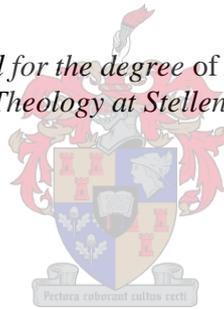


# **The faith healing practice in pastoral care: A pastoral assessment**

BY

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*Dissertation presented for the degree of Doctor of Philosophy in the  
Faculty of Theology at Stellenbosch University*



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April 2014

## **Declaration**

By submitting this dissertation electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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### **Abstract**

Africa is a continent ravaged by challenges of poverty, scourge of disease and many conflicts, some of which are motivated by religious fanaticism. Indeed, it is a continent in dire need of spiritual, economic and social transformation. In the midst of these challenges, however, faith healing practices have flourished among African communities.

Healing is a broad concept, which covers a whole range of social, psychological, cultural and spiritual issues and dimensions in response to unwanted threatening conditions that disturb a harmonious and peaceful existence. The concept of healing is firmly rooted in the soil and soul of Africa. To a certain extent, the popularity of healing practices in many parts of Africa is a result of an African epistemology that accepts healing as a cultural reality. The poor majority are mostly exposed to harsh socio-economic and hazardous health conditions. Thus, many poor people are drawn to healing practices for the following three reasons:

Firstly, faith healers promise to heal people of all kinds of illnesses and epidemics through fervent prayers. Faith healers are powerful and charismatic personalities that command a great following as a result of their charisma. Secondly, because African culture is spirit-centred and has a high regard for spiritual powers and forces, Africans are amused by supernatural and are therefore drawn to healing phenomena, as it speaks to their reality and reference framework. Thirdly, faith healing practice is a cost free, alternative intervention strategy for managing illness, especially to the poor masses, who do not have access to specialized medical care.

The close relationship between psychosomatic diseases and “African illnesses” is also explored. This is quite evident when considering the types of illnesses faith healers claim people are being healed from during healing practices, for example HIV and AIDS, hypertension, ulcers, bad luck, infertility, witchcraft, and so forth. African illnesses are believed to be unexplainable and untreatable by Western medicine. It is believed to be caused by witchcraft, sorcery and evil, and has similar manifestations as psychosomatic diseases.

In the context of a vibrant and growing faith healing practice, there is a need to investigate the spiritual and emotional impact of faith healing on healing seekers, especially when the desired healing doesn't materialise. The research field has highlighted the emotional and spiritual challenges caused by illness, as well as the lack of supporting systems to sustain people grappling with illness. The realisation is that healing, as a broad concept, needs a multifaceted approach for effective response. The lack of indigenisation of healing practices with African (Namibian) cultural symbols and cultural milieu was highlighted. Therefore, an effective and culturally relevant pastoral care system should take special cognisance of it and thus, the envisaged pastoral approach of hope and compassion build around it.

### **Opsomming**

Afrika is 'n kontinent wat geteister word deur armoede, dodelike siektes en konflikte, waarvan sekere gedryf word deur godsdienstige fanatisme. Dit is inderdaad 'n kontinent wat behoefte het aan geestelike, ekonomiese en sosiale transformasie. Nietemin, ten spyte van hierdie uitdagings, het die gewildheid van geloofsgenesings praktyke in Afrika gemeenskappe toegeneem.

Genesing is 'n breë konsep met 'n verskeidenheid van sosiale, sielkundige, kulturele en geestelike aspekte en dimensies, wat reageer op ongunstige toestande of moeilike situasies wat heilsame en harmonieuse leefwyse teenwerk. Genesings praktyke is inderdaad 'n integrale deel van mense in Afrika se kulturele bestaan. Die konsep van genesing is dus gegrond in die siel en sand van Afrika. Tot 'n sekere mate is die gewildheid van genesingspraktyke in baie dele van Afrika toe te skryf aan Afrika epistemologie, wat genesing as deel van die kulturele realiteit aanvaar. Die arm massas is meestal blootgestel aan hagslike sosiale en ekonomiese toestande. Dus word baie arm mense na genesingsbedieninge gelok vanweë die onderstaande drie basiese redes:

Eerstens, as gevolg van die beloftes wat geloofsgeners maak dat hulle mense van enige siekte en kwaal kan genees deur vurige gebede. Geloofsgeners het kragtige en charismatiese persoonlikhede waarmee hulle invloed uitoefen en baie volgelinge werf weens hul charisma. Tweedens, vanweë die Afrika kultuur wat geesgesentreerd is en hoë agting vir geestelike magte en geestelike werkings het; mense van Afrika word amuseer deur bonatuurlike werkings, omdat dit tot hulle kulturele en verwysingsraamwerk spreek.

Derdens, geloofsgenesing is 'n koste vrye, alternatiewe helings-strategie om siektes te beheer, veral vir armes wat nie bronne het om gespesialiseerde gesondheidsdienste te gebruik nie.

Die nuwe werking tussen psigosomatiese siektes en "Afrika siektes" speel ook 'n rol. Dit is veral duidelik in die tipe siektes wat geloofsgeners beweer dat mense van genees word na geloofsgebede, byvoorbeeld MIV en VIGS, hipertensie, maagsere, vloeke, onvrugbaarheid, toordery, ensovoorts. Daar word geglo dat Afrika siektes onverklaarbaar en onbehandelbaar deur Westerse dokters is. Die geloof is dat sulke siektes deur toordery en bose geeste veroorsaak word, en soortgelyke manifestasies as psigosomatiese siektes het.

In die konteks van 'n groeiende geloofsgenesings bediening, is daar 'n regverdiging om ondersoek in te stel op die geestelike en emosionele impak van geloofsgenesing op siek mense; spesifiek in gevalle waar genesing nie onmiddellik met gebed geskied nie. Die ondersoek het aan die lig gebring dat siek mense emosioneel en geestelik sukkel in hulle stryd teen siektes. Dit is ook uitgewys dat daar 'n gebrek is aan ondersteunende strukture vir mense wat met siekte sukkel. Daar is tot die besef gekom dat genesing as 'n breë konsep 'n veelvoudige benadering benodig vir effektiewe terapeutiese respons.

Gebrek en onvermoë van geloofsgenesings praktyke om inkulturering met Afrika (Namibiese) kultuur simbole en kulturele fassette te doen was ook uitgewys. Dus, 'n effektiewe en kultureel relevante pastorale sisteem moet kennis daarvan neem en dit integreer by die voorgestelde pastorale benadering van hoop en meegevoel.

## **Acknowledgements**

The dissertation would not have been possible without encouragement and collaboration from the following people and institutions:

First and foremost, I give thanks to almighty God who inspired, motivated and strengthened me on this strenuous road of discovery. The Lord has sustained me, especially during the last part of the research when I got ill with a chronic condition. Praise be to his holy name!!

Secondly, to my dear wife, Christina Kgomotso, and our two gorgeous daughters, Christelle Neo and Mercy Ntshelang, who have sacrificed greatly to let me pursue this study. It was a real challenge to the family as we experienced the realities of going on with little to nothing. I am sincerely grateful for your courage and faith, which kept me going.

Thirdly, to my promoter, Prof. Christo Thesnaar, for reading, correcting and guiding me throughout the research. Surely, without your input and wisdom I would not have come thus far. I thank you.

Fourthly, to Drs. Manitza Kotze and Tara Elyssa who meticulously read the dissertation and made valuable language editing.

Fifthly, to all the interviewees and respondents who zealously shared their stories and testimonies of their healing experiences. Their inputs were crucial for completion of my field research.

Finally, to all the institutions, churches and sponsors who have contributed through financial assistance and moral support, we pray that the good Lord bless you and increase your harvest.

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## Chapter 1 Introduction

### 1.1. Background

The challenges of the twenty first century seemed to be insurmountable when considering issues such as increased religious and political intolerance in the world and the threats of terrorism and nuclear weapons. The human hostility is not only felt towards fellow human beings, but also demonstrated in the way ecology as a whole (nature, environment, fauna and flora) are valued and treated. All these have dire consequences that threaten the continued existence and survival of living organisms on planet earth. The environmental concerns and the ramifications of global warming on the health situation are urgent challenges for the global family.

Africa is already grappling with the realities of the scourge of HIV and AIDS with devastating effects on the continent's health and productivity (Mash *et al* 2009:3-5). The majority of people living with HIV in Africa are between 15-49 years of age and are in the prime of their working lives. AIDS damages the economy by depleting skills. By making labour more expensive and limiting profits, AIDS makes investment in African businesses less desirable (Mash *et al* 2009:5).

