saying: 'God I want you to work, not me, but you'. The effect of these prayers must surely be to direct the patient's attention to the overarching religious universe which she inhabits. Mrs M. has managed to draw on certain memories or symbols which the patient must have. For example the ideas of God being like the water of Bethesda, the river of health and the life-giving spring. All these images help to encode the patient's experience by resonating with the cultural grammar which is her springboard into her religious universe. In other words, by drawing on images which are central to the patient's self-definition, Mrs M. is enabling her to project her problem in the broader light of that meaning system.

This generalisation is reinforced by certain elements of empowerment, in particular Mrs M.'s laying on of hands. This action serves to persuade the patient that she is experiencing the effects of divine power. It is allied to the process of trying to persuade her to switch her definition of the situation because of the impact of the prayer which Mrs M. prays while performing this action. The words of the prayer, invoking a God who is loving, who is all-powerful, who allows sicknesses to happen, who is all-knowing, and - importantly - who is willing to and capable of healing, serve to create an important concord between the patient and the patient's perception of the problem. She is able to cast her experience in the light of the religious discourse of which she is a part. A reciprocal movement has taken place: the healer has affirmed and the patient has accepted, the healer has elicited trust and belief and the patient has committed herself to the therapeutic ethos. The patient's experience has come to resonate

with, and be conditioned by, the symbolic meanings of the healing system. Thus, in picking up the patient's bandaged leg, and praying that it be God who should work to bring about healing, Mrs M. humbles herself and both she and her patient now wait expectantly for God to answer their prayers.

This, it is believed, He does through revealing to Mrs M. what the nature and causes of the patient's problem are. In this manner the process of switching communicative codes is completed through the process of particularisation. Here the healer extracts various symbols from the general meaning system and makes them feel personally applicable to the patient. Mrs M's diagnosis of the patient's problem does just this. What it does is to move from a generalised viewpoint in which the ancestors are able to affect a person's health by either deflecting good fortune or by allowing evil spirits to affect one, to a viewpoint in which the patient's specific complaints have been allowed to occur by the ancestors.

The ancestors have warranted the patient's sickness because they want her to heed the call to take up the *Isangoma's* vocation. The actual sickness is caused by evil spirits, but the ancestors have allowed it to happen so that the patient would return to the healer and in so doing discover the will of the ancestors.

In other words what Mrs M has done is to particularise symbols, taken from the general meaning system, and make them feel personally applicable to her patient. This strength of this particularisation is reinforced by what was called the 'interpretation of the spontaneous expression of endogenous processes'. What this means is that Mrs M's unaided diagnosis, her intuitive grasp of what problems the patient is experiencing, serves to reinforce the validity of the particularised symbol. In this whole process the patient feels that she has concretely experienced the power of God working in her life.

The final stage in the rhetorical movement is the rhetoric of transformation. The overall purpose is to achieve the construction of a self that is whole, healthy and holy. This is achieved either through confirming the transformation of a particularised symbolic meaning or through praying for the healing of a specific complaint. Mrs M's approach seemed to combine elements of both. She managed this by setting her earlier diagnosis (of the patient having stepped on muti in the road) within her diagnosis of the present situation. The ancestors had allowed all of these things to happen as a way of getting the attention of the patient. That was why she was suffering more problems, because she had not yet received the message clearly enough. As a result, Mrs M's approach was to confirm the transformation of the particularised symbolic meaning. In asking the patient to agree with all that she has said Mrs M. is confirming the transformation, or the switch in communicative codes, which has taken place.

What happens now is that Mrs M. receives an inspiration from the ancestors about which muti to give the patient. The experience of suffering of the patient has been named and she can now receive the gift of healing which God will allow the ancestors to impart to her. The potency of the muti which Mrs M. sticks into the bottle of water will help to usher in that healing. Furthermore, by striking three matches into the bottle, the water is given a double potency. The symbolic worlds of traditional African religion and Christianity are once again united, this time in the service of bringing healing to the patient.

In concluding the interaction, Mrs M held up the bottle of water and *prayed* that it would be the source of healing for the patient. That in drinking it all negative influences would be banished from the patient's life and thus she would be restored to health. Concluding the prayer, Mrs M. gave the patient the bottle, symbol of potency and healing. The patient has now only to drink the water and she will be healed.

The return to the lounge where the other patients were waiting their turn to consult the healer can be seen as the final act in this healing interaction. The patient has experienced the power of God and the ancestors and she is now returning to everyday life to find her rightful place in it. She is no subject to the bewildering disruption which marked her sickness experience but is now healed.

The act of serving cool drinks and other refreshments to those who had consulted the healer serves to reinforce the fact that these are now healed people, capable of 'normal' social interaction. They have been given the label 'healed' and it is now up to them to live it. The overall effect of this rhetorical movement, it is postulated, is to activate the endogenous processes which bring about healing. These processes operate along the sociosomatic continuum which links culture (symbolic code) and social relations, on the one side, and psychobiology (autonomic nervous system and neuroendocrine system), on the other. The overall effect is to foster a desired (hoped for, believed in) change in the patient's emotions, disordered physiology and social ties (Kleinman, 30:133), through constructing a 'self that is healthy, whole and holy' (Csordas, 16:356).

## Chapter Five

### Case study 2: Mrs D. Sobantu Village, Pietermaritzburg.

#### Background

Mrs D. is a fifty-five plus year old *umthandazi* who works from her home in Sobantu (she is a good number of years older than Mrs M.). As a healer she would fit roughly in the middle of the continuum between traditional healing and strictly Christian healing.

The events leading up to the advent of Mrs D.'s career started in 1972 when her mother died. Up until this time she had been living with her mother, trying to bring up five children at the same time. She lived with her mother as her husband, who had gone to Johannesburg in search of work, had deserted her. In August of 1972 her mother encouraged her to get her own house, but she did not pay any heed to this advice. Thus, a month later, in September, when her mother died Mrs D. was thrown onto her own resources. Her mother appeared to her in a dream which was so vivid that it was as though she was actually still alive. In this dream her mother reassured her and said that she was going to give her a house.

For the next two years Mrs D. managed to find work in an old age home, but at the end of 1974 the home closed and so she had to find new employment. She managed to find this at a nearby T.B. centre where she had to wash and iron clothes. Three significant things happened while she was working at this centre. Firstly, she began to experience some abnormal sicknesses. She sometimes had the feeling that there were 'white things moving on my face and I had to brush them off' (71). Secondly, the dream which she had had about her mother became reality while she was working at the T.B. centre. An old woman in the hospital heard about Mrs D.'s problems and she called Mrs D. to her saying



that Mrs D.'s mother had helped her and that she now wanted to give Mrs D. her house as a result. This house which Mrs D. was given is the same one she lives in today. The third significant feature of Mrs D.'s experience during this time was that, in addition to the unusual sickness which she experienced, she also discovered that she had the ability to pray for people who were sick. When she prayed for them they would be healed.

At the time of discovering her gift of healing Mrs D. was a regular member of an Apostolic Church. This gift of hers was confusing to some of the members of the church. The pastor, however, tried to explain to the congregation that this was a gift from God and not a demon. Mrs D. continued to receive patients in her special prayer room at home, where she would pray for them. Mrs D. had no relations with any men after moving into her new home and she brought up her children on her own. Often people would help her by bringing food, clothes and other things which her household was in need of.

After a while Mrs D. tried to join the Zionist Church but she found that she could not endure the services as the sound of the drums used in the church was a problem for her. She then went to Durban where a pastor from the Christian Assemblies of God recognised her gift and issued her with a certificate authorising the validity of her ministry. At this stage she did not actually belong to any church, but she soon joined the Anglican church.

While officially a tithing member of the Anglican church she does not attend any services as she experiences a painful swelling of the legs whenever she goes into a church building. Nevertheless she still continues her healing ministry at home. What is interesting here is her experience of being less able to heal people after she has been to a church service. She is thus wary of any large gathering of people, even in her home, as she finds this causes her to get sick (her legs may start swelling for instance, causing her great pain). She feels that this avoidance of church services and other gatherings of people is somehow tied

up with her healing abilities. She feels that her healing abilities are dissipated if she makes too much contact with people.

The sense of a proper inward disposition and balance in her life is what informs her need to go once a year to the sea to pray and receive her own healing and strengthening. She believes that she needs to go to the sea in order to cleanse herself from the sicknesses of other people. Bathing in the sea is an act of purification for 'the sea is like God, it is actually God' (71).

