

# **An Interdisciplinary Approach to Understanding and Assessing Religious Healing in South African Christianity.**

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## **1. Introduction**

The largest group of Christians in South Africa belong to churches which focus on healing of one form or another. According to the 1996 census this group comprised about 45% of all Christians and 51% of Black Christians (Froise 2000:76-82).<sup>1</sup> Historically divided into African Independent<sup>2</sup> Churches and Pentecostal/Charismatic churches (:60-65) these churches are better treated together since they respond to common human needs which are mediated through different cultural approaches. We refer to them as Coping-healing churches in order not to pre-empt assessment of the healing they offer (Bate 1999:4). Their success and rapid growth is one of the principal features of twentieth century South African Christianity (Froise 2000:76).

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<sup>1</sup>There is an error in this book. The figures for denominational totals for all South Africans in table 57 (Froise 2000: 76) are incorrect. This table is a repeat of table 60 (:82) the denominational totals for blacks. The correct figures used here were supplied by the author.

<sup>2</sup>Or African Initiated churches, African Instituted churches or African Indigenous churches depending on your level of political correctness. Each has its own proponent depending on the context and standpoint of the author. See Masuku 1996:442-443 for more

The question of healing in general and Christian healing in particular is one which is fraught with difficulties since there is so much disparity regarding the meaning of healing and the role of Christianity in healing people from their sicknesses. The attempt to unravel this complexity and identify what is going on in the Coping-healing churches was the focus of a previous study (Bate 1995; 1999). This paper attempts to highlight some of the results of that study as well as offering a framework which can assist in both understanding and assessing the kind of healing being offered in South African Christianity today.

Studies of Coping-healing churches and indeed religious healing in general, have tended to be from one disciplinary perspective: medical, psychological, anthropological, sociological, economic, and theological. We contend that a multi disciplinary approach is essential to both understanding and assessing Christian healing churches in particular and religious healing in general. Those studies taking cognisance of the multi disciplinary nature of what is going on in coping-healing have been collections of articles by different authors with little attempt to link the findings together. What seems to be lacking is the attempt to develop a matrix of different disciplinary analyses which can help us make an adequate assessment of the phenomenon. A preliminary attempt was made to do this in my previous study (Bate 1999:225-227). Here I would like to move this endeavour a bit more forward.

A multi disciplinary approach is essential because of the nature of both healing and religion. These two are in fact at the core of human experience everywhere. Sickness and health are the experience of all human beings. The same is true of religion, especially when it is understood in the way Geertz (1973: 90) presents it. It is also a fact that in most parts of the world, religion and healing are always linked together (Sullivan 1987:226). The weakness of disciplinary approaches to understanding and assessing a common human phenomenon like religious healing is that each does so within its own heuristic framework. So economic

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on this. In the text I will alternate between all four.

approaches are likely to provide an economic model of understanding as well as economic criteria of assessment leading to economic judgements about the matter; and so on within all the academic disciplines. A more complete understanding and assessment of what is going on will be achieved with a multi disciplinary approach.

Besides this, the array of competing and often contradictory truths emerging from each disciplinary mediation have to interact with one another if we are to come to some more transcendental<sup>3</sup> judgements about the matter. Whilst this is a difficult business and often ignored in compendiums of multi disciplinary works, it is of the essence of trying to get to the humanity of what is occurring: a humanity which often lies beyond the elemental and structural splitting which analysis and method in the modern human sciences prioritise.

Indeed, such is also the case with the healing ministry as practised by Jesus and his followers. An investigation into the biblically testified healings should not remain the preserve of the theologians and scripture scholars but also needs multi disciplinary investigation and assessment in order to inform the present day phenomenon of Christian healing.

After a brief survey of the types of coping-healing churches in South Africa we will summarise our previous attempt “mediate” the coping healing phenomenon through the epistemological lenses provided by different human sciences. This step will allow us to present the set of understandings of the phenomenon brought by each discipline as well as the kind of criteria used by that discipline which lead it to these understandings. From this we should acquire a wider understanding of the phenomenon. Clearly any assessment of coping healing is dependent on the criteria chosen. Finally, we should note that human sciences

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<sup>3</sup>By transcendental I mean no more than something which goes beyond, transcends, the parameters of each discipline. In this sense all multi disciplinary approaches are transcendental.

provide largely etic understandings of the phenomena. It is important to realise the limitations that such judgements “from outside” are prone to. This means the incorporation of emic criteria can providing a fuller assessment of what is happening.

## **1. Describing the Phenomenon of Coping-Healing Churches**

Coping-healing churches in South Africa are usually differentiated into two principal types. These are the African Independent churches which operate within the parameters of acculturation between African tradition, Urban Black working culture and traditional Christian practice and the Charismatic/Pentecostal type which operate within the Pentecostal tradition and incorporate elements of Postmodern Western culture especially those related to the media and the entertainment industry. This latter tends to appeal to the urban clerical and commercial class of all races.

Prescinding from the culturality<sup>4</sup> of both types of churches, we discover that they are in fact remarkable alike. Both strive to offer forms of well-being and a means of coping within society to their members. This is expressed as an experience of salvation available now in this life as a kind if precursor to salvation after death (Bate 1999: 42, 49-50, 56). This is called “healing” and may affect all aspects of the members’ lives: physical, emotional, spiritual and communal. One AIC leader opined “all we do is heal” (in Comaroff 1985:219).

In my study of “healing services” of these churches, I pointed out that

In a very general sense, we need to take account of the fact that those practising the Coping-healing ministry and those being healed report their experience as such. It is healing. In all the services I attended both in English and in Zulu, a direct call was made to God, to Jesus or to the Holy Spirit to heal the person from sickness. In many cases some response to this call, experienced as healing, was reported. (Bate 1999: 42)

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<sup>4</sup>I use this word to refer to the cultural nature or cultural dimension of a human institution.