Furthermore, high poverty levels in Africa are the main contributor to high levels of incurable diseases on our continent. Poverty and diseases have an incapacitating effect on African life and vitality. Therefore, there is a renewed urge by African people to free themselves from generational curses of poverty and diseases. Hence, many efforts were made by African leaders to emancipate Africans and work towards an African renaissance (Van der Walt 2003:494). Although the role of religion is not recognised in former President Thabo Mbeki's quest for African renaissance (Van der Walt 2003:505), the Church in Africa is part of African society and has a role to fulfil in creating a better and more fruitful Africa, as envisaged by the ten point vision for African renaissance (Van der Walt 2003:500-504). Therefore, the work of the Church in Africa should also be seen as part of a holistic response to African issues.

The Pentecostal churches in Africa advocate healing and power evangelism (Asamoah-Gyadu 2007:310) that depicts Jesus Christ as Lord over all situations, including sicknesses, witchcraft, and infertility. It is understood that Pentecostal type of preaching and deliverance ministries serves as a vital factor in breaking the cycle of poverty and diseases from a spiritual perspective (Asamoah-Gyadu 2007:307).

The quest for an African Renaissance and better living conditions that are advocated by African political leaders have also opened a way for the dynamism of the healing ministry among African societies. This is justifiable when realising that an African Renaissance argues for a comprehensive and multi-faceted approach in response to African challenges of poverty, diseases and conflicts. The multi-faceted approach covers spiritual, social, economic, cultural and political key response areas. Despite all the odds against Africans living in Sub-Saharan Africa, the Church of Christ is growing at an amazing rate on the continent (Hendriks 2007:29).

Africans are drawn to the preachings of the “prosperity gospel” as a result of poverty and all its effects. This is an enticing gospel (Kalu 2008:259) that originated in the United States of America, and many Africans seem to embrace it with the hope of escaping the vicious circle of poverty and diseases.

Where poverty, diseases and incurable illnesses reign, there is a high desire for physical healing. Hence, Africa is a fertile ground for faith healing practices (Kalu 2008:263). Faith healing practices<sup>1</sup> are an undisputed reality in many African churches. Masamba ma Mpolo (1994:15) already stated in 1994 that “healing only by use of a spiritual dimension such as prayer alone is one of the new phenomena attracting thousands of people to the Christian churches in Africa. It seems to be the quickest and easiest methodological approach to counselling for liberation from anxiety, fear, attack and from evil spirits, and a way to seek protection from socio- economic and political aggression.” This statement is a reflection of how mysticism and awareness of the supernatural is part and parcel of African epistemology, which is built on strong religious undertones (Masoga 2001:169).

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<sup>1</sup> Faith healing practices are various activities that healers engage with during healing services, such as praying for the sick, anointing the sick with oil, exorcism, deliverance prayers from bondages, the binding of evil spirits and releasing blessings and prosperity utterances to believers.

The macro-economic and social challenges Sub-Saharan Africa faces are a reflection of daily reality for many people in Namibia. Namibia has high economic disparities between the rich and the poor; and this gap is ever increasing (The Economist 2011:58). The scourge of HIV and AIDS, poverty and high unemployment are threats to productive and wholesome living for the majority of Namibians (The Economist 2011:58). The main group of people exposed to faith healing practices are those in the low economic stratum of our societies, who cannot afford specialised medical services. Healing services are mostly cost free and promise instant results, which attract the poor who have little or no alternatives for health treatment. Professor Allan Anderson (2002:526) observes that the majority of people in the world are underprivileged, while state social benefits like health insurance are absent, and efficient medical facilities are scarce and expensive. This may be a contributing reason why faith healing appeals to many poor masses of Africa, who by far are the majority on the continent. Poor people face a host of stressful situations daily resulting from low income and substandard health care, which makes their crises very likely and frequent. Subsequently, when healing doesn't happen they feel hurt, misused and lost.

Although faith healing practice has made inroads into African societies, especially among the poor masses, the extent and the nature of its impact are not known. There is no evidence of serious reflection on the impact of healing prayers on people coming for healing, especially in cases where healing is not instant. The excitement and anticipation that go along with healing services seem to cloud any critical reflection on the outcomes of faith healing practice. Thus, the researcher seeks to reflect critically on the impact of faith healing practices and its impact on spirituality and emotions of people coming for healing. Assessing the impact of faith healing practice on healing seekers' faith and emotions are central in understanding the research outcomes in the areas of meaningful and productive Christian living in the midst of illness.

The faith healing practice is mainly done by virtue of healing prayers to healing seekers. In other words, faith healing practice is primarily prayer based with strong promises and anticipation of instant healing. Therefore, the emphasis of the research study is on people who are prayed for but not receiving healing as promised by faith healers. The research study plans to fill this void or silence on the extent of spiritual and emotional aftermath where faith healing prayers were offered, but illness still prevails.

The study does not assess the validity or credibility of the faith healing practice, but rather evaluate how the faith healing practice has affected people who were prayed for but not evidently healed. The empirical studies were conducted with selected believers of Pentecostal and Charismatic churches in the city of Windhoek, Namibia.

## 1.2. Motivation for the study

The study has been prompted by personal experiences and exposure to the faith healing practice. The researcher has observed in personal pastoral practice and by attending healing services that people attend healing meetings with the faith to be healed from their illnesses. Faith healers promise healing to anyone suffering from any kind of illness or disease (Theron 1999:57). The healing services are charged with what one may call the “atmosphere of healing” and strong anticipation of miracles to take place. People experience such a positive “energy of healing faith” in the services, and once prayed for, they leave believing that they are “physically healed”. To confess sickness after such fervent prayers is seen as lacking faith, and positive confession is encouraged despite symptoms (Anderson 2002:526,528,529). Consequently, it becomes difficult to give expression to any pain the body may still experience, as not everyone is healed in such services. This may lead to people suffering emotionally and spiritually with unanswered questions and “unhealed bodies”. This becomes a vicious cycle which people suffering with ongoing illness seem to be trapped into, as they seek healing. Therefore, the curiosity of the researcher was triggered and he wanted to know the spiritual and emotional impact of healing practice on healing seekers, especially when desired healing don’t happen.

People grappling with ongoing illness need encouragement to share their inner experiences of hurt as a way to gain ownership of their own needs and concerns and not to be stuck in blaming others or feeling victimised (Greenberg *et al* 2008:185). If emotions are not properly dealt with, it could lead to the blaming of someone else, or inappropriately taking too much responsibility for the unfolding of events that surround the injury (Greenberg *et al* 2008:185). The question remains unanswered as to how extensively one’s prayers can affect physical disease. Roukema (2003:7) states that there is medical evidence that shows spontaneous cures even with the worst diseases, such as inoperable cancer. He alludes, however, that there are no immediate explanations for these remarkable restorations of health. In his view, if such

cures happen to be associated with prayers of a fervent believer, then the cures, of course, are ascribed to faith healing (that is, to miracles).

Reflecting on the spiritual and emotional impact of faith healing unabatedly forces one to assess healing from a broader framework, and not merely as a physiological reality. The quest is for approaches that foster holistic and integrated ways to respond to the plight of people suffering with ongoing illness. There are many other questions resulting from such reflection: Is there some pressure or expectation on people grappling with illness to confess healing after prayers, even if they are not healed? What resources do such people need to cope with their illnesses? All these are concerns that need some investigation and which motivated the researcher to engage with the study.

This study strives to assess the faith healing doctrine as practiced by faith healers in Pentecostal and Charismatic churches, especially in relation to pastoral care. This in turn will enable the researcher to highlight the emotional and spiritual battles encountered by believers in their daily grapples with illness. Ultimately, the research aims to benefit people not healed after prayers to cope and manage with illness in their quest for meaningful and productive Christian living that depends on the sovereign grace and loving care of almighty God.

### 1.3. Research Problem

The independence of Namibia on 21 March 1990 brought many opportunities with it. Prior to independence people were oppressed and restrained with little hope and few aspirations. Independence has introduced many possibilities and many opportunities; one result of this freedom has been the mushrooming of Pentecostal and Charismatic churches in the country with their emphasis on evangelism and healing. Generally, the practice of faith healing has proven (Anderson 2002:533) to be a powerful tool for evangelism and church growth in Africa among Pentecostal and Charismatic churches.