As mentioned, Mrs D. runs her healing sessions in a small room which is detached from her main house. In it there are just two or three chairs and a small table with candles and incense on it. Small, intricately woven, grass mats adorn the walls and a pair of buck horns hangs over the doorway. An atmosphere of expectancy, reinforced by the burning candles, pervades the dimly lit room.

Singing forms an important part of Mrs D.'s healing ritual, although prayer is obviously the most fundamental aspect of the healing process. Mrs D. lays a great deal of stress on singing as she says she finds it very uplifting. When lifted up into a different plane of consciousness she is able to receive revelations from God in which he tells her what problem the patient is suffering from. 'We sing, and while singing I get spiritually uplifted: this is when God reveals things to me. When I see what the person is suffering then I tell them what is wrong' (72).

Mrs D. is sometimes able to diagnose the patient's problem because she feels the same sickness in her own body as soon as the patient comes into her house. Usually, however, she relies on God to speak to her through either visions, dreams, or through a silent voice inside her. For this reason she lights yellow and white candles so that she can receive revelations about the patient. The

yellow candles represent those who are sent - angels - and the white represent those who come as messengers of peace and healing - *lezi thunywa*.

Once she has 'seen' what the patient's problem is she communicates this to the patient. Her patient is then able to confirm whether what she says is right or not. If she is right she then suggests possible healing methods. These methods usually include the use of water either for washing or drinking. The patient is made to go and fetch some water and Mrs D. then prays for the water. If, however, a person is strong enough in their faith, she would just pray for them - laying hands on the afflicted part of the body. Faith, Mrs D. maintains, is necessary in order for a person to be healed. Either faith in the Holy Water, or faith directly in God. Whichever way, God is ultimately the one to be looked to as the source of all healing. Mrs D. sometimes also uses *impepho*, but not too often as she suffers from asthma. The water and *impepho*, she maintains, are ceremonial devices which serve as reinforcements for those whose faith is not strong enough. In a similar vein she says that she sometimes uses herbs and razors for *ukugcaba* (cutting the skin with a razor and smearing the herbs onto the wounds), which, although this procedure is mainly performed by traditional healers, also serves as a reinforcement for people who need to feel a stronger sense of *uMoya*.

Mrs D. made it clear that the act of diagnosing a problem also carries with it the task of identifying the causes of the problem. While she would tackle the symptoms she would encourage the patients to address the causes of the problems. She maintains that people do not need to be baptised or to repent but that they must change their ways of living and read their bibles. There are cases where she would recognise that western medical help is necessary and so she would refer the patients to a doctor, at times even giving them money to afford to get to a hospital. She has also had occasion to refer patients to traditional healers, although she maintains this does not happen very often.

As with Mrs M., it appears that Mrs D. does not make her patients pay. She relies, rather, on their bringing her gifts of thanks if they receive healing. Both of these women enjoy moderately comfortable lifestyles. Each owns a nice home and each enjoys a measure of popularity and esteem which extends beyond the boundaries of the area in which they both live. The places which they have carved for themselves in the overall system of health care are, it must be recognised, important in terms of the contributions they make to upholding a general level of well-being. These contributions must certainly not be overlooked given the macroeconomic circumstances which prevail.

### Healing Interaction

This particular healing interaction was conducted during part of one of the interviews with the prayer healer. It involved one of the research assistants who was helping with the interpretation. This particular assistant had had no intention of consulting the healer for any specific complaint. What emerged was an entirely spontaneous interaction as no other patients of the healer arrived during the time that the team was with the healer. The assistant, in the throes of studying towards a degree in theology, is a committed Christian and a member of the Lutheran Church. The interaction took the following form.

[Moving from the main house to a separate out-building in the complex where the healer has her special prayer room set up for consultation with patients. The team was seated in this small, dimly lit room. The healer then lit the candles - red, yellow and white - and some *impepho*. She then sat and prayed silently for a few moments. When she had finished she said:]

We'll start work:

[sings]

Jesus my life wants you alone...

[to the interpreter]

You, come and sit here.

[sings]

In your glory I want to see you...

[laying hands on the interpreter]

In the name of the Father, the Son Jesus, and the Holy Spirit.

We ask in your name Jesus

We ask in the angels of light

In the angel of grace

Come inside to heal us.

We ask you, the Leader of Heaven

to lead us in whatever we are going to do.

We ask you to heal to his head and inject his bones,

then come into his body and give him a good mind in his studies

and give him light in the institution of heaven

and give him light always

In the name of Jesus, Amen.

Now, I just go briefly in explanation: you sometimes have a headache and when these headaches come it goes down to the eyes and then to the temples. And sometimes you feel heavy shoulders which makes you want to stretch yourself, and you have palpitations - and this feeling goes down and you feel something bad in your stomach and you feel something on your belly-button. It

goes down and makes your knee-joints loose. Sometimes you don't feel like talking and you feel like going to be by yourself in a secluded place.

Sometimes your feet get hot and sweat, then you feel like going to be by yourself where you feel the Holy Spirit of God. Then it makes you pray hard to the extent that you cry, and you look like a person who's suffering/worried, yet are not. You have a moment of meeting the angels/messengers.

Do you agree on these things?

[Interpreter]

Yes!

[Healer then says]

We'll pray and then go back. Sing, sing...

[Encourages the interpreter to start a song, which he does]

'I can do nothing suitable only you'.

[Healer prays]

In the name of the Father, Son and Holy Spirit.

Father we thank you for you are good.

Go out with these children

we ask you to let us remember you all the time

go with us now

God open our minds

Protect us from all these dangerous things

stay in our hearts and minds so that we'll succeed

Stay with us in your love. Amen.

**Analysis:**

According to the classification scheme specified above, the actual healing practice is a form of individual-based, direct healing. The stages identified in this individual-based approach, namely; diagnosis, vision about treatment procedures, verification and treatment of the problem are all discernible. Attention must now be turned to how these stages fit the model for analysing the discourse of the healing interaction.

According to the first stage the sociosomatic bridge present in this example is of a predominantly Christian origin although the influence cannot be discounted of the assistant's upbringing and his being situated within an indigenous context in which traditional African beliefs are held. The resonance which the healer's *modus operandi* must have had in his life is fairly clear. This is because of the predominantly Christian attitude which the healer adopts. The ancestors do occupy a place in her cosmology but they are subordinate to the greatest of ancestors who, this healer claims, is Christ. Accordingly, it is not deemed necessary to marry the two sets of rituals associated with each faith's orientation. Faith in God alone is enough the healer maintains. This would have struck a particularly harmonious chord with the research assistant given his strong Christian allegiance. However, in different circumstances, the healer did concede that she sometimes has to use elements which her patients can identify with more strongly. 'In truth it depends whether a person believes or not. To those who are believer's, prayer is sufficient. To those who do not believe - I give them water, then that person is placing her trust in the effect of that water. That water, because it is blessed, has God in it - therefore, it's God who heals people' (72). This mention of water has strong Christian overtones. However, it also resonates with the symbolic value it holds in traditional African religious practice.

Two other symbols which Mrs D consciously uses also deserve mention. These are the different coloured candles she burns as well as the *impepho*. These two things she purposefully lit before starting the session with the team. The candles are an interesting carry-over of the importance of colour symbolism (cf Kiernan, 27). 'Red - for enemies; yellow - for those who are sent (angels); and white - for messengers of peace/healing (*lezi thunywa*). I use them so that we can receive revelations about the patient' (interview). She uses the candles as an aid to revelation. The red candle, she believes, prevents her enemies/evil forces from giving her false revelations, and the white and yellow candles bring light and luck. The *impepho* she uses as an aid to remembering the African tradition. It is, she says, like Magdalene smearing the oil on Jesus. The past, while not of any immediate import in the proceedings, is represented in order to help the patient feel more at ease. Indeed, it serves the function of making the patient feel that he is definitely in the presence of the supernatural. The numinous power which pervades the universe is focused in this particular room. The intervention is, therefore, going to be successful.

Finally, in this consideration of the symbolic world which Mrs D. inhabits and makes accessible to her patients, it must be recorded that alongside the room which she uses for her consultations, is a prominently placed chicken hutch. Admitting that she does use chickens quite often in her consultations, Mrs D. said:

The red chicken and the guinea fowl are used mostly by *Izangoma*. I use the white ones and the black ones. I use the black one to remove all bad luck. It is used to throw away accidents, injuries, all bad things. You must kill it and leave it far away on the hills. Then you must come back and kill the white one. The white one is killed so that everything should be in the light - to open up luck (71).