The principal method of healing is through the healing service. In those churches inspired by the Pentecostal tradition this usually takes the form of an “altar call” in which those who wish to be healed are encouraged to come forward to be healed by the prayer of the healer. This occurs after a period of emotion arousal which is achieved through music, the sermon and prayer (Bate 1999:21-24). The ritual cultural form borrows heavily from the modern/postmodern Western entertainment industry. It is a stage show which people watch and get involved in as audience.

In African Independent churches there is more variety in the way healing services are organised but a similar attempt at emotion arousal always occurs before the healing. This is achieved by means of music, dance and prayer but there is more participation by all present than in the charismatic-Pentecostal type. This is clearly a reflection of the communal and participatory nature of African traditional culture and its ritual forms (Bate 1999:18-21; 27-31).

There are two other main ways in which healing is offered. The first is by means of interpersonal encounters between patient and healer and the second occurs on the level of the group where belonging, affirmation and world-view are the main dimensions of healing. The therapeutic value of interpersonal encounter is well known. In Neo-Pentecostal<sup>5</sup> type churches one-to-one encounters for healing normally take the form of counselling and personal prayer for healing. Often there is a focus on the need to confess sin and to be forgiven for it. The healer mediates this forgiveness (Bate 1999:41). Within the African Independent churches the prophet healer/prayer healer (*umthandazi; mofodisi, umprofethi*) has emerged as a cultural form borrowing heavily from the traditional healer in African

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<sup>5</sup>I use this term to refer to churches which have emerged since the 1960's as a result of the charismatic and Pentecostal movements. See Bate 1999:326n1.

tradition (*isangoma, ngaka, inyanga*) (Sikosana 1995). Prayer healers are consulted on a regular basis, usually at their homes, for a whole host of problems that people have. They are successful when they are able to do a spiritual discernment regarding the nature of the problem and offer a specific remedy which can take the form of prayer, water for drinking or sprinkling and other forms of medicine (Bate 1999:34-40).

On the communal level, Coping-healing churches seek to become communities which respond to communal needs for affirmation, coherence and stability. The quality of interpersonal and communal interaction is high and this provides a stable environment within which more long term moods of well-being and motivations of lifestyle may be established. Often the sicknesses affecting people who come for healing have etiologies within the prevailing society. Poverty, lack of status, fear of the future, and living in communities of social chaos have been common aspects of South African life for many years now and were particularly acute between 1980 and 1994 as the society went through social upheaval leading to the emergence of the new South African democracy (Bate 1999:126-130). The coping-healing church provides a supportive, affirming environment where people can reconstruct the humanity which is destroyed during the exigencies of daily living (:135-136). Besides this it also offers a coherent simple world view which allow those disoriented by the complexity and seeming unpredictability of daily living to develop a set of values, reasons and understandings which make sense out of life and which can lead to effective behaviour patterns to deal with the problems of life (:136-137).

## **2. Understanding Christian Coping-healing using the Lenses of the Human Sciences**

Christian healing practices in South Africa were initially studied by missionaries

(Sundkler 1961, Becken 1975, Oosthuizen 1968, Daneel 1971) in order to determine the Christian value of such practices. They were largely anthropological and comparative in nature. Other anthropological assessments have followed (Kiernan 1990, Comaroff 1985, Schoffeleers 1991) and studies from the perspective of the other human sciences have also emerged: medical (Anderson 1986, Wessels 1985), psychological (Edwards 1985, Buhrmann 1986, Mkhwanazi 1986), sociological (Morran & Schlemmer 1984, Easthope 1986), economic (Sales 1972, Feierman 1985), and theological (Mosala 1985, Verryn sa). Multi disciplinary approaches began to emerge from the mid 1980's (Oosthuizen 1986; de Villiers 1986, Oosthuizen 1989; Bate 1995).

The theologian Christopher Grundmann (1995: 53-55) has made it clear that the kind of healing that goes on in Christianity is not specific to Christianity. And in the human sciences it is usually treated together with other forms of religious healing (Sullivan 1987). I have pointed out (Bate 1999:76) how this fact allows us to use studies of religious and traditional healing practices in our own attempt to understand Christian healing in South Africa . The various human sciences, whilst they obviously overlap, tend to reveal different aspects of the phenomenon of religious healing as they attempt to understand it within their own particular heuristic categories. This is helpful in the analysis of the phenomenon but should alert us to the fact that serendipity apart, their findings will tend to be limited to what they are looking for. So each disciplinary mediation reveals only a partial understanding of the phenomenon as a whole. The following sections summarise the understandings of Coping-healing revealed by disciplinary mediation.

### ***3.1 Psychological understandings of Coping-healing***

The main cognizance of religious healing brought by psychology relate to the psychological categories of emotion transfer, therapeutic relationship, transference, cognitive

factors, psychosomatic mechanisms, psychogenic factors and dissociation.

Psychological understandings of religious healing suggest that the central feature of the process is emotion transaction (Dow:1986:58). The way in which emotions are transacted in the healing process is complex and many mechanisms are at work including suggestion, persuasion, catharsis and conversion (Bate 1999:206; Buhrmann 1986:109). On the most basic level the emotion transaction can be understood as the change from feeling unwell to feeling well. Healing is thus concerned with dealing with negative feelings that a person has about herself and her life and replacing these by more positive feelings of well-being. Religious healing is often concerned with the establishment of emotion charged environments which enhance the emotion transaction. This can be done in two ways: by increasing emotion stimuli or by reducing them. The former tends to happen in the healing service and is achieved through music, dance, preaching, environment and decor as well as other culturally appropriate dramatic mechanisms. The latter occurs in the different forms of meditation, counselling and prayer which are healing processes for some religions including some forms of Christianity. The healer is someone experienced in leading the patient through process of emotion transaction and uses whichever emotional atmosphere he thinks will effect the healing.