Historically, faith healing practices for Pentecostals have almost exclusively been about praying for healing of the sick (Anderson 2004:494). Healing crusades or healing services are popular in the African context, as many people flock to such gatherings to be cured of illnesses and diseases (Anderson 2002:525). Faith healers promise people deliverance and

healing from all kinds of conditions. Many genuine and sincere Christians who are prayed for, however, are not instantly healed from their illnesses as promised by faith healers (Theron 1999:57). People who are not healed after receiving faith healing prayers may be subdued to inner pain, inner hurt and faith conflict (Theron 1999:57, 59). This may be unexpressed, yet may severely torment the victim. Promises of healing that faith healers make in the way the healing services are advertised to offer guaranteed results, and that at actual healing services people are promised instant healing cause high expectations. As such, when persons are not healed after healing prayers it becomes a mental and spiritual battle to make sense of why they are not healed. This may result in guilt or sense of blame that own faith is weak or not sufficient; but also cause some restraint and fear for not knowing how confessing that prayers did not result in healing would be received by a faith healer (who was confident of positive outcomes). A predicament arises when an ill person feels handicapped and overwhelmed by something perceived to be stronger than his or her own ability. These results after failed attempts to mobilise old coping skills and resources (Louw 1994:3), after all desperate attempts have failed, and one's own shortcomings and inabilities are exposed a crises situation arises. Louw (1994:1) states as follows: "The tension increases to such an extent that we begin to disintegrate and negative feelings, for example fear and desperation, take over. The common reaction is 'I cannot take it any more; it is too much for me; I cannot cope on my own any longer.' In a severe crisis the feeling of inadequacy could lead to an experience of anxiety, insecurity, loneliness and despondency."

The aforementioned scenario caused by illness and resulting pressures from faith healing practice need a broad responsive strategy of intervention. The researcher has observed the following issues with the faith healing practice and endeavours to address these through the research study:

- The belief and expectation that prayers will guarantee healing without taking cognisance of God's sovereignty or openness to any other outcome may have serious implications when healing doesn't materialise: It may lead to discouragement and despondency and exert pressure both on faith healer and the healing seekers. Another possibility could be that it may lead to the neglect or minimising of the effects caused by illness, and subsequently, failure to address illness with holistic intervention strategies responding to the physical, emotional and social challenges that the illness causes.

- The faith healer has the pressure to perform a healing miracle as a result of the high expectations he/ she has created, while the healing seeker is placed in an awkward position, as being unhealed may be perceived as lacking enough faith or having sin in his/her life. Although the emphasis of the research is on the experiences of healing seeking persons, nevertheless the pressure because of expectations has a spin effect that also bears on the integrity of the faith healer. Anderson (2004:495) observes that:

The excesses in Pentecostal healing practices, especially those found in some Charismatic independent churches, had created prejudice against genuine healing ministry. The elevation and veneration of the healers, their lack of humility, their dependence on tools and techniques, the preoccupation with large churches that hinder real relationships between people, and the flow of people into healing services with little follow-up are some of the challenges that need addressing.

Thus, the observations mentioned previously necessitate the investigation of psychological and spiritual effect of faith healing on people grappling with ongoing illness. The research explores the effects emanating from faith healing practice when people are not instantly healed. The possible problems of disillusionment, pain, confusion, sense of abuse and questions on faith and spirituality will be dealt with throughout the study. There is not much material in the literature that deals with the emotional and spiritual impact of what one may call the “unanswered prayers” in the context of faith healing. Thus, the research project will fulfil a vital gap by responding to this need.

#### 1.4. Practical Theological Methodology

Practical Theology deals with a particular context by interpreting what has been discovered, through application of Christian norms with the view to constructing a model of Christian practice. This process involves epistemological and hermeneutical exercise. Therefore, practical theology is transformative in nature and should employ a framework that allows interdisciplinary work and interpretation of experience in a given context (Park 2010:1f). A fundamental shift has occurred within society over time, and Christianity is no longer seen as normative expression of any culture (Ballard & Pritchard 1996:3). We live in times of postmodernism and pluralism, which tolerate different faiths. On the other hand, the rapid increase in social sciences and various related fields since and after the Second World War,

such as social work, education and psychology, has required Christianity to engage or dialogue with these new intellectual challenges (Ballard & Pritchard 1996:3). Ultimately, all these disciplines reflect on the praxis and the role of the Church and theology in responding to the plight of humanity. Thus, practical theology became an important vehicle for Christian response to issues of modern culture.

Traditionally, practical theology was seen as a sub-discipline of theology; this has changed over the last three to four decades however. Dave Hazel, a United Church minister in Jamaica, (1999:345), indicates that the whole nature of theology has been re-examined, including the place of practical theology within it. The redefinition of theology and the place of practical theology in recent years have opened a dynamic relationship within the various disciplines of theology. Hazel (1999:350) states that a practical orientation to theology is characterised by a richer inter-relationship between different branches of theology and between theology and other disciplines. From this perspective, practical theology is not just the phase of application of theological theory, or a bridge between theology and practice. There is a multi-directional flow between aspects of theology rather than the unidirectional flow. The research study integrates such a multi-dimensional nature of practical theology and engages with some aspects of psychotherapy and secular models dealing with care and counselling in its pursuit of a holistic healing paradigm for people grappling with ongoing illness. This is done within the dynamics of interviews and shared experiences of targeted individuals. In fact, this research study would not be possible without the communication process, which is governed by various language expressions and understanding of different cultural realities of the interviewees. Viau *et al* (1999: XVI) indicate that “the entire discourse of practical theology is a product of a language, or in other words, the product of a system of signs defined, in a whole or in part, by faith practices of Christians .... The rebirth of theology that perceived theology as having a more practical orientation. The production of theological discourse consists of presuppositions and sentences, which, laid out in a more or less systemic manner, shape the linguistic apparatus.” This is an important observation, as it suggests that engaging in practical theological discourse has its own context and rules for interpretation. Practical theology should produce a theological discourse that is a body of utterances governed by the rules of semiotic process, which uses signs as occurrences of Christian religious belief incorporated in experiences (Viau *et al* 1999:193). In general, theology has an inborn inclination to the experiential side of religion (Heimbrock 2011:153).

This doesn't suggest that practical theology is a non-scientific field, but rather demonstrates the broad nature of practical theology and its methodology. Hans-Günther Heimbrock (2011:154), a German theologian, highlights three facets of practical theology, namely "that it always relates and reflects the religious life of a congregation, that it makes use of scientific models, concepts and methods developed to study religion for academic research, and finally that it participates in overall reflection on faith, culture and life from a bottom-up approach." This approach starts with practice to challenge the notion of "pure faith" with concrete realities of everyday life towards responsible practice of religion.

The study is underscored by practical theological methodology. The preferred methodology, in this case Richard Osmer's four task approach, is discussed as the whole study is structured around it.

#### 1.4.1. Prominent approach to practical methodology

The interdisciplinary relationship between theology and other human sciences should be viewed from the point of what Louw (2000:100) calls perspectivism. Louw states that perspectivism presupposes, methodologically, the method of correlation and correspondence. At the same time, differentiation is needed to safeguard identity. Both pastoral theology and psychology work with the same subject of human beings but from different context. They operate, however, from totally different paradigms (mindset, belief system and philosophical framework).

Louw (2000:106) argues on the question of methodology that pastoral theology cannot operate without the correlation between biblical texts and human context. It is quite evident that practical theology warrants its own methodology, which is contextually relevant and theologically sound to engage and analyse different human experiences within empirical setting. Richard Osmer's task four approaches to practical methodology are sufficient to engage the context of a person suffering with illness and to interpret it with psychology and theology for sustainable treatment options. The study makes use of practical theological methodology with special focus on the four task approach as explained by Richard Osmer. Osmer (2008:4) has suggested four questions as a guide to interpret various situations in practical theology. These questions are: What is going on? Why is this going on? What ought to be going on? How might we respond? The whole study is structured around these

questions, which informs also the different chapter divisions. The four questions that form the structure of the study are the descriptive-empirical task, interpretive task, normative task and pragmatic task, and they are shortly outlined as follows:

❖ The *descriptive-empirical task* explores the gathering of information to discern patterns and dynamics for particular episodes, situations and contexts. It deals with the first question of what is going on. In fact this task goes beyond mere gathering of information in crisis situations. Osmer (2008:33) argues that “it has to do with the quality of attentiveness congregational leaders give to people and events in their everyday lives. This is helpfully explored in terms of spirituality of presence.” Spirituality of presence has to do with attending to people in their otherness and in the presence of God. The main concept is attending that covers informal, semi-formal and formal attending:

- Informal attending involves listening and showing genuine concern with people’s plight.
- Semi-formal attending involves activities that have some sort of structure, such as small groups and focus groups where people shared and are supported in their crisis.
- Formal attending investigates particular episodes, situations and context that are analysed through empirical research.