Thus, although there is a self-conscious differentiation made between her Christian practice and the traditional practices, what is evident is a strong overlap between the two. This must aid her work particularly as her clientele, although predominantly Christian, must have that Christianity strongly rooted in a traditionally African sense of holism, a sense of holism which, as was pointed out in the general considerations, allows room for ideas regarding the mystical causation of illness. Mrs D. takes advantage of this residual traditionalism in her treatment approach. It forms the matrix of the symbolic bridge between mind and body which she shares with the majority of her patients.

Patients become sick within this context. They ascribe certain meanings and values to their sickness state which are drawn from this overall meaning system. Indeed, the shaping of symptoms into a specific sickness experience follows the specific frameworks of interpretation, or explanatory models, which are invoked to make sense of this disruption of the natural order. The experience of sickness and the methods of trying to explain or come to terms with it are parts of the same process.

Mrs D. would be most likely to recognise sicknesses situated within the first three categories outlined above, viz.: caused/not caused by the patient's sin, sent/not-sent, and strong/weak. The category of traditional/non-traditional would crop up more rarely in her assessment. She admits, however, to having referred patients to *Izangoma* when she felt unable to deal with their problems. This indicates a willingness to recognise *Ukufa KwaBantu*, as well as the fact that sometimes *Izangoma* are the ones best able to deal with such sicknesses when they appear. Her strong faith in God's power to heal, however, makes it hard for her to concede this point.

Enjoying a reputation for her Christian gift of healing, Mrs D is approached largely by those who find a degree of concord between their own beliefs and

what they perceive Mrs D. to represent. Their experience of suffering is based on the 'cultural grammar' or the 'symbolic clusters' which are found in the central myths around which they orient their lives (see the exposition on this theme given above). It is these myths which are generally shared between Mrs D. and her patients. They form the overall meaning system which is activated when the patient seeks Mrs D's help. This is the second stage of the healing interaction: the activation of the symbolic bridge. In this particular example the activation was not consciously sought but occurred spontaneously. It was facilitated by the degree of concord which existed between the 'patient' and Mrs D.

Turning to the third stage, the process of rhetorical movement, what becomes clear is that the first two stages are easily discernible but the third is slightly blurred. Extrapolating from the interviews with Mrs D. it is possible to construct an analysis of how this third stage would operate.

The first stage of the rhetoric of predisposition can be seen in Mrs D's stress on the importance of singing. 'We sing, and while singing I get spiritually uplifted: this is when God reveals things to me' (70). The effect of the singing, especially with the potency of words such as 'Jesus my life wants You alone' and 'In Your glory I want to see You', must serve to induce a spirit of reverent expectation in the patient. The act of singing creates a feeling of worshipfulness and expectation. The healer is leading the patient into contact with the divine. The words of the song serve as reminders of the respect and abeyance in which God and His representative are to be held.

By singing with the healer the patient is making a determined effort to enter into the exoteric world of the healer. Healing is available to all who would ask and the healer stands as a representative conduit of God's power. Other factors which reinforce this attitude of expectation include the potent symbols which the healer employs in her therapeutic setting. The different coloured candles, the

*impepho*, the carefully woven grass mats which hang on the walls of the room and which are decorated in specific patterns and colours, and even the horns of a buck which are ceremoniously nailed above the doorframe, are all factors which must resonate with the belief system which the patient brings with him to the healing session. They serve to reinforce that belief system, to establish the congruence between the two individuals, and to thus confirm the correctness of the patient's choice of healer.

The patient is able to relax for now the bewildering disruption of his life is going to be resolved. The setting created by the healer's singing and the symbols which she employs, serve as persuaders about the coherence and legitimacy of her claims to healing. The reputation which preceded the healer and which more than likely acted as a stimulus to the patient 'trying her out' is reinforced by the appropriateness of the therapeutic setting which she has created.

The second stage in the rhetorical movement is that of empowerment. Here, it must be remembered, the purpose is for the patient to experience the efficacy of the believed in power. This rhetorical movement happens in two stages, through the processes of generalisation and then particularisation. The process of generalisation is meant to bring about a switch in communicative codes. In this case it is more likely that there was just a refinement of existing views. The healer directs the patient's attention to new aspects of his experience. She aims to get him to view his problem in a new light. This must be seen as a continuation of the movement of predisposition. The patient places his trust in the healer. He considers her approach to be effective. The healer now capitalises on that trust by skilfully altering the perspective from which the patient views the problem.

In the example, Mrs D. lays hands on the subject. This must have served to create a link between the patient's own symbolic world and his felt experience.

It is a way of establishing a link between the patient's experience and the symbolic meanings of the healing system. While laying on hands she prayed aloud for him, invoking the Godhead, the angels of light and the angel of grace to enter into his head and to heal him. She allied this with a request to bless him in his studies and to ensure his place and blessing in the overall scheme of things for ever.

The invocation to the Godhead, the angels of light and the angel of grace is significant as it establishes a broad scope for possible intervenors. While Mrs D. has stated that she does not follow the forms of traditional beliefs, she is nevertheless, including the powers which inhabit the netherworld of her cosmology. The ancestors, while technically asleep, are given recognition for the possible role which they could play in bringing about healing. The healer has kept her options open, allowing the patient to fill her words with the meaning which he chooses.

The problem the patient experiences is now no longer viewed in the light of the individual's solitary experience. It is imbued with the understanding and insight which the healer brings to bear on it. Albeit ever so slightly, the patient's problem and with it his experience, have begun to be changed by the healer's taking control of the situation and starting to redefine it.

The healer now moves into the phase of particularisation. This stage is about mediating symbols particularised from the general meaning system. This process is often helped along by what has been called the 'spontaneous expression of endogenous processes'. This can be seen in the healer's offering a 'revealed' diagnosis for the patient's problem. She has somehow discerned what it is that the patient suffers from and she offers an account of how to interpret the problem. In this example she correctly diagnoses that the patient occasionally suffers from headaches which develop into other complications. As

a result of these the patient feels the need to go into seclusion where, praying very hard, he has a moment of meeting the messengers/angels.

What the healer has done here is to correctly diagnose the nature of the patient's problems: headaches resulting in the desire to be by himself, during which time he feels overwhelmed by the intensity of his emotions. What she then does is to particularise symbols drawn from the general meaning system and to make these feel personally applicable to the patient. The patient's feeling the Holy Spirit and his times of meeting with the angels/messengers are interpretations of his experience which the healer draws out of the general meaning system. She particularises these symbols in order to allow the patient to change the meaning which he ascribes to his experience. This change in meaning has a practical outworking in the felt experience of the patient. He feels empowered by the experience, thus far, of the intervention and feels capable of being healed.

The final rhetorical movement is in the rhetoric of transformation. In asking the patient to verify what she has said Mrs D. is seeking to confirm the transformation of the particularised symbolic meaning. In other words, the patient now understands the sickness from which he is suffering and he can ask God to heal him. Csordas writes that the point of this rhetorical movement is to direct the patient's attention to his action and experience in order to achieve 'the construction of a self that is healthy, whole and holy' (Csordas, 16:356).

Before Mrs D. prays for God's gift of healing she again encourages singing, presumably so that she can gain strength for the actual task of healing. By encouraging the patient to lead this singing she is reinforcing the active role which he must play in seeking his own healing. It is an affirmative response which encourages the patient to start viewing himself in the new light of one 'healed'. He is no longer subject to possible mysterious forces but is back within the fold of God's protected ones and capable of seeking God's will (Kiernan, 28:19). This transformation into wholeness is what Mrs D. seeks to

confirm in her prayers. The final prayers are more like a benediction than a request for healing. She thanks God for His goodness, and asks that He accompany the patient in future. The patient's attention is thus drawn to the field of symbols, motives and meanings that constitute his religious milieu. He is situated within those and sent along his way.