Clearly the quality of the therapeutic relationship between healer and patient is fundamental to the effectiveness of the healing process. "The healer has to build this relationship in order to be effective. It is described as a relationship in which confidence, trust and expectancy are enhanced thus providing the conditions in which healing can occur"(Bate 1999:205). When an effective therapeutic relationship has been attained, the healer is able to use the mechanism of psychological transference in the healing process. Undoubtedly, the status of the healer in the mind of the patient is important here. Sick people will seek out healers of high status and so it is in the interest of healer to cultivate such a persona (Bate

1999: 205).

Psychological transference refers to the shift of negative issues, emotions and understandings about oneself coming from past broken relationships onto the relationship between the healer and the patient. The skilled healer is then able to take the patient through these experiences to a more positive outcome. Here a new set of beliefs, understandings and emotions may emerge as the person is able to reconstruct a better self-understanding within a more healthy framework of understanding (Bate 1995a: 13-14). This brings us to the role of cognitive factors in healing.

The effectiveness of cognitive therapeutic methods is achieved as the patient is helped to make sense out of his sickness and to see a reasonable, acceptable pathway to being healed from it. Naming the illness in terms of an acceptable vision of sickness and health is the first step in this process. This vision is in terms of the world view of the healer to which the patient must accede for healing to occur (:209). Such labelling: “this is a demon”, or an “ancestor”, or a “virus” is essential since this allows the sickness to come from the world of the unknown and fearful into a world where it is known and can be coped with (Bate 1999:206). The healer’s world view contains the remedy for the identified sickness and once the patient is informed that a clear remedy exists, cognition leads to hope and expectancy of a cure. After this the healing process continues through mechanisms of persuasion and suggestion as the healer points out and leads the sick person through the pathway to healing. The healer has to help the person to believe in the healing process so that he can be open to it and develop an expectation of success. The provision of success experiences, however small, by the healer enhances faith in the healing process(:207). Faith understood as the expectation of success linked to acceptance of the process rooted in the healer’s world view, is central to achieving healing on the cognitive level (:87).

Psychology also alerts us to three other mechanisms which play a role in the healing

process and are used by healers. The most common of these is the psychosomatic mechanism which is a statement of the relatedness of psychological and somatic processes (Bate 1999:71,203). Many of the kinds of sicknesses that get cured by religious healers can be shown to be influenced and even caused by psychological factors. Arthritis, ulcer, heart problems, skin irritations and asthma are some of these (Bate 1999:63). Stress is a common name given to indicate the psychological etiology of the condition. Dealing with the underlying psychological issue often either relieves or even removes the condition.

Secondly we should point out that psychogenic factors also play an important role in religious healing. Here we are concerned with the psychological make up of the person. Certain kinds of personality types respond more easily to religious healing than others. The optimum personality is described as the “traditionally religious person, with a capacity for faith, a mood of expectancy and hope and an ability to relate one’s self to others in a strong and life modifying relationship” (Jackson 1981:29). People oriented around external factors rather than internal factors will be more susceptible to healing. Those more rigidly controlled internally, however, may demonstrate more striking manifestations of healing as the rigid controls of either ego or culture are broken down to effect the healing. Indeed it may be necessary for other aspects of the person to emerge before this can happen. It is here that we discover the phenomenon of altered states of consciousness and dissociation, the final psychological way of understanding healing we shall consider.

Entry into some form of altered state of consciousness is a necessary part of most forms of spiritual healing. Psychologists usually refer to these as “dissociative states” (Kiev 1972:29). Crapanzo (in Davies 1995:23) suggests that “spirit possession may be defined as ... any altered state of consciousness indigenously interpreted in terms of the influence of an alien spirit”. The psycho genesis of trance/dissociative states is explained by Kiev (1972:30) as the

psychological inducing of regressive or altered states of consciousness, through either a reduction or an increase of external stimuli. The contagiousness of excitement ...may also lead to a breakdown of the higher integrative functions of the central nervous system, thereby producing the possession state. (Kiev 1972:30).

In the altered state, other aspects of the consciousness are allowed to take control of the individual and behaviours and emotions which are usually blocked by the ego or the culture are allowed expression. In this way, “dissociative states can provide emotional catharsis, a sense of renewal and an improved capacity for dealing with reality” (Kiev 1972:33-34).

Probably an essential part of human wholeness is the ability to have a space where aspects of our humanity which are normally inhibited either by our ego or cultural and social strictures, can emerge. The experience of “becoming possessed” by a spiritual being can increase the status of people whose normal place in society is low. States like meditation provide activists with a place for the introverted side to emerge. In extreme pathological forms these can emerge as multiple personality disorders and the clinical diagnosis “dissociation” usually refers to these more extreme cases. However the milder forms of acting out of repressed parts of our selves are often the first stage of integration and psychological health.

### **3.2 *Anthropological studies***

Anthropological studies of the Christian healing ministry in South Africa and religious healing in general usually concentrate on the role of culture in healing. They look at how the structure of the cultural system and cultural functions within it influence the way in which sick roles are interpreted and healing processes are set up. They also look at the way that world view influences how common underlying human processes are accessed and interpreted. On the semiotic level anthropological studies of healing investigate how symbols

within the culture allow access to power and how the manipulation of this power is involved in effecting the healing. Such symbols include the myths within the culture understood as the symbols about accepted truths as well as rituals interpreted as repeated symbolic behaviour.

For anthropology, Christian healing, as indeed all religious healing, is a cultural phenomenon. In the field of medical anthropology both illness and healing are cultural constructs. Illness is defined as “the psycho social experience and meaning of perceived disease...the shaping of disease into behaviour and experience ...created by personal, cultural and social reactions to disease” (Kleinman 1980:72). Illness is linked with perception and the categories of perception are given to us by our culture. The relative stigma associated with various diseases is also cultural which increases the weight of some illness more than others. Dying of tuberculosis is sad but dying of tuberculosis as part of AIDS is much more serious in western culture. In this way culture is also pathogenic (Bate 1999:209). Many African diseases (*izifo zabantu*<sup>6</sup>) which are culturally labelled as very serious do not even affect people from outside the culture (Bate 1991:58-59).