The descriptive-empirical task will be used to discuss chapters 2 and 3 of the study. There is a need here to give a short description for the following terms: Episodes, situations and contexts.

‘Episode’ is an incident or an event that emerges from daily life situations and causes explicit attention and reflection. It is a single setting and happens over a short period.

‘Situation’ is a broader and longer pattern of events, relationships and circumstances in which an episode occurs. It is generally viewed as a narrative within which a particular incident is located in a longer story.

A ‘context’ consists of social and natural systems within which a situation unfolds. Osmer (2008:12) observes that “a system is a network of interacting and interconnected parts that gives rise to properties belonging to the whole, not to the parts”.

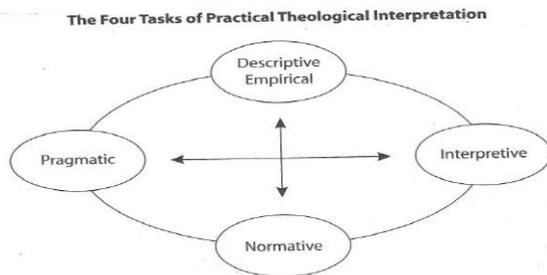
- ❖ The *interpretive task* employs various theories of arts and science to better understand why certain patterns and dynamics occur. Practical theological interpretation must seek for interconnections and realtions in experiences of people, and not only deal with individual cases. Practical theological interpretation is contextual. “It thinks in terms of interconnections, relationships, and systems” (Osmer 2008:17). The art of hermeneutic, which is the science of interpretation of ancient texts, is employed in practical theology to also include the interpretive task of ordinary people in everyday life. This is very fact to build rapport; listen to people and enable them to share their experiences of their struggles with illness. This is also in line with human beings, who are by nature geared towards interpreting their environments and life experiences to make sense of life issues. The interpretive task is also important for academic purpose, and in that sense for the study of this research. Hermeneutical dimension of scholarship is important, as it enables the researcher to engage with collected data and new insights to test theories and develop new concepts. The question of why is this going on is is dealt with by interpretive task under chapter 4 of the study.
  
- ❖ The *normative task* investigates the question of what ought to be going on by making use of theological concepts to interpret particular episodes, situations and context and to form ethical norms that guide responses and bolster learning from acceptable conduct. As Christians people who are suffering with illness grapple with additional questions related to conduct and behaviour such as: What ought to be going on? What to do in response to events of shared life and world? Osmer (2008:8) states that “these questions lie at the heart of the normative task of practical theological interpretation.” The normative task engages three dimensions of interpretation:
  - Firstly, it deals with certain type of questions that reflect on theological interpretations regarding episodes, situations and contexts. The following types of questions are asked here: In relation to what we know of God, how might God be acting in a situation or context of one’s life experiences? What patterns are fitting for possible human responses in these situations?
  - Secondly, these types of questions seek to find ethical principles, guidelines and rules that are relevant to a given situation of an affected person, and can contribute to devise action plans or strategies.

- Thirdly, the area investigates past and present practices of Christian tradition that provides normative guidance in the way Christian patterns are shaped and guided. People who are going through life crises must be enabled to reflect and share through scriptural examples on faithfulness of God and draw strengths from past traditions of God dealing with his people. This must be done to discern ways God may act in present challenges a person faces with the view to pave a way forward. Osmer (2008:8-9) indicates that “A key dynamic is at work here. The recitals of God’s actions in events like the exodus and wilderness wanderings provide identity descriptions of God. Yet these very descriptions of God’s identity are reinterpreted to articulate the new thing God is doing and will do as the people of God continue on their journey.” The normative task is dealt with in chapter 5, which reflects on theological issues related to responses to illness, suffering and health.
  
- ❖ The *pragmatic task* deals with the question of how we might respond by determining strategies for action that influence situations in desirable ways, as it engages in reflective conversation that emanates from such interaction. This is a task that involves critical thinking abilities from leaders. Osmer (2008:176f) suggests three forms of leadership, namely task competence, transactional, and transforming.
- Task competence is about a leader’s ability to execute his or her duties such as teaching, preaching and leading committees etc.
- Transactional leadership portrays the ability to influence others, in context of reciprocity and mutual exchange.
- Transforming leadership works towards change and leading the organization towards renewal and identity to fulfil its mission and mandate.

The significance of all these leadership functions is that together they express the spirituality of servant leadership. Working towards the spirituality of servant leadership is crucial for fulfilling task four, which reflects on the pragmatic task of practical theological methodology. Therefore, pragmatic focus is geared towards enabling people to grow and experience spirituality that is modelled according to life principles and teachings of Jesus Christ. The ultimate purpose is to realise that both the leader, in this case a faith healer, and the recipient, a healing seeker; are called to spirituality of servanthood. Therefore, they must minister to each other as fellow

beings that need mutual respect, care and appraisal. Osmer (2008:1919) states it profoundly “the Lord is a servant, and the servant is the Lord. Power and authority are defined. A reversal takes place. Power as dominion, or as power over, becomes power as mutual care and self- giving. Power as seeking one’s own advantage becomes power as seeking the good of others and the common good of the community.” The pragmatic task is discussed in chapter 6 and deals with ways to enable people suffering with ongoing illness to solicit resources to live hopeful and courageous despite facing challenges of ill- health.

Ballard and Pritchard (1996:16) also suggest four tasks for practical theological methodology; these tasks complement those by Richard Osmer, although they are differently termed. The categories they use are the descriptive task, normative task, critical task and apologetic task. The following image of a hermeneutical circle shows the distinct, but interrelated nature of the four tasks of the practical theological interpretation:



This is more a spiral than a circle, which constantly resorts back to the task that has already been explored. A back and forth spiralling process continuously happens as insights emerge. Thus, the first question of what is going on enables the researcher to gather information about the research question and employ the descriptive-empirical approach. This question is vital to the study, as it allows investigation of the spiritual and emotional state of people grappling with illness and who have undergone faith healing practices. The nature of the research requires the use of theories of other fields like anthropology and psychology as part of practical theological interpretation (Osmer 2008:8). The cross-field referencing and utilisation of various resources are confirmed by Ballard and Pritchard (1996:17), who state

that “because of its focal concern for Christian practice, practical theology draws on the methodologies of the social sciences as its critical partners.” Theoretical interpretation is an important task, as it draws on theories of arts and sciences to respond to particular episodes, situations or contexts (Osmer 2008:83).

Another model that is complementary to this one by Richard Osmer and also helpful in this research, is the pastoral cycle by Paul Ballard and John Pritchard (1996:74-86). The pastoral cycle has four-fold action, consisting of key areas of experience, exploration, reflection and action. The pastoral cycle employs various aspects of the four approaches discussed at the beginning of this section to create a socially reflective response to pastoral situations. In explaining the key areas, they argue that theology emanates from shared experienced based on Paulo Friere’s notion that knowledge as power is a reciprocal experience between the teacher and the student. The research study is underscored by this fact of human dignity and the conviction that a person suffering illness is not less valuable than the faith healer as they are co-equals. Theology is done and interpreted from the viewpoint of the poor and marginalised.

The research study recognises the socio-economic factors that contribute to illness and health, and how this gravely impacts on the wellbeing of poor and marginalised members of society. Therefore, the research study engages and allows vulnerable people suffering from illness to share their own experiences and to be heard, listened to and respected in the quest of healing and wholeness. Ballard and Pritchard (1996:17) further view theology as dialogue between various groups, classes and people. The dialogue is around making sense of the situation, discussion of possible action strategies and on assumptions and value systems to be considered at various levels. The fact that practical theology feeds from other traditions, boundaries and fields in creating its own context is an important point to reiterate. This fact supports the multi-faceted approach of practical theology and the researcher endeavours to integrate various fields dealing with the impact of faith healing on people suffering from illness. Theoretical engagement is done from the understanding that any theory is not an absolute truth, but only an approximation of truth. Osmer (2008:83) calls this fallibilist, which suggests that theories are fallible and always subject to further testing. This informs the research study in the manner data is handled within the research. In fact, the question of faith healing is not investigated with the aim of verifying or disputing its legitimacy. The

research seeks to observe, describe and analyse the experiences of people grappling with illness; this is done with the view to establish a framework for holistic treatment. In order to propose an alternative response to cope with illness, there is a need to employ normative task, which involves normative discernment.