It is just before these final prayers that Mrs D. would pray over water, if the patient's lack of faith required it. Also, if the problem merited it she would prescribe the slaughtering of chickens. These symbols are used to bolster the individual's belief in the efficacy of the intervention when their faith is not strong enough to rely only on prayer. This final prayer is not, however, the end of the healing process. The concluding step back into 'normal' reality must also be seen as part of the process. The healing has not occurred in isolation. The buildings and people outside of the sacred space created in the prayer room may look the same as they did before the patient entered, but the patient's reality has changed. He has personally experienced the power of God and he can now expect to be able to view things in a new light. The bewildering disruption of his normal life occasioned by the advent of the sickness episode has now been brought under control and named. He has experienced the empowering touch of God and he can now start living as though that touch had transformed him. The dialectic linking culture and social relations, on the one side, and psychobiology, on the other, has been activated in order to foster a desired (hoped for, believed in) *change* in his emotions, disordered physiology, and social ties. The patient has been rhetorically moved into a state dissimilar to both sickness and pre-sickness reality.

**Chapter Six****Case Study 3: Ukukhanya Mission, Impendle.****Background**

The Ukukhanya mission is distinctive from the other two case examples cited in that it falls at the extreme end of the continuum representing those indigenous healing practices which rely totally upon 'faith in God'. Essentially a post-church movement, one which claims a divinely ordained healing ministry, the Ukukhanya mission is notable in this context because of its steadfast rejection of any traditionally religious views or practices. However, this does not make it un-African as the hierarchical structure and practical functioning of the mission is run along strictly Zulu lines.

In overall control is the third president of the mission - a succession based on patrilineal descent - who enjoys a papal-like control over the spiritual well-being and destiny of his flock. Serving under him and obedient/submissive/subject to him in all matters - administrative and pastoral - are priests, evangelists, deacons, lay-preachers, prayer-healers, and the congregants. The mission, with its headquarters situated on a farm in Impendle, is run on a practical day-to-day level along agrarian lines showing a strong emulation of a traditional Zulu tribal structure. Within this structure the president is the Great Chief who has several loyal subjects serving under him. But both the Chief and his servants are subject to the King, in this case God, to whom - ultimately - all allegiance is due.



The picture to be painted of the Ukukhanya mission is one of a community who have taken to heart the command - believed to have been given by God over eighty years ago to the present president's grandfather - to bring God's word and God's healing to the African people. But theirs is no ordinary following of Christ's example. Christ and Rev. Timothy Cekwana (the founder of the mission) were brothers! Both, it is believed, were conceived by the Holy Spirit and both were born under auspicious and miraculous circumstances. Jesus' mission had been to the Jews, and through them the rest of the world. Timothy's mission had been to the African people. God, it is believed, chose to make His presence felt in Africa in a unique and affirmative way for the African people.

Timothy was the first bearer of that Good News - the first proclaimer of the third testament between God and His people *UmAfrika*. The power which God bestowed on Timothy, was passed down to Timothy's son Frederick, and from Frederick to the present president, the Rev. Alfred Cekwana. The main sign, it is believed, of God's anointing of Timothy was Timothy's bleeding from his mouth and hands. This blood, the cleansing and healing blood of Christ, is believed to be present on everything at the mission, albeit in an invisible form. The gift of bleeding, which is interpreted as a sign of God's special imbuing of a person with the Holy Spirit, is still to be witnessed to this day. The person who is blessed with this gift is thought to be especially efficacious when it comes to praying for the gift of healing. In accordance with the rigid patriarchal pattern which is espoused in Zulu society, this gift is limited to the menfolk, although this does not prevent women from becoming *abathandazi*.

The reputation of the mission for successfully healing people extends, it seems, well beyond the borders of Natal, with people coming to the mission from as far afield as Swaziland, the Northern Transvaal, Eastern Cape and Lesotho. Aligned with this to the deep respect which is accorded to the president, and it can be



understood why such a sense of expectancy is created whenever a sick person approaches those at the mission for healing.

The procedures which a sick person goes through in order to obtain healing at the mission may, at first glance, appear to be less involved and complex than those involved with the two *abathandazi* mentioned above. But this is not the case. The steps a person who is sick has to go through are as follows: on arriving at the mission - no small feat given its fairly remote location in the foothills of the Drakensberg - the patient is required to report to one of the elders. She tells him what it is she is suffering from or why she has come to the mission, and the elder then goes to the president and tells him about the patient. The president makes a decision whether or not to give the patient permission to come into the mission. If he decides against it, the patient is required to leave. This is unlikely in most circumstances, although this research team were refused permission on certain occasions. If the president decides to allow the patient to come in, the patient has to report to him personally and relate her problems to him. Three possible courses of action arise at this point:

- 1) After listening to the patient's version of her problems the president could tell her to return home. *En route* home or immediately upon arriving home the patient is healed.
- 2) The president could allow the person to stay for a night or two before being sent home. This usually happens in cases where it is revealed to the president that a person is not going to be healed. Rather than having the person die at the mission because of all the complications that this would incur, the president allows her to regain her strength and to experience some succour from being at the mission, before sending her home.

3) The third possibility is that after listening to the patient the president could have it revealed to him that the patient will be healed if the patient stays for prayer. The patient is allowed to stay and live with the community for a certain period, during which time the president organises a service of prayer for all the sick people at the mission.

A distinction is made here, however, between those who had been using muti before they came to the mission and those who had not. Those who used muti are just prayed for, they do not receive the laying on of hands, but those who did not use muti do receive the laying on of hands. In addition to the special prayers, members from both groups have the benefit of staying at the mission, where they are in constant contact with the blood - they are cleansed, purified and healed by it.

For those who can not get to the mission a number of possibilities exist. Three of these are:

- (i) requesting that one of the elders and several members from the mission make a personal home visit;
- (ii) sending in requests for prayer by proxy. These requests are either phoned in or mailed, and
- (iii) if a member has, by circumstances beyond her control, landed up in hospital then she can request that a group of people from the mission come and pray for her in the hospital.

Before elaborating on each it must be pointed out that in all of these circumstances the two main elements of healing are: first and foremost - prayer, and secondly holy water. The water is taken from a spring at the Mission. It is prayed over and then drunk by the sick and those who are praying for them.

The water is seen as representing the blood. As an interview with two of the Mission's elders revealed: 'That water has the spirit/blood. It and the prayers are the only things that help the sick person' (78). Sometimes the water may also be used for washing and, on rare occasions, it is used as an emetic. 'The water when drunk cleanses your veins and the sickness is diluted. It is normally for drinking and washing but it happens that people are used to vomiting so they also do that' (78).

For those unable to get to the mission three possibilities have been mentioned. Dealing with these:

(i) the sick person can request a special service to be conducted in their own home. In such circumstances it is generally expected that the people travelling to the sick person's home will take it upon themselves to pay for the trip. They do, however, expect food and lodging to be provided. This makes the whole enterprise quite a costly affair and it can thus be deduced that it is not a matter undertaken lightly. The commitment which both the sick person and those coming to pray for her have to invest must contribute to a significant raising of expectation about the efficacy of the intended intervention.

Again a distinction is drawn between those who have used *muti* in an attempt to deal with their sickness state and those who are relying totally upon God. The latter receive the laying on of hands while the former do not. If the president does not go with the group to the person's home then he usually writes a note - a prayer or verse - on a piece of paper and sends it with one of his priests/evangelists who is going. The note is read to the patient and the members of the church gathered there pray for the sick person, laying on hands where they consider it appropriate, 'and the person is healed' (78).

(ii) A person who is feeling sick or embattled by evil spirits and who cannot get to the mission can send in a request for prayer by either writing to the president or phoning the mission. The president receives these requests for prayer and prays for the people in their absence. So strong is the belief in the need to present one's problems to the president, to lay before him one's sickness, that the act of communicating with those at the mission appears to bring tangible relief. 'By merely reporting the problem people are getting healed' (76).

(iii) Members of the mission who land up in hospital can also request that other members come and pray for them. In such cases, as with the muti users, there is no laying on of hands. The members simply kneel around the bed of the affected member and pray for her. So strong is their belief in the power of prayer that it is claimed that 'the other patients who are there would benefit from our prayers too' (78).

Whatever the context of healing may be it is generally accepted that the president or *abathandazi* know what sickness it is that the patient is suffering from. They know too what the cause of the sickness is. Unlike the interventions described in the two case examples given above, however, this knowledge is not conveyed to the patient. It is enough that the patient report the problem in the expectation that the president or *abathandazi*'s prayer, being a prayer prayed in the knowledge of what is causing the suffering, will bring healing. 'There is no need for explanation, only that God should perform miracles, that is the need' (78). And this is not necessarily such a tall order as the causal theodicies invoked to explain suffering draw directly on either evil spirits or God. There are no other causes of sickness. Thus it is held that God, as the ultimate victor over evil, will always have his way - whether the patient is 'healed' or not. One of the possible reasons for this belief in the power of prayer lies in the explanation of the cause of sickness which members of the mission subscribe to, namely that sickness has two causes: evil spirits or God.