Healing is seen as the psycho-cultural construction of well-being as a result of the application of effective remedies by the healer. The remedies have to be culturally acceptable and as new ones are found they are incorporated into the cultural healing system. The role of perception is crucial and each culture provides categories of perception as labels and symbols of health. Such symbols are carriers of power within the culture and can be either pathogenic like demons, evil spirits, witches or germs or curative like prayers, blessings, casting out demons, slaughtering an animal to appease ancestors or medicines (Bate 1999:109-113).

Culture also provides the world view as the symbol system which communicates

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<sup>6</sup>*Izifo zabantu* means literally “peoples sicknesses” and refers to those kind of illnesses which are not cured by normal medicines and are caused by other people usually through witchcraft or the influence of angry ancestors.

truth and reason to all members of the society. The world view also provides the explanatory model within which the illness is explained and its remedy clarified (:209-210). Patient and healer have to share the same world view for the healing to be effective or the healer will be unable to lead the patient through the ritual process (Bate 1999: 209). Sometimes this may involved the process of conversion where the patient in a moment of rapid resolution accepts the world view and symbol system of the healer. Dissociative states where the normal ego personality is suppressed clearly enable this process.

Ritual is the process through which healing is effected. Ritual is repeated symbolic behaviour in which the symbols used are carriers of power within the culture. These are manipulated through the ritual process by the healer who is the mediator of this cultural power to the sick person. Power used in this way enables emotion transfer which is the healing. Healing rituals include experiences as diverse as going to hospital, being exorcised, the anointing of the sick, casting out demons, psychotherapy and counselling. All these symbols are accepted signs of healing within their own cultural frameworks and are accepted as such (believed in) by both the healer and the patient (Bate 1999:211).

### **3.3 *Socio-economic studies***

Socio-economic studies of Christian coping-healing usually look at the relationship between involvement in coping-healing churches and prevailing socio-economic conditions. Studies have indicated a positive correlation between participation in such churches and various manifestations of social alienation expressed as social deviance, social deprivation and social disorganisation. Some studies have also considered the role of such churches in social reconstruction. Within the church itself this happens as it constructs itself into an alternate healthy functioning society within the prevailing social dysfunction. Sometimes however the church also has a healing role within the greater society as an agent for social

amelioration (Bate 1999:123-146).

All societies prescribes roles and duties for their members. When a person is no longer able to adequately fulfil their social responsibilities they are considered to be ill. It is in this way that illness is understood sociologically as a form of social deviance (Freidson 1970, Schoffeleers 1991). Besides this, societies also set up structures concerned with the provision of health. These become the normative health care systems within that society. Sometimes however, alternative forms of health care emerge which do not follow the prescribed social norms and understandings regarding sickness and health. Such alternative forms are also, at least initially, considered to be a manifestation of social deviance. Such was the nature of many judgements made on African Independent church healing practices (Rounds 1979; Zulu 1986 Bate 1999:131-2) and Morran and Schlemmer's (1984:25) social analysis of the so called new churches of neo-Pentecostal inspiration.

Social deprivation is one of the major forms of social deviance. It is not part of the ethos of societies that people should be deprived yet the reality is that social deprivation exists within most societies in the world.

Deprivation theories represent the oldest sociological attempts to understand the growth of sects and New Religious Movements. Early research in the United States showed that sects grew most rapidly amongst the economically deprived sector of the population who "transcend their feelings of deprivation by acquiring feelings of religious privilege which the status of sect member accords them" (Morran & Schlemmer 1984:25). (Bate 1999:130-131)

Sales (1972) was able to show how economic deprivation could be correlated to membership of churches which provided a stable, clear authoritarian system such as one finds in the Coping-healing churches. Dube (1989:30) has pointed out that "Zionist healing measures are effective in a community which finds itself disadvantaged" and Morran and Schlemmer (1985:25) have highlighted the fact that social deprivation need not only be on the economic level but "consists of lack of power, prestige, status and opportunities for social participation

afforded the high status members of society”. They note that the newer charismatic-Pentecostal type churches attract people who feel alienated from society since they feel powerless to control what is happening as it is being “run by the few people in power and there is not much that the ordinary person can do about it” (:68).

Healing in such a context is access to, and experience of, power and status which is denied within the ordinary world of daily life. This is because the world is experienced as socially disorganised. When society stops functioning as an ordered reasonably predictable entity, when violence, chaos and upheaval are part of daily life, then the whole society becomes in some way socially deprived. When societies become more socially disorganised, as was the case in post 1976 South Africa then religious groups which offer healing and a sense of control and order will grow. This “explains the growth of the new churches quite successfully” (Morran and Schlemmer 1984:23). The social disorganisation brought about by colonialism also explains the emergence of African Initiated churches whose growth mirrored the encroachment of colonialism and westernisation into African traditional society (Zulu 1986:152).

The coping-healing church is seen as a place of human reconstruction. Healing means not only a personal reconstruction to a healed person but also the acceptance of the world view, way of life, norms and morality of the new society (Bate 1999:136). This implies social reconstruction as well. Out of the chaos of the social disorganisation all around, a person is able to live in “Zion” (:136, 142-143) or is “born again” into a new lifestyle (:143-144). The coping healing church becomes the new society in which one finds, life order, wholeness and peace.

Some sociologists have been quite critical of this role of coping-healing churches considering it a withdrawal from the world into quietism and thus an opting out of socio-political involvement which could change the society into a better one. Zulu (1986:152)

suggests that white social hegemony in South Africa led to two reactions amongst blacks:

- i) they either found strength in organizing and consolidating the black majority against white rejection (black consciousness and black theology fall into this specific category) or
- ii) they retreated into their own separatist churches where they felt they could redefine their existential situation.

Schoffeleers (1991:18) is of a similar opinion and he identifies the healing ministry of these churches as “the root cause of their quietistic character”.