The research works with the imagery of Jesus through the threefold function of Jesus as king, priest and prophet. This is done to highlight the normative task of practical theology as it relates to people in their own episodes, situation and context. The important characteristic of prophetic function is the realisation of what Heschel (1962:26) states as “a fellowship with the feelings of God, sympathy with the divine pathos.” The concept of a passionate God who understands the suffering of his people becomes an important capstone for pastoral ministry and a basis for caring for those in need of healing. This is done from a theological and ethical interpretation within the normative task of practical theology. Osmer (2008:139) states it profoundly, as follows: “Just as attending in the descriptive task opens out to empirical research and sagely wisdom in the interpretive task, to dialogue with theories of arts and sciences, so too the normative task opens out to forms of theological and ethical reflection. In discerning what we ought to do in particular episodes, situations and contexts, we will do well to use an explicit approach to forming and assessing norms.” This statement demonstrates the fact that practical methodology is imperative for this research study. It dictates the way the research is conducted and forms the undergirding basis for the dissertation.

Doing research in practical theology strengthens the whole ethos of theology. This is confirmed by Heimbrock (2011:153), as follows: “Christian theology follows a twofold practical interest, in its analytical endeavour it tries to reconstruct praxis, and in its formative attempt it tries to give way to experiences in line with the freedom of the gospel.” Understanding the very type of religious experience connected to life-world-experience is crucial. In this light, Heimbrock (2011:163) indicates that “no serious theoretical attempt to deal with religious experience can ignore the difference between the life-world-experience and theoretically detached reflection. However, experience grasped as matter related to the fullness of human existence can be adequately represented in the theoretical sphere only, if the description does right to the actual first-person-perspective.” In this manner, Mattias Jung (1999:265) also further states that the phenomenon to be explained does only come up

by the subjective meaning giving activity. In other words, although practical methodology assesses human experiences and situations, it has value and credibility to be treated in its own right as a credible discipline.

### 1.5. Research Design and Methodology

The study employs empirical research methodology. The main research design employs qualitative research methodology as its basis. This involves various tools for data collection, namely face-to-face interviews, tape-recordings and surveys. The following section gives a brief summary of the background of research methodology employed in the research study. The main part on research methodology that covers technical aspects such as data collection, sampling, transcription and data-analysis is explained in chapter 3, which deals with empirical research.

#### 1.5.1. The Qualitative Research Methodology

Qualitative research seeks answers to questions by examining various social settings and individuals who inhabit these settings. Thus, this kind of research deals with how people arrange themselves and make meaning of their surroundings through symbols, rituals, social structures, social roles, and so forth (Berg 2009:8). Qualitative research methodology is primarily used to examine, compile and draw conclusions around the question of faith healing and the problems it may cause if not dealt with maturely and theologically. Qualitative research is chosen for this study because it is rich and versatile and cuts across various disciplines, opening ways for multiplicity and diversity in approach (Struwig & Stead 2001:10). This methodology is best suited for the research as a means to collect and analyse information (Blaxter *et al* 2001:64). Hence, the researcher makes use of measuring tools suited for qualitative research, as outlined in the underneath sections. In practical theology, the debate is always about the methodology (Dreyer 1998:18).

There is a growing consensus that qualitative and quantitative methodologies could be used in a complementary manner (Dreyer 1998:19). There are many debates about the use of quantitative and qualitative methods of research. Some people (Blaxter *et al* 2001:64) view them as very different and distinct, while others are happy to mix them and use them interchangeably. As the qualitative approach is exploratory in nature, the researcher makes

use of the participants' own world and understanding of events in analysing their social settings and experience as given in response to the research question. The researcher makes use of an interactive process, where experiences of participants are shared and lessons of what has happened are reflected upon. The attempt is to keep an open mind and to foster new lines of enquiry. This does not close the possibility of using the quantitative mode as the research project evolves, however (Allan & Skinner 1991:180). Although the major part of the research deals with empirical research epistemology, the underpinning conviction of the research is still the evangelical ethos of faith.

This adoption of social-scientific methodology in theology and religious studies does not imply, however, that practical theologians agree on the methodology of empirical research. Anyone who wants to conduct empirical research has to choose from a vast array of research paradigms, strategies, methods and techniques embedded in different meta-theoretical and theoretical frameworks (Dreyer 1998:15).

The empirical methodology has that niche to bridge the gap between what Ricoeur (1976:21-28) discusses in his hermeneutical theory as the tension between the ideology and utopia that is experienced in religious or Christian tradition. The empirical research has a positive aspect and contribution to the research study, especially in its role to create a platform for self-discovery and self-exposure in order to get better control of one's own life and environment. Van der Ven and Scherer-Rath (2005:9) state that "empirical research from a theological perspective can contribute positively by giving insight in the religious imagination, the symbolic frameworks, the attitudes and ideas that influence people's religious actions." Thus, the empirical research methodology is an ideal medium to evaluate the practice of faith healing in pastoral care, especially creating an environment where affected people can express their feelings and their emotions and how these relate to their faith in Christ.

The quality of the envisaged research project is further enhanced by empirical methodology as a result of its generic nature and openness to other social science disciplines. The research cross-fields practical theology, counselling and psychiatry in its attempt to understand emotions and certain medical conditions of the target group. Van der Ven and Scherer-Rath (2005:33) indicate that "the development and use of empirical methods has been crucial in creating new discourses both with other theologians and with social scientists."

### 1.5.2. Process of data gathering

Various instruments that deal with gathering and analysing of information are discussed. All these instruments allow the researcher to follow an inductive approach, beginning with empirical observation and resulting in development of theoretical categories (Blaxter *et al* 2001:14). Dealing with the inductive mode of reasoning is quite vital, as the inductive mode creates a mechanism to test, reject or validate the seemingly opposing viewpoints around faith healing (Mouton 2001:167).

Field research has its own challenges, such as how to use translations in cases of language barriers and creating a safe space for people to express themselves without fear and favour. The realities are that poor people live in crowded spaces where privacy is difficult to maintain. The researcher understands these kinds of challenges and will ensure best possible alternatives that would not compromise the validity of the research outcomes. Theoretical research is primarily done by academics, while applied research is engaged by both academician and practitioners (Fern 2001:4). The researcher makes use of grounded theory. Blaxter and others (2001:15) observe that “this method aims to construct theory by producing concepts that fit the data. The theory is thus grounded in the data from the study.” The data received from field studies inform the theoretical framework that serves as the basis for formulating findings and conclusions for the research. It is a theory that is systematically developed from the study of phenomena (De Vos 1998:81). The data collected is used to develop theories as the basis for the research results and to contribute towards the establishment of a crisis-intervention model as the final product of the research outcomes.

### 1.6. Scope and Limitations

The faith healing practice is quite a controversial exercise in Christian circles and has been debated from different theological viewpoints. There is a great number of literature dealing with faith healing practice, but it is mostly written by American authors with a particular theological position. Some views support the faith healing practices, while others are sceptical about the practice (Anderson 2002:530). The value of this research, however, is that it looks at the facets which have been most neglected - on the question of how we minister to people hurting and distraught after failing to be healed by means of “faith exercise” (Findlayson n.d.).

The scope of the research is clearly defined by the topic, namely, faith healing practice in pastoral care: A pastoral assessment. Thus, result outcomes are confined to this scope. The interest and the focus of the research is to work towards a pastoral support strategy that will give some hope and ensure restoration and wholeness for those suffering with illness. This research project collects data from Christians who struggle with ill health despite prayers of healing; the focus is on the spiritual and emotional impact resulting from “unanswered prayers of healing”. The demarcation further enables the researcher to carry out the research with relative accessibility and cost effectiveness because of valuable contacts and resources available in the identified city.

#### 1.7. Significance of the Study

It is generally understood that the Church in Africa is growing at an alarming rate (Joe & Phiri 2007:22f), but generally perceived to be shallow on Christian maturity. This is also reflected in the manner that the faith healing practice is conducted in Africa. There is a little reflection on the impact of faith healing practice as such; preoccupation is with the excitement of doing healing. Therefore, the research will contribute valuable information in the areas of faith healing and pastoral counselling, especially on how to respond to the spiritual and emotional disturbances in people who are evidently not healed after a faith healing exercise. The research works towards the boosting of such persons’ faith in Christ and affirming their human dignity. Thus, it is restorative and emancipative in nature, enabling these believers to come out of their closet of “silent suffering” for fear of ostracism and from being labelled as “lacking faith,” to a life of wellness and wholeness in Christ to the glory of God.

The research is done within the African and, more specifically, the Namibian context, which offers a unique and contextualised contribution to the faith healing discourse from pastoral care and counselling perspectives.