**Healing Interaction.**

The service began with a procession from the home of the president to the church building. All the men were waiting for the president to lead the way to the church before they could put on their gowns or belts. When the president appeared from his house everybody dressed quickly and followed him to the church. Some women were already in the church sitting on the floor. The entrance for the men was on the right hand side of the building and the women entered in what looked like the main door, facing the alter. The women sat on the left hand side of the door they used and the men sat on the right. All of the men had wooden benches and chairs to sit on while the women sat on mats or on the floor. The president sat right in the front, facing the congregation, on a stage specially made for him. On his left were the priests, deacons, preachers, and prayer healers. After the arrival of the latecomers the doors and windows of the church were securely shut. This was probably to indicate the distinction between the outside world of sin and chaos and the world inside where God was going to come to meet with his people (Kiernan, 28).

The introductory hymn was followed by a period of singing in tongues. During this time three people come under the strongest influence of the Holy Spirit, and after a brief, very vocal performance from each, they were overcome by the Holy Spirit. They fell on the floor and appeared to have fainted. Blood appeared to come out of the mouths of two of these people and church wardens rushed to wipe the blood from off the floor. After they had been neatly arranged so as not to obstruct other members in the congregation the president knelt down, followed by the congregation, and said '*Sizokhuleka sonke*' (we shall all pray). He announced that prayer was necessary because the blood indicated the presence of Christ. He then led the congregation in silent prayer. After this a hymn, which was related to what was happening, was sung. While the hymn was being sung the president descended from his raised platform at the front of the church and, with his arms held up high, moved across to the three

unconscious people. He then proceeded to touch each of them on their heads. With the slightest touch from the president they shot up, whirled around, looking and sounding extremely disorientated, and managed to resume their places in the congregation. The president resumed his place.

After the hymn ended a man came up to the lectern to the left of the president. This man was apparently one of the preachers and he was appointed on that day to read the scriptures. He shook and trembled noticeably and occasionally he wept. Having read the appointed biblical passage for the day and after having enumerated on it he resumed his seat. He was followed by another man who came up to the lectern and gave his own testimony based on the text which had been read.

Once this time of teaching and sharing was over it was announced that all those requiring healing were to kneel in front. A large number of people gathered on the floor in front of the president's raised platform. They knelt. The president signalled that all the doors were to be opened. This, seemingly, to allow for free passage to those evil things which were causing sickness to those in the congregation. Once this was done the president again descended from his platform, with his arms raised, and stood in front of all those requiring prayer. He was joined by about thirty others who were gifted with the laying on of hands. They too kept their arms raised. Together they formed a circle around those kneeling on the floor.

While everyone was getting into position both the sick and those who stood along the walls sang. After saying a prayer, the president began laying hands on those who were in the front of the kneeling crowd. Soon, however, he stopped and moved backwards, with his hands raised. Leaving the laying on of hands to others the president, with his arms raised, presided over the healing session. It appeared as though he were helping to focus the power of the Holy Spirit on those before him.

The process of laying on hands was fairly unstructured. Those 'laying on hands' would jostle and shove those kneeling, sometimes pushing them quite harshly to the floor, slapping them on the body where ever it was that they supposedly required healing, slapping their hands, their feet and just generally trying to force out any evil spirits which may have been lurking in the person's body causing their particular complaint. This process took about fifteen minutes. Those gifted with the laying on of hands appeared most satisfied when the person for whom they were praying collapsed on the ground. Very often it looked as though they were trying to help such a collapse by the vigorousness with which they laid hands on the person. A person collapsing in such a manner to the floor was believed to have had the evil spirit causing their disease leave them.

This time of laying on hands ended with a prayer in which everyone thanked God for the gift of healing which He had given to them. Finally there was the pronouncement of the benediction by the president in which all the people raised their hands to receive the grace of God. Announcements were the last item on the programme. The ritual of dismissal from the service also followed a tightly regimented order. The president used a door that was in the front, next to his stage, and the men and women went out through the respective doors they had used coming in.

**Analysis:**

This is an example of a congregation-based, indirect form of healing. It fits the framework suggested by Edwards for healing which occurs in the context of church services. These four stages are: (i) worship, prayer and singing (a time when the group is marked off from the rest of the world, when they are behind closed doors, barefoot and dressed in special robes); (ii) bible reading and preaching; (iii) a presentation of those requiring healing (here there is usually

the laying on of hands, praying in tongues, and the drinking of holy water); and (iv) the concluding prayers of thanksgiving for the gift of God's healing (Edwards, 18:184-8). This example accords well with the proposed model for analysing the discourse of healing. The first stage of the sociosomatic linkage, however, requires more explication than was the case in the previous examples given the esoteric nature of the healing practice.

The cultural grammar which orients the participants of the Ukukhanya Mission to the world around them and to their own interior worlds is to be found in the central myth which governs the values of the group as a whole. This myth concerns the 'Third Testament' which, it is believed, was revealed to the Mission's founder the reverend Timothy Cekwana back in 1910. The third testament states that God has chosen the people of *Ukukhanya* (the light) to be the forebears of His regenerative work in Africa. God's desire is to regenerate the African nation, to lift it out of the darkness of its past ways and to usher in the new light of His glorious Kingdom.

The members of the mission have inherited this divine commission. Moreover, their leader, the Rev Cekwana, is the grandson of the founder Timothy Cekwana. Timothy Cekwana is believed to have been more than just the founder of a particular indigenous church. His auspicious and seemingly miraculous birth establish him in the minds of those at the mission as being the brother of the Jewish Christ. Jesus' work was for the Jews, Timothy's is for Africans.

The core of the esoteric nature of the mission is this: the people at the mission have been specially sealed by the blood of Christ, they are to remain absolutely faithful to the demands put on them by their privileged position. There can be no backing down. In order to stand in line to receive God's gifts of healing, regeneration and upliftment the member has to be obedient to the will of God as it is expressed through his representative, the Reverend Cekwana. God's



demand on them to work towards the goal of regeneration is accompanied by his demand that they keep themselves pure from any secular indulgences. Absolute faith is required. When people fall sick there is to be no secular intervention: western medical doctors as well as traditional specialists are taboo.

Sickness is believed to have its etiology in two sources: God and evil spirits. God makes people sick for the purpose of bringing them nearer to Him so that He can communicate His will to them. Evil spirits attack the faithful wherever they may be and attempt to erode and undermine their faith through making them suffer. As God is ultimately victorious over evil so it is that the sick person has just to turn to Him and she will be healed.

The types of sickness treated would, therefore, only fit two of the categories suggested by Edwards. They would fall either into the category of sent/non-sent or into the caused by the patient's sin/not caused by the patient's sin category.

An important symbol which pervades life at the Mission is the notion of the ubiquitous, unseen 'blood'. This blood, which evidently covers everything at the Mission, has the power to regenerate and to heal. For this reason people discard their shoes whenever they come to the Mission. Another important symbol is the bleeding from the nose and mouth which sometimes happens spontaneously to people who have been blessed by the Holy Spirit. This is believed to be a sign of that person's special imbuelement of the gift of healing. The founder Timothy was reported to have experienced a similar kind of bleeding and so this spontaneous emission is seen as a particularly efficacious sign of God's presence in their midst (77).

The tightly regimented fashion in which the mission is run is seen as being in strict accordance with the wishes of God. The Reverend Cekwana is believed to be in near-constant personal contact with the deity and is thus informed of all that is happening at the mission. This includes knowledge of any sickness or

problem which a member may be experiencing. Thus, when a member falls ill, it is sufficient for her to just report the incident and it is believed that the president will know what the nature of the problem, its cause and its best treatment options are.

The second stage of the proposed model is the activation of the symbolic bridge for a specific sickness episode. For those who are members of the mission the symbolic bridge is activated when a member, having become sick, decides to go to the mission or to tell someone at the mission about his problem. In the case of the latter he can either request prayer from the community or he can request, if the circumstances so dictate, that he receive a home visit from some representatives of the Mission. In the example given above, those who attended the prayer service were obviously those who had made the journey to get to the Mission, and who, on having reported their problems, were accepted into the community and allowed to stay for a few days in order to receive prayer.