Other authors however disagree with this analysis suggesting that the African Initiated churches are sites of struggle against prevailing cultural and social norms and that in the Apartheid era they played a role in mobilising people to reject the evil of the dominant society and to keep the hope alive for something better provided in their praxis the seeds of a better life for all (Comaroff 1985: 1795; Mosala 1985:110-111). In the same way the charismatic Pentecostal type coping-healing churches can be considered as a challenge to the prevailing norms of alienation, and social structures which favour the rich and powerful.

The political analysis of power in society clearly has to take account of the multiple sources of social power which exist in the society. Coping-healing churches are themselves sources of social power within the South African context. The impact of these churches on society is clearly quite large since they involve such a large component of society. In a country where 45% of Christians belong to these churches it is clear that their social and political influence is quite large. It becomes quite difficult in our society to refer to these groups as the marginalised fringe. In South African Christianity they have become the numerical mainstream.

### **3.4 *Medical studies***

Medical studies have tended to interpret other forms of healing through the medical

model with its reliance on the scientific method of verifiable repeatable conclusions. As a result, medical opinion has been rather negative regarding coping-healing churches. A typical approach is that of South African medical doctor Des Stumpf who writes in a letter to the South African Medical Journal:

As a committed Christian, I have made an in-depth theological, sociological and medical investigation into the Pentecostal and Charismatic movements and their preoccupation with and heavy emphasis upon so-called 'miraculous' healings. Regrettably I have not witnessed a single genuine miracle, nor confirmed that one has occurred at the hands of these people. (Stumpf 1985:574)

In this he echoes the views of Rose (1968) who was unable to find a single verifiable medical cure in a study of thousands of people who had been cured by faith healers. Indeed medical studies have shown that such healings are usually temporary cures based on feelings of well-being and emotion (Weatherhead 1951:201-208). The approach taken in Lourdes and in the *Congregatio pro Causis Sanctorum*<sup>7</sup> assumes that a miracle occurs when there is a verified suspension of the natural medical laws of sickness and health. Only such healings are recognized as miraculous cures.

The influence of medical anthropology as well as a more focussed study of spiritual issues by the medical fraternity has led to a tempering of this rather negative judgement of religious healing in general. The work of Jerome Frank (1961) at John Hopkins university Medical School has shown the importance of a medically defined faith in the healing process and Arij Kiev (1972) has demonstrated the role of dissociative states in empowering healing. In the South African context, medical studies by both Wessels (1985) and Edwards (1985) have emphasised the role of culture in disease etiology and verified the effectiveness of traditional and religious healers on this level.

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<sup>7</sup>The congregation for the causes of saints is part of the Roman Catholic Curia concerned

In the USA, the National Institute for Healthcare Research published a series of three volumes between 1993 and 1995 collecting together medical research on Spiritual subjects.<sup>8</sup> The conclusions from this study were that “most of these studies indicate a positive benefit for religious commitment” (Matthews et al 1993: v). Whilst the limitations imposed by the scientific model mean that religious parameters such as faith, prayer, casting out demons and so on have not been studied, some quantifiable, verifiable, repeatable criteria were found. The principal one being religious commitment. Matthews (1993:iii) describes the following trend emerging from the seventy abstracts in Volume 1:

The effect of religious commitment on physical symptoms and general health outcomes included improved general health (4/5 (80%)), reduced blood pressure (4/5 (80%)), improved quality of life in cancer (7/8 (88%)) and heart disease patients (4/6 (67%)), and most importantly, increased survival (8/9 (89%)).

In another sign of changing world view within the medical profession, the Harvard Medical School’s department of Continuing Education and the *Mind/Body Medical Institute* recently sponsored a conference on “Spirituality in Healing”.<sup>9</sup> A large number of medical studies were collected to show how spirituality can help patients to “Prevent, Cope with or Recover

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with investigations and judgement on the Beatification and Canonisation of Saints

<sup>8</sup>The books entitled “The Faith Factor” Volumes 1,2 and 3 were all subtitled “An annotated bibliography of clinical research on spiritual subjects”. The idea was to provide a collection of clinical abstracts of research carried out using the medical model and the scientific method showing the influence of religion on medicine and psychology.

<sup>9</sup>The conference “Spirituality and Healing in medicine” was held in Denver Colorado from March 19-21 2000. Details of the conference are available at [www.templeton.org/spirit\\_health\\_advance.asp](http://www.templeton.org/spirit_health_advance.asp). Note the misspelling of health as heath. Further details of medical literature on this theme are also available at [www.templeton.org/Course98/highlights.asp](http://www.templeton.org/Course98/highlights.asp)

from illness” and that “Spiritual patients live longer, healthier lives”.<sup>10</sup> These studies and others like them allow us to venture that medical science is also now beginning to recognise the operation of clinical factors in religious healing. As yet the identity of these factors has not been clearly incorporated into the medical model though they appear to be along the lines indicated by researchers like Frank, Kiev and Kleinman positing a greater opening to the psychological and anthropological factors indicated earlier.

### 3.5 *Theological studies*

Early theological investigations of the coping-healing churches were limited to studies by missionaries of the African Indigenous churches. The general opinion of these authors was that the healing found in these churches was an assimilation of African cultural approaches to healing into Christianity. Theological justification for the ministry was given by the practitioners as a continuation of Jesus’s own healing ministry and that of the apostles (Becken 1975:237-242; Oosthuisen 1968:88-89; Sundkler 1961:237). Initially most of these authors assessed the practice as syncretistic and therefore unacceptable. However in their later writings these authors were to adopt more positive judgements seeing the emergence of a more African theology and ministry. Daneel (1983:43) sums up this latter position most succinctly:

In conclusion, it should be emphasized that prophetic faith-healing practices provide African theologians with a vast field of interaction, dialogue and confrontation between the Christian message and traditional religion, between Christ and the ancestors - a field well worth serious consideration. For although the independents are not generally engaged in reflective theology, their intuitive enactment of theology at the grass-root level of their own world-view and philosophy, constitutes an enriching and original contribution towards a developing *theologia africana*, which should not be overlooked under any circumstances.