### 1.8. Research Goals

The Pentecostal and Charismatic churches are known for vigorous evangelism and a healing ministry, which has contributed greatly to the growth and expansion of these churches in Africa. Thus, the primary focus of this research is to explore the extent of the faith healing practice on people who are not being healed, especially the spiritual and the psychological impact. This is done from the understanding that modern faith healing practices mainly deal with psychosomatic diseases, and that a link should be established between faith healing and psychotherapeutic treatment for these psychosomatic factors. Chapter 4 elaborates further on the relationship between psychomatic diseases and faith healing practice. The research study has as its goals the following:

- To assess some of the main contributors to illnesses in Africa, namely poverty, unemployment and HIV/ AIDS and how these relate to faith healing practices.
- To assess what the impact of healing practices are on the spiritual and emotional state of healing seekers.
- To seek a holistic intervention support strategy to deal with illness and health realities which include hope and compassion as elements of pastoral approach.

As faith healing is based on a strong concept of positive anticipation or expectation of positive results, the research will respond to this in view of God's sovereign reign over all facets of our lives, even when experiencing "unanswered prayers".

### 1.9. Research Hypothesis

Babbie (2004:44) states that "a hypothesis is a specified, testable expectation about empirical reality that follows from a more general proposition; more generally, an expectation about the nature of things derived from a theory. It is a statement of something that ought to be observed in the real world if the theory is correct." This is an important observation also confirmed by De Vos (1998:116), as follows: "Hypotheses are statements about the relations between variables and they carry clear implications for testing the stated relations."

The faith healing paradigm is one of the main components of African spirituality and is unabatedly practiced in many religious circles. The socio-economic hardships of poverty, unemployment and cultural breakdown have contributed a great deal to various illnesses and

diseases in Africa. This has been one of the breeding grounds for the faith healing practice in Africa. The psychological and spiritual effect of such practices on believers however, is under researched, especially when we consider cases where faith healing prayers were made without apparent healing manifestation. The following hypotheses underpin and create a philosophical framework for the study:

#### 1.9.1. Hypothesis 1

Faith healers often create high expectations of healing to people suffering with illness by making promises to heal people through faith healing practice. This creates faith conflict and emotional crisis for people when they are not ultimately healed (Theron 1999:57). Thus, the indiscreet use of faith healing practices (Woolmer 2000:243) leads to pain and hurt for some genuine and well-meaning Christians in need of help from physical ailments. It affects such peoples' emotional, psychological and spiritual state of wellness, leading to pain and trauma with serious spiritual and emotional effects (Lynch 1999:112). People who are not healed after being promised healing by faith healers may experience additional ongoing ill- health<sup>2</sup> conditions, also psychological suffering. Roberts, Kiselica and Fredrickson (2002:423) indicate the common negative reactions of anxiety about pain and discomfort, fear and uncertainty about the future, and depression. This is confirmed by Theron (1999:57), by stating that: "Apparently such people suffer from guilt-feelings and even rejection because of their situation."

#### 1.9.2. Hypothesis 2

Faith healers mainly deal with psychosomatic diseases, which may best be treated by pastoral therapy. Many illnesses that are claimed as being healed during faith healing practices such as headaches, ulcers, evil spirits, pain in chest etc. have strong psychological aspects to it and therefore need more than just a good prayer. Such illnesses may better and effectively be treated through holistic intervention strategies that involve psychotherapy and counselling. A good psychotherapy approach involves (Goodheart & Lansing 1997:65) "an understanding of the illness, the patient's response to the illness, and the patient's personality functions and individual history."

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<sup>2</sup> See the conceptualisation of terms such as illness, ill- health, healing and others under heading 1.10; from pages 31-37.

Therefore, the research seeks to address the question of how faith healing practice affect ill people who are promised healing and prayed for, but subsequently not healed. This is done from the perspective of African epistemology and spirituality around the question of illness and health and introduces concepts of holistic healing and restoration as intervention strategies. The effect on the spirituality and personality of such believers, as viewed against Christian productivity and wholesome living, must be determined. In this regard, a hermeneutical and systemic understanding of faith healing in terms of what is meant by Christian spirituality plays an important role. There is a need for mechanisms and systems that would offer people facing trauma as a result of ill- health ways to manage with their situations and to pursue wholeness and fulfilment in Christ. Those experiencing emotional and spiritual trauma because of “unanswered prayers” after healing did not take place, need a system that responds not only to their physical need, but also addresses their longings for essence of life. In fact, counselling is effective in dealing with the disequilibria caused by faith healing practices. The psychologist, Romeria Tidwell (1992:246) states that when a person regains equilibrium, this enables him/ her to some degree to resolve problems that cause need for therapy. In the light of all aforementioned factors and assumptions, the research goals seek to direct the research process to inquire, investigate and propose suggestions that would benefit ill and hurting people in pursuit of healing and wholeness.

#### 1.10. Conceptualisation

There is a need to explain the meaning of some cardinal terms used in the research in order to avoid any misinterpretation. The following terms are explained: Church, illness, sickness, ill-health, healing, cure, psychosomatic diseases, and emotions.

##### 1.10.1. Church

The researcher makes use of different notions of the word church, such as early church, African church, Evangelical church and Pentecostal church. In these cases, the meaning becomes clear as it defines a specific church period or certain Christian movement or denomination. In cases where the word church is independently used, however, it is to be understood as follows: Church capitalised in the study refers to the world wide church of God, whereas church in lower case usually refers to a particular denomination or a local

church (Le Roux 2011:98). This definition is also confirmed by well-known missiologist, Patrick Johnstone (2000:11), who indicated that “Church” refers to the whole visible church on earth, including all who call themselves as Christians, and that “church” means a local church or congregation of believers. This is in line with the general usage of these words over centuries by Christians. Generally the Church is conceived (Le Roux 2011:98) “as one, holy, catholic and apostolic.” Thus, a local church is an assembly or a congregation of believers in a certain geographical setting with a distinct denominational or doctrinal affiliation.

#### 1.10.2. African Independent Churches

The term African independent churches indicate that these churches have originated in Africa and have no foreign or ecclesiastical control (Bediako *et al* 2004:96). In other words, these are autonomous groups with African leadership and usually all African membership. These churches are labelled according to origin, historical period, geographical location and theology as prophetic, Ethiopian, African or Nationalist, spiritual, Zionist, Aludara or prophet- healing; Charismatic and Neo- Pentecostal (Bediako *et al* 2004:96). The reference here to Pentecostal and Neo- Pentecostal Churches must not be confused with classical Pentecostal Churches that have American or European origin. African initiated Pentecostals meet the requirements related to African Independent Churches as stated above.

#### 1.10.3. Pentecostal Churches

There were indications of early Pentecostal experiences in the Holiness Church, Tennessee in the 1890s; and later at the start of the twentieth century many independent prayer and revival groups were started in Wales, Scotland and India. However, historical consensus (Kay & Dyer 2004:xxv) attributed the Azusa street revival in Los Angeles, 1907 as the crucial starting point for pentecostalism. It was here were the main protagonists of Pentecostal life and experience first caught fire (Kay & Dyer 2004:xxv). It started in the poor suburb of Los Angeles with a mixed congregation, led by a black preacher- a freed slave, W.J. Seymour. The congregation experienced the outpouring of the Holy Spirit with speaking in tongues. This experience resulted in a strong zeal for evangelism and mission work that causes expansion of the movement to other parts of the world in a relatively short span. The protégées of American and European Pentecostals are found all over the world, and have also established various Pentecostal Churches in Southern Africa. The wellknown examples are

the Assemblies of God and the Full Gospel Church. The classical Pentecostal doctrines are: Speaking in tongues, evangelism, prophesy, Second Advent, literal millennium and healing (Kay & Dyer 2004:25f).

#### 1.10.4. Charismatic Churches

The beginning of the Charismatic movement is usually dated from 1960s, an era of social change and freedom-loving individualism, in which the old mainline denominations were facing a culture they were unfamiliar with. Charismatic movement started within the mainline denominations, as an off spring of Pentecostal doctrines and experience to which venerable ecclesiastical traditions for which these were altogether unexpected phenomena. In that sense, classical Pentecostal could be called 'the first wave' and Charismatics 'the second wave' (Kay & Dyer 2004:xxxii). The majority of Charismatic Churches in Southern Africa have American and European origin, of which the well known examples are the Vineyard Ministries, the Rhema Church and His People Church.