This is where the third stage, the rhetorical movement of healing begins. The beginning of the healing ritual can actually be traced to the granting of permission to stay at the Mission. It is at this point that the rhetoric of predisposition starts to take effect. The expectation that the president is aware of the nature and cause of the problem from which the patient is suffering, and the fact that he has granted permission for this patient to stay at the Mission in order to receive prayer, are factors which cannot be overlooked in considering the degree of expectation which must surround all those planning to attend the actual healing service.

Coming to the actual service, the act of waiting expectantly for the president to appear before the patient can actually put on the garments which mark him as a member of God's elect, must help to instil an attitude of growing expectation. When at last the president does appear and the patient hastily puts on his jacket and follows the growing procession to the church building, an almost palpable

feeling of excitement is in the air. Gathering in the church, obediently obeying the dictates of custom which demand the separation of the sexes, as well as of the elders from the rest of the congregation, the patient joins in the affirmation that this is indeed a group of people marked off as different from the rest of the world, for here God is expected to perform great and marvellous deeds. The doors and windows to the church are securely shut in order to reinforce this sense of separation.

The atmosphere created by the opening hymn and the period of singing in tongues is one of quiet, reverential expectation. God is going to work in His people's midst, and He is going to do so in His own time. The manner in which the Holy Spirit came upon three people who were overcome and fell to the floor hardly caused a ripple in the congregation. This sort of thing is what is expected. It helps to reinforce the expectation that God is indeed going to work in their midst. The appearance of the blood, however, does cause some response. God is showing Himself in a very powerful way and as a result great things can be expected.

All these factors seem to contribute to the attitude of expectation. The patient must feel vindicated about his decision to come to the Mission and to make his problem known to the president. This is because, in the context of the community of believers, and in the act of approaching God for healing in one of the services, the patient must feel that the claims which the group makes to healing are both coherent and legitimate. This is the place where God has performed miracles and He is going to fulfil His promise and repeat His intervention for the sake of the patient who has come humbly before him.

The second rhetorical movement is that of empowerment. The desired effect of this process of empowerment is to enable the patient to feel that he has actually experienced the power of the believed in deity. The rhetoric at this stage operates through the twin processes of generalisation and particularisation. In this example it is, firstly, in the bible reading, the teaching based on the reading

and the follow-up testimony based on what had been said, that it is possible to see the process of generalisation operating. Through these things the patient is able to project himself into the field of symbols which constitute the religious discourse in which he operates. The exhortation from scripture and the visible effects which the power of God is having on the life of the one speaking, serve to reinforce the role which the patient creates for himself in the overall religious discourse.

Moving into the actual time of healing, when all those requiring prayer are made to come and kneel in the front of the church, the potency of seeing symbols such as the president standing with his arms upturned and by being encircled by those who have been blessed with the laying on of hands, serves to make the patient see himself in the context of one who has now come within the healing fold of God's love. Within these walls it is believed that God is victorious over all the forces of evil which could cause sickness. For this reason the doors and windows to the church are ceremoniously flung open as the time of praying for healing starts, so that the evil spirits which have been causing the sickness can depart from the company of the saved.

The process of empowerment continues with the powerful symbolic gesture of the laying on of hands. Unlike the examples of individual-based healing, where the healer is revealed the nature and source of the patient's sickness, in this form of congregation-based healing the manner of healing is indirect. There is no discussion about what the nature or cause of the sickness is. The patient submits to be prayed for in the belief that the healer knows what the problem is from which he is suffering and that his needs will be taken directly to God who will occasion healing. The laying on of hands is, therefore, the culmination of the process of generalisation as well as the beginning of the process of particularisation. The patient believes that he is experiencing the healing touch of God. That in having brought his needs before the rest of the community and in asking for healing he has fulfilled the injunction to live his life with total

dependence on God. He is living and trying to project himself into the framework of the overarching religious discourse of which he is so lucky to be a member. Outside the world of sin, chaos and Godlessness exists, but inside are God's divinely appointed elect. Sealed by the blood of the new covenant all he has to do is to reach out and claim the healing which, according to God's revealed word, is rightfully his.

The rhetoric of empowerment is about convincing the patient that he is experiencing the effects of divine power. This is accomplished through the processes of generalisation in which the patient projects himself into the symbolic world which constitutes the religious discourse in which he lives. In projecting himself into this world he comes to see his problem in a newer, fresher perspective. The process of particularisation then comes into play as he draws on symbols within that discourse in order to view himself in the new light of one blessed and healed by the healing touch of God. A healing touch brought to him through God's representatives on earth, the people who have been blessed with the laying on of hands.

This process of particularisation is completed if the patient experiences temporary motor-dissociation while being prayed for. This spontaneous experience of an endogenous process is one of the elements of empowerment which reinforce or help to concretise the experience of the divine other. Having being 'slain in the Spirit' the patient is now convinced that he has indeed been touched by the healing hand of God.

The final rhetorical movement is the confirmation of that new status. The concluding prayers which thank God for His gift of healing serve to do this. Having resumed their places amidst their family or friends, those who have been prayed for now join with the rest of the congregation in thanking God for remaining true to His word. God's healing touch has indeed been felt and it is

now up to the patient to live according to that promise. The president pronounces the blessing. All those who are gathered there are assured of their special place in God's overall scheme of things.

The return to the everyday world is still within the context of being at the Mission itself. What this means is that the patient is still in a place where an attitude of expectancy prevails. His healing has been prayed for and confirmed in the service, now he can grow to experience that healing by still being in contact with the blood which covers everything at the Mission. The symbolic transformation which has been wrought on him can now be actualised in experience. The dialectic which links his symbolic world and his physical world has been activated and he can expect to foster a desired change in his emotions, disordered physiology or social ties. In other words the rhetoric of healing, acting as the chief exogenous factor governing change, has now activated the endogenous processes of healing which operate along the sociosomatic continuum linking mind and body.

**Chapter Seven****Categorisation of patient-healer transactions  
in some African Indigenous Churches: a summary**

Employing the framework alluded to earlier, which Kleinman uses as a means of making cross-cultural comparison and analysis, it is possible, using the above three cases studies, to flesh out the following broad analytic categories.

**1. Institutional setting:**

Clinical transactions between *abathandazi* and patients in South Africa take place in the folk arena of care and belong to what is becoming an increasingly large and diverse subsector of religious folk healing.

**2. Characteristics of the Interpersonal Interaction:**

a) The number of participants varies. On the one hand, with the patient-healer transaction more closely resembling a traditional *Inyanga/Isangoma*-patient interaction, the interaction was usually dyadic. On the other hand, with the transaction being of a more Christianised form, the interaction involved not only the healer and the patient but also the rest of the congregation. Indeed, the role of the 'healer' in terms of a concrete person is nonspecific for many people assumed responsibility for laying on hands. But, viewed within the semantic framework of the participants, the healer can most clearly be identified as the Holy Spirit or God. In the latter case there are no real intermediaries to be worked through such as the prayer healer or the ancestors - for healing could in fact occur without any such 'clinical transaction' ever transpiring.

This differentiation between patient-healer transactions which more closely resemble traditional interactions and those which follow a more Christianised format, accords well with the distinction drawn between individual-based and congregation-based interactions. The healing interaction in both cases is still dyadic, although the dyad in the latter is more clearly between the patient and the discourse in which she is seeking healing.

b) Patient-healer interactions may be episodic or continuous. An episodic interaction is one in which the therapeutic relationships are organised around particular sickness episodes. 'That is, clients presented only once or several times for treatment of a specific health problem, and transactions with (the healer) were limited to this sphere' (Kleinman, 29:238). These types of interactions can be seen most clearly on the traditionalist side of the continuum presented by different AIC practices. Moving along the continuum to the more congregation-based healing practices it is possible to distinguish episodic from continuous interactions. The latter involve the treatment of sickness episodes in the context of an ongoing relationship with the church and the healer who has been endowed with the gift of healing (This distinction draws attention to the task of delineating a patient's primary community of reference - with this task obviously being easier when a continuous form of interaction is observable). The time in the treatment setting may range from a couple of minutes to several hours, even days (at the Ukukhanya Mission it was considered efficacious to be allowed to stay at the mission for a number of days; the effects of contact with those around one who would no doubt offer sanguine advice and spiritual counsel being held in great regard).

c) The quality of the relationships between the healer and the patient can be said to consist of both formal and informal phrases. Consultation with the healer, where such a clear dyadic stance exists, is a strictly formal relationship which shares similarities with other practitioner-patient relationships. In these interactions language and behaviour is marked by the great respect and abeyance



in which the healer is held. A noticeable social distance can thus be observed as existing between the patient and the healer. The interaction is separated from routine social transactions and marked as a special event. In this way both the 'space' and 'time' coordinates of the relationship are sacralised. Accordingly, the verbal communication is characterised by polite speech, the use of titles or other special terms of address. With the two *abathandazi* this formal phase was delineated quite clearly by the healers opening and closing the healing sessions with prayer - directed either directly to God or to both God and the ancestors. A more relaxed, informal phase both preceded and followed the official consultation and healing ritual. Mrs M. ended her one afternoon of consultations by serving tea to all those who had come to see her.