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<sup>10</sup>These articles are referenced at [www.templeton.org/Course98/highlights.asp](http://www.templeton.org/Course98/highlights.asp)

The neo-Pentecostal type coping healing churches have been more negatively judged by Southern African and other theologians who consider that the churches remove people from their culture and society to create a passive subculture and that their teachings are in error. They teach a misguided notion of faith which is faith in faith rather than faith in God (Verryn nd 8-9). This leads to people being blamed for their own illness if they are not cured since they are considered not to have sufficient faith (McConnel 1990:165-166). These churches are also seen to place too much emphasis on disease as spiritual in nature and to ignore physical etiologies often denying medical access to their members (McConnell 1990:150). They are also accused of turning Christianity into a healing cult (:158).

It is our contention that the current over positive judgement of African Independent churches and negative judgement of charismatic-Pentecostal churches is as a result of political and social factors. In fact, these churches are better considered together since they offer the same kind of ministry operating within different cultural paradigms (Bate 1991:57). They provide “a partially inculturated ministry in which culturally mediated needs are being responded to by empirically based culturally mediated pastoral responses” (Bate 1999:321). I have introduced the theological concept of inculturation into the discourse on the healing ministry since it is an increasingly acceptable term within ministry and includes a number of criteria for assessment. It also provides the framework for emic judgements which cannot be made outside a standpoint of Christian faith. The two principal criteria for assessment provided by the inculturation model are faithfulness to the gospel and church unity (EA 62). I have attempted to assess this ministry in terms of a number of accepted gospel values and generally accepted theological truths (Bate 1999:283-316).

There are a number of different ways that theologians try to understanding sickness and healing. Some have affirmed the traditional relationship between sickness and evil since Jesus' healing ministry is predicated upon his determination to fight against these evil forces

(Kelsey 1973:80-90; MacNutt 1974:176). It is for this reason that illness is also linked theologically to sin although theologians are careful to point out that this relationship is not directly causal. Sin is human participation in evil which is at the root of sickness (Hollenweger 1989:173; Kelsey 1973:95).

In a similarly way the relationship between faith and healing is affirmed but expressed with caution. MacNutt (1974: 120) suggests that healing by faith is normative but does not always take place. For Hollenweger (1989:173) “Christian healing is rooted in the belief in God’s freedom and sovereignty....Faith does not automatically lead to health....There are many healing stories in the New Testament where faith plays no role”. Maddocks (1990:66) points out that the source of the church’s healing gifts is in the cross of Christ which is the source of healing gifts since “the uncrucified is the unhealed”.

Theologians have stressed the importance of the believing community rather than just the believing individual in the healing process. Sebahire (1987:14) articulates this position as follows: “It is the support of the believing community which makes health and salvation available”.

Christopher Grundmann (1995:55) has pointed out that throughout the history of the church, the power to heal illness has not been a specifically Christian pursuit: “it is impossible to found an exclusively Christian claim to healing on the fact that there are various reports of healing in the New Testament...Healing...cannot be monopolised by Christians. Herein lies one of the special difficulties of describing healing as a dimension of ecclesial-missionary activity”. At the time of Jesus, healing movements were manifold and the healings of Jesus and the apostles would have been examples of quite common practices at the time. From a non-faith standpoint, the anthropologist Stevan Davies (1995:104) makes a similar kind of claim suggesting that Jesus “was a spirit-possessed healer to use my vocabulary. The overall parameters of his role in first-century Palestine are nothing unusual”.

In the scriptures the word mainly used to describe Jesus' healings is *dunamis* (\* $\lambda < \nu : 4H$ ). *Dunamis* is a powerful or marvellous force which originates in God (Grundmann 1973:301-302). We get our English word dynamic from the same Greek word. Unfortunately *dunamis* has often been translated "miracle" in English translations and the current Western understanding of this word is an event which is outside the normal rules of nature. This restrictive usage is not really what the original biblical term wishes to communicate. Similarly the words used for healing are words concerned not so much with medical curing but with the restoration of the whole person. The two main words used in the New Testament are *sozo* ( $\Phi / . T$ ) and *therapeuo* ( $2, \Delta \nu B, \beta T$ )<sup>11</sup>. *Sozo* is the same word used for salvation whereas *therapeuo* is the root of our English word therapy (See Bate 2000 forthcoming).

Theologically then we can see that healing is not restricted to the church but is clearly part of its mission as it was Jesus'. The goal is the manifestation of signs of salvation in the lives of people. Healing is part of the process of inculturation and an essential dimension of the Church's mission to fight sin and evil (Bate 1999:321).

### 3. Assessing Coping Healing.

#### 4.1 *The confluence of religion and healing*

Healing has a prominent part in all religions (Sullivan 1987:226). The Buddha was portrayed as a healer in his teachings on impermanence and meditation. Zoroaster used techniques of divine cure to overcome sickness resulting from the influence of evil. Yahweh

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<sup>11</sup>Five different Greek words are used to refer to the healing work of Jesus. These are *sozo* ( $\Phi / . T$ ) and *therapeuo* ( $2, \Delta \nu B, \beta T$ ) discussed in the article as well as three others used less frequently. The first is *iaothai* ( $\text{O} \square \Phi 2 \nu \lambda$ ) which refers to the kind of healing done by a physician and is used frequently though not exclusively by Luke. The other two are far less common: *katharizomai* ( $6 \nu 2 \nu \Delta 4. \text{z} : \nu 4$ ) (cleansing) is related to our English word catharsis and *apokathistemi* ( $\nu B \cong 6 \nu 2. : \Phi 90 : 4$ ) to cure or restore.

says “I am the Lord your healer” (Ex 15,26). Jesus was a healer through signs and wonders. In Islam the *Qur’an* and *hadith* express healing as coming from God. Indeed, the *Qur’an* refers to itself as a cure (10:57). In African traditional religion and culture, traditional healers mediate healing through the influence of ancestors.