#### 1.10.5. Illness and sickness

The distinction between illness and sickness is important to show in order to structure the research around it. Thus, Louw (2008:105-106) distinguishes between the two terms as follows: Sickness has to do with the biological and physiological dimensions of medical pathology and total predicament of being a patient or being hospitalised. Illness on the other hand is the patient's awareness of the illness, his/ her responsive behaviour, perceptions and emotional experience of pain. A patient's behaviour and views affects how a patient responds and copes with his illness. There is a distinction between illness behaviour and sick role behaviour. Illness behaviour involves activities oriented toward determining one's state of health undertaken by people who feel ill, and finding suitable remedies, while sickness role behaviour involves people who consider themselves to be ill, either because they were formally diagnosed or because of self-diagnosis (Louw 2008:105).

Social dimension is important in dealing with sickness, especially in the African context. Turner (1996:717f) emphatically agreed with others and stated that illness is a socially or culturally devalued condition that sets people apart and discredits or disqualifies them from full social participation. Sickness brings disruption to relationships and also causes stigma

and degradation in certain instances. This is quite important, as illness should be viewed as more than mere physiological-biological reaction. Illness is a personal reality with physiological, biological, psychological, existential, sociological and religious dimensions. It affects the person in totality. The following general definition stated illness as (Louw 2008:107-108) “a disturbance or disharmony in the optimal psychosomatic functioning of the body system and the human person, including the possibility of an existential disorientation which affects the social and psycho-religious functions of the total person. Illness can also be described as an obstacle resulting from the lack of effective functional meaning systems and future-oriented values. Illness is closely related to sick behaviour and dysfunctional reactions.”

#### 1.10.6. Ill-health

Ill-health is combination of two words, “ill” and “health”. These words are shortly explained as background to understand what ill-health is. The aforementioned distinction between illness and sickness have illustrated that sickness is a blanket term that expresses human experience of illness and diseases; while illness is an explanatory term that describes human perception, experience and interpretate illness from personal and social reality, in that sense it is a cultural construct (Pilch 2000:25). On the other hand, health as defined by World Health Organisation is “a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity” (Pilch 2000:24). Thus, ill- health is personal and social perception and interpretation that physical, mental or social disturbance in one’s state of well-being has taken place, as perceived from culturally relevant interpretation.

#### 1.10.7. Healing and cure

Richardson (2009:193) observes that “whereas cure is operational, measurable and narrow, healing is wide and subjective. Cure can be part of healing, but it is not necessarily so. On the contrary, healing can be experienced even when there is no cure.” In that sense, “curing is the anticipated outcome relative to disease, that is, the attempt to to take effective control of disordered biological and/ or psychological process. Healing is directed toward illness, that is, the attempt to provide, personal and social meaning for the life problems created by sickness. Treatment can of course be concerned with one or the other aspect of human problem (disease or illness), and either or both can be successfully treated” (Pilch 2000:25).

As partners with medical practitioners, especially in hospital ministry, churches promote cure, but the churches' overall focus is wide and holistic healing (Gennrich 2004:94). The healing function of the Church is more than just curing of diseases; it has to do with the well being of a person in his/ her totality. Therefore, healing is geared towards restoring to health or helping a person suffering from illness or disease to live a meaningful and productive life.

#### 1.10.8. Psychosomatic diseases

The psychosomatic factors deal with the relationship between the body and mind. Psychosomatic diseases should not be confused with somatization<sup>3</sup> disorder, although they are related they are still different manifestations. This condition usually develops into psychosocial distress (McWhinney *et al* 2001:235). The patient complains of physical symptoms, for which there are no demonstrable organic findings (Lipkowski 1987). Somatization is a term used in Western medicine as a result of its dualistic ontology and has as its basis in the assumptions that (McWhinney *et al* 2001:236) “emotions instead of being expressed symbolically in words, are “transduced” to bodily events, and further assumption is that our emotions are embodied in the first place.” The concept of somatization is foreign to many cultures, especially in Africa, as we do not differentiate between mental and physical illness *per se*. There is also no clear distinction in African epistemology between illness as symptoms experienced and disease as a biological process. In fact, until the nineteenth century, the Western world maintained a unitary view of illness, whereby a patient was diagnosed and not the disease. In the twentieth century, the unitary view was replaced by diseases viewed as having a bodily location that brought about the eventual separation of mind from the body (McWhinney *et al* 2001:237). In the final analysis, somatization is understood in the Western medical world as bodily expressions or emotions that are ‘in the mind’ and therefore not “real” and can only be attributed to mental illness (McWhinney *et al* 2001:237). Louw (2008:37) remarks that “illness is closely related to neurological and psychological factors. Mindset and attitude play a role in the experience of being either sick or healthy. Ulcers, for example, may be the result of severe stress. Sometimes people who believe they are ill start to present symptoms of a specific disease.” The close link found between the psychological factors and physical health/ illness is clearly seen, for example, in

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<sup>3</sup> Somatization disorder is defined as a tendency to experience and communicate somatic distress and symptoms unaccounted for by pathological findings, to attribute them to physical illness, and to seek medical help for them (Lipkowski 1988:1358-1368).

how cancer manifests itself. Larson *et al* (1989:265-278) observe that people committed to faith and religion have less stress than those with no such commitment. The purpose of psychosomatic medicine is to treat the influence of psychological factors (e.g. stress, anger) or philosophical problems relevant to physical diseases (Benner & Hill 1999:984).

#### 1.10.9. Emotions

Emotions are an integral part of human existence and human survival that communicate in expressive ways a person's feelings and state of mind. Bowman (2001:256) argues that most patients will have an emotional response to their illness, but anxiety and depression are unlikely to be representative of most patients' experience. Bowman (2001:258) was hereby criticizing the generally held assumption in a clinical setting that attributes anxiety and depression as determinators of a patient's mood and mental state. Emotion as a component is not seriously considered in health care systems. For example, anxiety and depression are universally used in a clinical setting to recognise and describe patient reaction and mood change following an acute illness episode (Bowman 2001:258). These pathological terms (anxiety and depression), however, in view of life threatening illness limit the understanding of the reality of the life-threat and also reduce intervention strategies to adjust to major life changes (Havik & Mealand 1990:271-285). The importance of emotions, such as sadness and fear, in illness are to be taken seriously in engaging with an ill person. Bowman (2001:256) indicates that despite the fundamental acceptance of emotions as a major part of human condition, there is little factual knowledge of the part primary emotions play in patient adaptation. The main reason for a lack of understanding of emotions is the notion that views them as highly theoretical, difficulties of measurement, lack of pharmacological intervention and lack of ability to control (Bowman 2001:256-261).

According to Gross and Munoz (1995:151-164), there is no one true definition that will determine what is and what is not an emotion. Notwithstanding this, Plutchick (1994) observes that some primary emotions, such as fear, sadness, anger and joy are observable in mammals. These emotions are expressed many times by people going through pain and debilitating illness. Patients experience illness through biological, psychological sociological paradigms (Bowman 2001:257). The way a person grappling with illness responds to acute illness determines his/ her mood.

The researcher employs the literature review to lay a theoretical framework for the research. The research cuts across the available material in a way that offers a system that takes faith healing seriously, but engages critically with it to create a dialectic relationship between practice and theory in the areas of healing and counselling. The research is not meant to duplicate already disputed issues of validity and relevance of faith healing, but rather aims to create new insights and alternatives for the mission of the Church in her expression of healing and restoration.

### 1.11. Literature Review

There is generally a lack of academic or well researched material dealing with the research topic of the emotional and spiritual impact of faith healing on people suffering from illness. Notwithstanding the lack of well researched material on faith healing experiences, a researcher, Richard Peel (1987:13-14), claims to have recorded healings in the Christian Science Movement<sup>4</sup> from conditions such as cancer at an advanced stage and many other serious heart conditions after serious intervention by prayer. In fact the general practice during healing services are that usually people who are healed are given an opportunity to testify to their healing, and which are also being confirmed by faith healers. Mohr (2011:73, 77), however, states that these kinds of healings are untested and without medical verification.

The literature review covers material dealing with the concept of faith healing, as well as books on pastoral therapy and pastoral care. The literature review serves as a necessary background that reflects on different aspects relating to healing from scriptures, pastoral counselling and psychotherapy. Thus, the literature review is to engage viewpoints from different authors to enrich the research study. This is only a selected review and does not exhaust all the sources that would be used for thesis writing (Vyhmeister 2001:181). The

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<sup>4</sup> CSM is a religious movement founded by Mary Baker Eddy in 1866 in the United States of America. Followers are from the First Church of Christ, Scientist and non- members. The main reference sources are the Bible and the book by Mary Baker Eddy, called "Science and Health". This textbook describes religion as a complete and coherent science that is both demonstrable and provable. Christian Scientists believe that man and universe are spiritual and non- material; that truth and the good are real, while the bad and error are just an illusion of fictitious material existence. They believe that through prayer, knowledge and understanding, all things are possible. They teach that all people have some experience of material existence, but this ultimately become obsolete, with the increase of spiritual understanding of God and creation. In their view, healing manifests through spiritual enlightenment ([http://en.wikipedia.org/wiki/Christian\\_Science](http://en.wikipedia.org/wiki/Christian_Science) 06 June 2010).

review aims to reflect on various pieces of literature dealing with the question of healing. This enables the researcher to reflect on various literatures dealing with faith healing from various evangelical viewpoints. Subsequently, this will enhance the process of developing a pastoral care and counselling framework for healing seekers.