Analysis of the Ukukhanya Mission is slightly more difficult due to the fact that the patient is generally moving within her primary community of reference. For this reason the transition between formal and informal phases is less marked although by no means entirely absent. What is meant here is that because a patient's participation and membership in the Mission may be viewed as quite a formalised thing in itself, the transition into a formalised phase during a healing service may appear to be less of an adjustment for the person to make. What this points to is the idea of relative degrees of formality depending upon the context in which the transaction occurs.

Although the phases of an interaction may be noticeably different they can all be regarded as being of important therapeutic benefit. The value of being allowed to stay at the mission has already been pointed out in terms of its likely benefits for the patient. The sense of community which is often involved in congregational participation in healing rites is important because it opens up personal and family problems to public scrutiny. The therapeutic benefit of such an unburdening cannot be dismissed. As Becken points out:

This sense of communion, of experiencing care and charity, is reinforced in the healing service by the collective intercession of the congregation. The significance of feeling that the whole group is making direct contact with the living and life-giving God on your own behalf cannot be underestimated (in Pillay, 58:13).

Moreover, the patient-practitioner relationship is an *holistic* one. Not only are a patient's sickness perceptions placed within a larger familial and societal context, but sickness episodes are also placed within a broad range of human miseries, given sense in terms of the overarching religious discourse, and related to everyday life events and experiences (eg. unemployment, financial difficulties, typical family tensions, and the commonly experienced frustrations and disappointments associated - in South Africa particularly - with human deprivation and struggle). Consequently, the intimacy and trust built up by a patient-practitioner relationship serves as a hedge against sickness, which is viewed as a potentially hazardous disruption of day-to-day living. The view of sickness as resulting from someone deflecting your good fortune confirms this. So too does the view that sickness is caused by evil spirits.

d) The attitudes of the participants in these interactions can best be described as mutually ambivalent. While the healer is shown great respect and accorded a significant status because of her perceived contact with the spirit world; she is also sometimes envied and distrusted because of her financial success and, therefore, given her contact with the spirit world, it is possible that she can perform acts of sorcery. Mrs D. aptly described this ambivalence when she stated her reasons for burning a red candle when she is engaged in a consultation: 'People don't take what I do very seriously, they tend to think that I am lying or deceiving people. Such enemies are against my praying for people - some even regard me as a witch. The red candles are against such people' (72).

Likewise, the healers also hold an ambivalent view of their patients. A patient presents the healer with an opportunity for the healer to demonstrate the power of the god in whom she believes. Being able to heal a patient not only serves as a confirmation of this belief but also brings with it the financial benefit of payment or a gift of thanks. Thus, patients are welcomed. But, a difficulty arises when not all patients are healed. When a patient presents a persistent complaint the healer is hard pressed to explain why the failure of her treatment does not signify that God or the ancestors, is ineffective. Given this challenge to the legitimacy of healing, especially by those patients presenting chronic sickness complaints, the healers in the AICs have come up with a number of innovative responses. One form of response is to say that God does not wish for the patient to be healed. In effect, their time has come or else the purpose behind God's allowing the person to become sick has not yet been revealed. When that purpose has been revealed then God will act to heal the person. (1)

Another response, and this is one of the most ubiquitously cited explanatory models to explain chronic sickness, is to say that the patient is suffering from *uthwasa* - the sickness associated with the calling of the ancestors. The patient is herself meant to become a healer and until such time as she does there is no hope for the alleviation of symptoms. A third response, possibly the most interesting one given the heterogenous nature of the social world in which so many AIC healers operate, is to refer the patient either to a western doctor or to a traditional specialist. The thinking which informs this is the tacit acknowledgement of the superiority of either one of those practitioner's skills for the particular case at hand. This is just the response which needs to be inculcated in indigenous practitioners if any sort of inclusion in the formal health care system in this country is to be achieved. Conversely too, medical practitioners need to recognise the potentially greater skills of intervention which indigenous practitioners may have for particular sickness episodes. (2)

### 3. Idiom of Communication

a) The idiom is one which articulates personal or social problems in the combined cosmological, spiritual and moral language of the popular culture.

b) Patients and practitioners, more often than not, share explanatory models. These are openly expressed and negotiated. This results in fewer conflicts over the nature of the problem and the appropriate treatment plan than is often the case with the patient who seeks help from a biomedical practitioner (Mkhwanazi, 48:87). Accordingly, it can be postulated that these clinical interventions enjoy a greater degree of success than do interventions from biomedical personnel - depending of course on the type of sickness being treated. Patient satisfaction, however, must always be analysed within the context of the patient's primary community of reference as this, more than any other factor, will prescribe the expectations which they place on treatment.

A marked characteristic of the interventions brought about by healers in the AICs is the target of those interventions in the patient. What is noticeable is the manner of holding onto beliefs which so clearly conflict with the western-based education which is being given to young black people. This ambiguity can be noted in the holding of dual-membership in both imported/mainline churches and indigenous churches. It seems as though people construct complex and conflicting EMs for use in the different situations in which they move in day-to-day life. Indeed, the complex interaction between microcosmic and macrocosmic world views, to use Oosthuizen's phrase (Oosthuizen and Hexham, 56:176), surely necessitates these differing EM frameworks. For others, however, the EM framework is derived solely from an overarching religious understanding which governs and directs their day-to-day living. In such a context there is no room for a conflicting EM - the EM held states that God is the source of all things, most especially the control of one's health and sickness.

#### 4. Clinical Reality

a) The clinical reality constructed in patient-healer relationships is most definitely a religious one although, given the hesitancy to distinguish between sacred and secular reality because of the unity of being which supposedly marks the African ontology (Mbiti, 42:18), it is difficult to categorise the clinical reality as either sacred or secular. The intervention can, thus, be billed as indigenous rather than Western and it is upon the strength of religious/indigenous nature that it draws much of its efficacy. The healer is believed to be in possession of a special gift of insight, bestowed upon her by the ancestors or God, which allows her to know the nature and cause of the patient's suffering. Given this insight she is either in possession of special skills or at least enjoys a special relationship with the godhead such that she can effect a cure which lies beyond the power of ordinary doctors. Kleinman writes: 'Faith in the god's powers and in the efficacy of ritual surely contributes significantly to the placebo and the psychotherapeutic effects of the (patient-healer) relationship' (29:241). This assessment of Kleinman's can also be applied to those interactions which draw less on indigenous healing practices and rely more on faith in God. The 'clinical reality' in these forms of healing activity is seen in a totally spiritual perspective. It is believed that evil has occasioned the person's suffering and now God is going to avenge Himself and bring about a miraculous halt to the process of suffering.

b) As has been mentioned Kleinman's categorisation here between disease-oriented and illness-oriented interventions is problematic because of the implicit biomedical assumptions it makes. What can be done though is to analyse the clinical reality with regard to the type of causal theodicy invoked to explain it. In doing this it is possible to give due weight to the mechanisms of formation which go into the construction of any sickness state.

In the African cosmology, while the difficulty of distinguishing between the mental and the physical is recognised, the interventions of indigenous practitioners in the cases observed in the fieldwork are more psychosocial than physiological. In other words, the problems presented seem to be more the physiological concomitants of particular psychosocial stressors. In Kleinman's terminology, used with due caution, it is the management of illness problems which is the core function of practice by healers in the AICs.

c) Thus it can be said that therapeutics are almost entirely symbolic, rather than instrumental. Occasionally an instrumental intervention may occur, but this is based more on the chance effect which an *Isangoma's muti* may have on the patient. In the traditional realm, however, there is sometimes a greater likelihood of successful instrumental intervention owing to the knowledge of the curative properties of specific kinds of plants. This does not really happen in the healing practice of the AICs.

d) Therapeutic expectations concerning the rules of etiquette are fairly well established, drawing as they do upon the traditional notions of respect due to any indigenous healer. These notions have already been outlined above. In the case of the Ukukhanya Mission this traditional respect is certainly complemented by the inclusion of ultimate divinity, along with its sole earthly representative, into the cosmology invoked in order to bring about healing. Furthermore, the therapeutic objectives of intervention are fairly well delineated.