Geertz (1973:100-108) points out that religious symbols respond to areas of limitedness in human experience in three main areas: the limit of analytic capacity to understand the world, the limit of powers of endurance in dealing with suffering principally in the two main forms of sickness and death and the limit of moral insight expressed as the problem of evil. It is for this reason that religious discourse and praxis concerning illness and healing is inevitable for those sicknesses which transcend our human capacity to solve routinely. It is within this context that the South African Christian Coping-healing ministry situates itself.

However our analysis of this ministry in term of the mediations of the various human sciences allows us to widen the horizon of that which can be understood and thus moved into the area of “analytic capacity to understand the world”. To the extent that this endeavour is successful the religious symbols are challenged in their ability to respond to what continues to remain beyond the limit. This then presents us with two areas for assessment. One which comes from the criteria developed through the disciplinary mediations and another which transcends them and responds to the specific efficacy of the religious symbol. We will limit ourselves to the first of these areas in this paper.

#### **4.2 *Assessing Coping-healing using criteria from the human sciences.***

Each human science provides its own criteria for assessment and so it finds what it is looking for. We expect economics to find economic reasons for human behaviour, anthropology to find cultural reasons based in structure, function or symbol and psychology

to find psychological reasons for the same experiences. The strength of the Western scientific approach is focus and depth and these limitations allow for thorough analysis within the parameters chosen. The weakness is that the interrelatedness of phenomena and indeed of the analyses is often ignored.

In our study we have tried to overcome this weakness by mediating the phenomena through a number of epistemological lenses and the criteria they provide. It is now time to put these together. Each study has provided a series of understandings or truths about the coping-healing phenomenon. These “truths” can then be set up as a series of criteria by which any religious healing practice can be assessed from the perspective of the human sciences used in our mediations of the phenomena. In this way we are able to set up a series of assessment questions to which assent implies a positive assessment. These are questions like “Does this practice lead to emotion transfer from negative (unwell) to positive (well) feelings by the individual concerned?” This reflects one of the psychological criteria emerging from the analysis. On the anthropological level a relevant question would be: “Does this practice lead to approval by the individual’s primary community that healing has occurred?” Clearly the setting up of these questions is somewhat tricky. What follows is a first attempt to do it. Hopefully feedback on these questions will lead to a more refined assessment model. The mediations presented in section three above have led to the emergence of thirty criteria which can be formed into questions in the following way.

#### **4.2.1 Assessment questions from the psychological mediation**

- i Does this practice lead to emotion transfer from negative (unwell) to positive (well) feelings by the individual concerned?
- ii Is the healer able to set up an effective therapeutic relationship with the patient?
- iii Does transference occur?

- iv Has the healer responded to issues of psychological stress and empowered the psychosomatic mechanisms which can lead to healing of physical conditions brought on by stress?
- v Have altered states of consciousness been promoted to allow those imprisoned by rigid egos or cultural strictures to achieve “emotional catharsis, a sense of renewal and an improved capacity for dealing with reality“ (Kiev 1972:30).
- vi Does the process create an acceptable cognitive vision of sickness and health within which the illness can be named and the remedy executed?
- vii Has the sick person developed faith understood as the expectation of success and the acceptance of the healing process?

#### **4.2.2 Assessment questions from the anthropological mediation.**

- viii Is the healing in terms of a world view which is accepted within the culture?
- ix Is the illness understood within the culture of the patient?
- x Has the ritual process of healing allowed the normal manipulation of the symbols carrying healing power within this community/culture?
- xi Does the healing of the illness occur in a way predicted by the cultural system of healer and patient?
- xii Is the healing perceived as such by members of the patient’s immediate community and cultural grouping and thus accepted as healing by them?
- xiii If the healing led to conversion or incorporation of another symbol system or world view in the life of the patient, is this incorporation judged in a positive way by the immediate cultural community of the sick person: i.e. is it acceptable healing for them?

#### **4.2.3 Assessment questions from the socio-economic mediation**

- xiv Is the sick person from a socially deprived sector of the society?
- xv Does the sick person experience the effects social disorganisation in their daily life?
- xvi Does the coping-healing church exercise a political role in the society: i.e. is it an agent for the mobilisation of social power?
- xvii Is the coping healing church providing social access to health within society: i.e. is it *de facto* part of the primary health care structure?
- xviii Does the healing open the way for the sick person to participate in social reconstruction through participation in the life of the church?
- xix Is it recognised as such by the society as a whole?

#### **4.2.4 Assessment questions from the medical mediation**

- xx Is the healing a medically acceptable clinical cure?
- xxi Is the healing acceptable within the parameters of medical anthropology?
- xxii Does it form part of those kinds of healings where spiritual remedies seem to empower or promote clinical curing?
- xxiii Is this cure unusual and unexpected in terms of current medical knowledge and practice?

#### **4.2.5 Assessment questions from the theological mediation**

- xxiv Does the healing represent a victory over evil or sin?
- xxv Is the healing an expression of the ministry of a believing community?
- xxvi Is the healing compatible with one or other scriptural healing forms: *dunamis*, *sozo*., *therapeuo*, *iasthai*, *katharizomai* or *apokathistemi*?
- xxvii Is the healing theologically acceptable or is it a distortion of Christian teaching?
- xxviii Does the healing bring salvation, new life and freedom to the sick person or does it

confine him within a narrow cult with rigid prescriptions?

xxix Is the healing Christian rather than syncretistic?

xxx Does the healing represent inculturated Christian healing?

#### **4.3 *Making the assessment***

These thirty questions provide the possibility of a preliminary assessment of the healing ministry within both coping healing churches and indeed any form of Christian healing. Though somewhat unrefined and yet complex they do provide us with a tool to help resolve some of the conflict and controversy which surrounds this ministry. Each question provides the possibility of three answers: yes, no or uncertain. The more “yes” responses attained, the more one is able to recognise the validity of the healing. The more the “no” responses the less likely is healing to have occurred.

Clearly the judgements made in answering each question will retain an element of the subjective about them but the fact that they do come from within the categories of the human sciences each of which has somewhat clear categories and parameters to formulate judgements enhances the probability that some consensus can be reached.

The criteria developed and the questions formed from them obviously lead to a largely etic assessment of the phenomena of coping-healing. Since we are concerned with a human phenomenon we should recognise the limitation of this. Whilst the culture of science always wants to make judgements that are somewhat “objective” since this forms part of its metanarrative, we should recognise that this is not necessarily going to influence the opinion of those directly involved in the process of coping-healing itself. For that reason assessment should seek also to incorporate an emic component where both the criteria of assessment and the metanarrative underpinning these criteria are likely to be very different. These are cultural issues and an unwillingness to acknowledge both the culturality of the Western scientific

approach and the cultural criteria of assessment coming from within the coping-healing churches themselves only impoverishes the assessment. Whilst this paper has focussed on criteria emerging from the human sciences we would like to urge research on the development of emic criteria for assessment of Christian coping-healing. We have already indicated (supra 3.5) that it is within the theological mediation that such criteria will have to be found. They will also need to come from the members of coping-healing churches themselves, both healers and those who have experienced healing. They will clearly have to be presented in a way that reflects the world view of this group. At the same time, the search for truth should lead such criteria to be accessible to those outside. Often members of such churches feel themselves to be threatened by those outside who would seek to judge them. Effective dialogue is the way forward here.

#### **4.4 *Multi disciplinary criteria: assessing the competing truths.***

Finally I would like to make some comments regarding the weighting of the various criteria of assessment presented in this paper. It would be strange to expect that all the criteria presented above are of equal importance in assessing the effectiveness of healing procedures. But how to find a way of weighting them or at least ranking them in some sort of order of importance. Clearly this investigation will require further research and study. Nevertheless we would like to indicate some avenues which could be explored in attempting to solve this particular problem.

The first step would be to solve the problem of weighting the criteria *within* the various disciplinary mediations. This is a weighting *ad intra*. Looking within each discipline it seems that we can identify different kinds of criteria. There are those which respond to the very nature of the healing process. Without these healing will not occur. Examples of these include “emotion transfer” (criteria i) in the psychological mediation, “world view” (criteria

viii) in the anthropological mediation, “clinical cure” (criteria xx) within the medical mediation and “victory over evil and sin” (criteria xxiv) in the theological mediation. Then there is another kind of criteria which describes various kinds of mechanisms in the healing process which are usually but not necessarily present for healing to occur. These include “transference” (criteria iii) in the psychological mediation “ritual process” (criteria x) in the anthropological mediation, “spiritual remedies” (criteria xxii) in the medical mediation and “ministry” (criteria xxv) in the theological criteria. Finally there are a less critical set of criteria which are concerned with setting up favourable conditions which can empower the healing process. These include “altered states of consciousness” (criteria v) in the psychological mediation, “acceptance of healing by the culture/community” (criteria xiii) in the anthropological mediation, “social reconstruction” (criteria xviii) in the socio-economic mediation and “inculturated Christian healing” (criteria xxx) in the theological criteria. The ranking of criteria within disciplines is an area for further study and is only the first step in the process of weighting them. In fact we have already attempted to do this. In the list of questions we have presented, the order in which we have presented the criteria within each discipline is a first intuitive attempt to make this ranking.

When it comes to cross disciplinary ranking we are clearly faced with a far more complex problem. Whilst the three criteria presented above can obviously be used in a cross disciplinary way to set up a 5x3 matrix reflecting the five mediations and the three types of criteria, there are other issues at play. Some of these are philosophical, concerning metanarrative, ideology and intentionality. On the level of metanarrative we find philosophical systems like Marxism, structuralism, functionalism and semiotics. Deconstruction of these may help us to recognise why a particular system favours one criterion over another and whether this is justifiable. But this is a difficult business. More promising is the question of intentionality. It seems at least here we can see a relatively

important factor affecting the relative weighting of the disciplines. Of the five mediations, two have as their specific intentionality the question of healing the sick. These are psychology and medicine. This being the case it would seem (though need to be verified) that criteria emerging from these two mediations, concerned as they are with the very intention of healing, become more important in judging issues of healing. Here then is a way of weighting our five mediations into two specific groups.

As well as this, we have noted the importance of incorporating emic judgements into our assessment. Clearly such judgements can only be done within the theological mediation since emic judgements can only be done by those with Christian faith. So here too is a further way of separating our five mediations into two other specific groups. However, not all Christians are convinced of the efficacy of Coping-healing churches in the way their own members are. Emic judgements can only really come out of theological assessments made by this latter grouping.

The matter is clearly more complicated than these initial thoughts but it is hoped that these reflections will open the way for further research in this area.

## **5. Concluding Remarks**

It is of the nature of religious healing to deal with sicknesses which do not respond to those remedies which our human knowledge and skill has allowed us to develop. Religious healing is never a proven remedy but rather a mechanism for bringing the fearful and the unknown into our human horizon and into the realm of that which can be dealt with. Consequently any attempt to make sense out of religious healing has to recognise that here is work done on the boundary between the known and the unknown. However this border is constantly changing as human wisdom and culture extends the frontiers of knowledge and

brings the unknown into the known. Our study then was concerned with investigating what is going on at this boundary and searching for that which can be added to our knowledge and become part of the known. However our investigation has shown us that this endeavour should not be limited to one discipline for synergistically multi disciplinary approaches are able to make sense of more than any one discipline on its own. They also encourage disciplines to extend their own boundaries as has been strikingly shown in the changes in medical science regarding the clinical validity of religious and cultural healing forms. This does not mean however that we shall destroy religion as some scientists seem to assume, since God's creation will always contain mystery. The weakness of modern Western science currently being remedied today has been the omission of this truth from the whole.

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