The treatment styles, including as they do a unique integration of prayer, ritual acts and explanatory exchanges, are well illustrated by the case examples. It is apparent that the expectations regarding these interventions, as well as the therapeutic objectives, are commonly shared by the healer, patients and families/communities.

In these interventions it is expected that sacred sources of therapeutic efficacy are tapped into. For this reason, a great deal is expected from the relationship and so a lot of emotion is invested in it. It may well be due to this that much positive therapeutic effect is obtained.

e) The perceived locus of responsibility for care is a divergent one, with much depending on the context in which the intervention occurs. For Mrs M. and Mrs D., being more influenced by healing rituals drawn from African Traditional Religion, the locus would certainly seem to be more with the individual and that individual's family. The healers are responsible for ascertaining what the problem is and for prescribing actions to circumvent it. However, it is then up to the patient, as well as the patient's family, to take steps to help put things right. Thus, although the locus of responsibility can be seen as a shared one it does seem more probable that the patient and the family bear the majority of the weight. Further, the patient-healer encounter in these examples seems to work on the assumption that for a particular sickness episode the healer may not be the most appropriate treatment resource available and so different forms of treatment must be sought. These other forms of treatment are spoken about as appropriate ways in which to supplement care.

For those at the Ukukhanya Mission, however, alternative forms of intervention are untenable. Here the locus of responsibility for care lies entirely with the community. It is the community's task to bolster the individual's faith so that she will come to receive the fullness of the healing which, it is believed, God intends for her.

## 5. Therapeutic Stages and Mechanisms.

(a) Healing processes in the AICs seem to most definitely move through the three stages proposed at the end of chapter two. As the AICs are situated within a very specific, albeit heterogenous, worldview, so the processes involved in these three stages follow some broadly identifiable themes. These themes have been briefly outlined above. What remains to be said is that although the actual mechanisms of change do vary greatly, depending on which side of the continuum the practice of the healer falls, what remains constant is the overall structure which guides the outworking of these mechanisms. So although psychological, social, cultural, physiological or chemical processes may be invoked as being responsible for bringing about 'healing', what must be looked to are the overall rhetorical structures which guide that movement.

(b) This section on the mechanisms of change is subsumed by the model proposed in the previous point. Suffice to say though that the proposed mechanisms of change which are incorporated in the model have to do with the process of rhetorical movement operating across a sociosomatic structure which unleashes both exogenous and endogenous healing processes at various levels along the mind-body continuum.

(c) Although this study did not specifically aim at gathering this sort of data, the following impressions were gained. Firstly, adherence to the prescribed regimen is relatively high. It would seem that this adherence depended to some degree on the degree of urbanisation and the level of education of the patients. As the individual moves into a more heterogenous community of reference so she is more likely to 'hedge her bets' and to try more than one type of treatment simultaneously. This inevitably effects the rigorousness of her adherence to the treatment regimen.



In the case studies, several patients were chastised for their failure to follow the healer's instructions. These individuals were, on the whole, much younger and better educated than rest of the clientele. Dissatisfaction with this form of care was rarely expressed. This is evidenced by the fact that the healer's source of income depended upon the patient's expression of satisfaction. Thus it appears, secondly, that the evaluations of outcome are consistently held by both patient and healer. Thirdly, termination of treatment is usually quite clear cut. This follows the successful intervention against the complaint. This does not, however, spell the end of the relationship with the healer. The initial intervention seems to establish a clear bond between the patient and the healer such that the patient will immediately seek out the healer when experiencing different problems, or will even pre-empt possible problems and seek help against any possible deflections of good fortune.

## Chapter Eight

### Conclusion

The purpose of this paper has been to articulate the form of discourse which healing in many AICs takes. The model which has been proposed aims at increasing understanding about the processes involved in healing transactions. It does not purport to explain why healing occurs.

In arriving at this model for understanding healing transactions it was recognised that such analytical work needed to be situated within the broader context of the discourse about health care. All too often analyses of indigenous healing tend to ignore the context in which such healing occurs (cf. Kleinman, 29). What is recognised in this paper is that not only is a contextual approach fundamental to any meaningful analysis, but it is also unavoidable. Therefore, the need to foreground any enquiry into faith healing by consciously recognising the discourse from within which that enquiry is directed is crucial.

Accordingly, the approach decided upon was two-fold. The first phase involved the empathic observation of healing practices. In observing the healing practices in indigenous churches a great degree of 'bracketing' was needed in order to arrive at what could be called an existentially appropriable account of the healing transaction. This is recognised as being the 'relativist' stage of the work. Following this, the second phase involved the 'universalist' definition of categories into which to put those observations. These categories serve as the access points for any cross-cultural analysis of observations garnered from the fieldwork.

To arrive at these categories for comparison extensive use was made of the work of Arthur Kleinman. The framework for analysis which he proposes: the health care system, rests, fundamentally, on the recognition of *difference*. What

is meant by this is that all discourses about health care are cultural constructions. There is no outside, objective reality from which to view the questions of health and healing. Any enquiry into healing transactions has to foreground its approach in such a framework. Through detailing the framework suggested by Kleinman it was possible to arrive at an awareness of the need to understand the broader cultural factors at work in any healing transaction. The five categories for comparing cross-cultural healing transactions were then briefly outlined.

The fifth category which Kleinman proposes involves the actual therapeutic mechanisms involved in healing transactions. These mechanisms were outlined in chapter two in order to facilitate the understanding of the process of healing. Kleinman's model of healing draws heavily on the ideas about the cultural positioning of people within particular discourses and so it served as a logical continuation of his health care system framework.

However, it was not felt that Kleinman's approach offered an adequate enough explanation of the processes involved in healing. Accordingly, the work of Thomas Csordas was detailed in order to better situate healing transactions within particular discourses about health care. By holding these two models in opposition it was possible to arrive at a new three-point proposal for analysing healing transactions.

This is the proposal which was used for analysing healing practices in some AICs. To arrive at the application of the model a brief time was spent detailing some general considerations about healing in the AIC. After this the examples drawn from the fieldwork were discussed and then the proposed model was applied to specific healing transactions.

The fieldwork was conducted over a period of eighteen months and involved two individual healers and one church community. It is felt that the proposal for analysis works well in the context of individual-based healing. These were the examples referred to in chapters four and five. The healers concerned were very willing to allow observation of their interactions with patients and they proved to be very co-operative in providing more information about the nature of their healing practices. The depth of information gathered probably accounts for the more successful application of the model as the model seeks to understand the healing interaction as a particular form of discourse. This implies the whole meaning system which each individual brings to the transaction. As this meaning system was able to be more clearly detailed so it was easier to analyse the healing transaction according to the model.

The difficulty which was experienced in gathering information for the third example of congregational-based healing more than likely accounts for its relative paucity in terms of yielding a comprehensive grasp of the transaction. This does not mean to say that the model is necessarily unsuitable for application to all forms of congregation-based healing, rather it points the way forward to more comprehensive research into these forms of healing.

The paper concluded this attempt to apply a model of analysis to indigenous healing practices by situating the enquiry within the broader categories for cross-cultural analysis outlined in the first chapter.

The recognition of the cultural shaping of the sickness response, and the awareness that any attempt to deal with that sickness state occurs within a particular cultural framework, points to the awareness that in all forms of healing (as opposed to curing) it is somewhere in the hinterland between literal lesions and literary tropes that the movement into a healthy state occurs.

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### Field Research Notes:

70. Interview with Mrs D. May 1993.
71. Interview with Mrs D. August 1993.
72. Interview with Mrs D. May 1994.
73. Interview with Mrs M. April 1993.
74. Interview with Mrs M. August 1993.
75. Interview with Mrs M. June 1994.
76. Ukukhanya visit. May 1993.
77. Ukukhanya visit. August 1993.
78. Interview with Ukukhanya elders. June 1994.