The review will firstly deal with faith healing practice, then evaluate various counselling approaches, and finally highlight problems emanating from the review.

#### 1.11.1. Literature review of different healing viewpoints

The views of different people practicing healing, as well as of those who don't necessarily make healing a focus of their ministry are reviewed. This is important in order to understand the theory beyond healing practice, as well as to understand the perspectives of people interviewed in chapter 3 during field research.

There are various persuasions or convictions on the issue of faith healing within the broader Evangelical Church (Hacking 2006:39). This is confirmed by Thomas (1987:7), who states that there is wide variety of opinions regarding the ministry of healing prayer that exists in the Christian Church. He further argues that behind this wide diversity of opinions is a lack of agreement about the nature of this ministry. The Pentecostal and Charismatic churches have a pro-faith healing stance, while extreme evangelicals maintain the dispensationalist doctrine of cessationism that denies and rejects faith healing practices as unbiblical and unscriptural (Hacking 2006:39).

Thus, firstly the views by John Wimber, Cannon Jim Glennon and Oral Roberts as practitioners of faith healing are engaged in group 1. Although the review is limited to the persons mentioned previously, their writings have been widely used within the faith healing circles. Secondly, group 2 deals with views of people for whom faith healing is not a necessary focus of their ministry. The material by Evelyn Frost, Martin Israel, Richard Mayhue, Ronald Kydd, Keith Warrington and Geoffrey Bingham are reviewed. These contributions argue that healing is more than merely physical, as it covers spiritual, psychological and social dimensions.

Group 1: Practitioners of faith healing:

- John Wimber is a founding member of Vineyard Churches, who has written numerous articles on healing. His views are that anyone could be healed of any disease, as long as the person exercises faith (1986:160). He worked with the concept of God's kingdom and viewed signs and wonders as manifestations of the reign of God's Kingdom on earth (Wimber 1986:6-7). He attested that in the person of Jesus, the Kingdom of God came in power. There was always a twofold pattern in Jesus' ministry; first proclamation, then demonstration. He firstly preached repentance and the good news of the Kingdom of God. Then he performed miracles -- casting out demons, healing the sick, raising the dead -- thus proving that he was in the presence of the Kingdom, the Anointed One (Wimber 1986:6). The argument that he stressed was that the power of the Kingdom of God was not only given to Jesus, but was also to be exercised by the apostles and the Church of God through all ages, until today. Wimber uses scriptures to justify the healing ministry of the church. His concept of the Kingdom of God and how Jesus embodied this in his earthly ministry is appealing. The question is how far Jesus' ministry, which was salvific in nature, should be literally modelled by his Church. Wimber indicated the cruciality of the Great Commission mandate in Mathew 28:18-20 for the Church's healing ministry (Wimber 1986:10). In the same manner, Cannon Jim Glennon (1978:25-30) has written a book, *Your Healing is within You*. This book was widely used as reference material by faith healing proponents. In the book, Glennon argues for divine healing today. Glennon (1978:25-30) states that Christ and his disciples did not only have the healing ministry, but the modern Church is also enabled to pray for the sick, according to James 5:14,15. He believed that according to the promise embodied in James 5:14, 15, God hears and responds to prayers of faith offered by the Church leadership. His arguments are intriguing, as they take away the focus from an individual gifting to corporate ministry of the leadership. In talking about James 5:14,15, Glennon (1978:30) states "as a matter of fact, the only instruction given in the New Testament to Christians as to what they are to do when they are praying for the sick is to call the elders of the church."

John Wimber and Charles Kraft have suggested the reasons for the absence of power evangelism in the Church today as being two folded:

- ❖ Firstly, some people hold a theological viewpoint, based on dispensationalism, which advocates that miracles have stopped at the end of the apostolic age.
- ❖ Secondly, the popularity of philosophical or anthropological perspectives, especially within the Western worldview makes little room for miracles. (Wimber 1986:9 & Kraft 1989:2, 3, 72).

These observations call for deeper reflection on the practice of healing, especially in the African context, which has a high regard for supernatural realms. The African worldview upholds the magico-spiritual realities of African societies where people believe that the invisible has influence on the visible (Mpolo 1994:24).

- Oral Roberts, who is the founder of Rhema Church International and Rhema Bible College, in his book *Seven Divine Aids for your Health*, mentions that healing manifests itself at times through mass healing. He encouraged people to touch each other for healing to transfer from one person to another (Roberts 1960:35). Although there are other situations, like the account of Peter's shadow that fell on the sick healing them, and Paul's clothes used to heal a sick person, there is no command in the Bible that instructs that healing is to be officiated in this manner (Acts 19:11-12). Barret (2002:292) comments that physical contact between the healer and a sick person was a common feature of miracle stories, but remarks that the wonder is heightened by the fact that contact is indirect. He draws a parallel however, between this event and the effect of Peter's shadow on the sick (Acts 5:15f). It is worth noting that some biblical accounts are unique and fulfil a specific purpose and therefore are not providing mandatory instructions that should be made a norm for Christian practice. In other words, miracles in the New Testament were primarily signs confirming the sonship and the redemptive purpose of Christ (Pilch 2000:120, 121) and are therefore not meant to be used as proof for modern miracles. Notwithstanding this, there is a case to be made for the working of miracles from commissioning chapters to the disciples, such as Matthew 19:16ff and Mark 10. The purpose of miracles however, was always in the context of evangelism and to introduce the concept of God's kingdom and was never meant for showmanship. Warrington (2007:190) indicates that Jesus' healing powers are to be recognized as signposts to him and not to a more successful healing ministry for us. To confirm the purpose of

Jesus' healings, Carroll (1995:30f) argues that "Jesus casts out demons and heals the sick as part of his larger mission to summon God's people to metanoia, to a new mode of life reflecting a single-minded commitment to the rule of God ... Jesus heals the sick by virtue of his authority as Messiah and Son of God, and healings and exorcisms are the way in which he, the Messiah, serves the people."

It is clear from the reviews of faith healing practitioners that they seem to work within a dualistic framework of spiritual and secular dimensions. A person is not viewed as a complete entity that needs a comprehensive intervention in dealing with illness. Even where medical treatment is recognised, emphasis is still made on the fact that true healing only comes from God and by implication through faith and healing practices.

The following section reviews sources that reflect on healing from a different understanding than that of the authors in the previous section. This is important, as it enriches the research study with a broader framework on views related to the healing ministry.

Group 2: Viewpoints where physical healing is not a priority focus:

- Evelyn Frost has written a book entitled *Christian Healing*, which masterfully gives a careful academic account and analysis of the ministry of the healing in the first age of the Church's life. The book extensively deals with the early patristic evidence in the Ante-Nicene Church of martyrs' faith, despite persecution, that kept them faithful to Christ and his spiritual healing ministry (Frost 1954:5-6). It painstakingly works through the writings of early Church Fathers, looking at their doctrine, life and practice and shows patristic evidence of their concept of healing both from sin and sickness. It is important to note that from the review of this book it becomes clear that healing was part of the normal life of the Church and not something spectacularly done with advertisements and promotions. The miracles of healing were practical consequences of doctrine. It is in the Fathers as the preservers of doctrine rather than as recorders of miraculous events that the greatest value lies. Healing flows as a consequence of doctrine (Frost 1954:113). The book implies that following the principles of the early Church and her example, the modern Church could rediscover its function of divine healing through sacraments of holy unction, laying on of hands and by corporate intercession of her members. The Church's healing function is thus

seen as sacramental rather than psychological (Frost 1954:6). The writer suggests that in a practical sense the Church could restore Christian healing through evoking revivals. Revitalisation of the Church is here not necessarily understood as the forsaking of sin, but rather as maximizing the power of God that is readily available for the redemptive task commissioned to the Church. This healing power comes from the victory of Christ and is manifested in the physical, mental, and spiritual spheres of people in the world (Frost 1954:359). The further implications of the review of this book show the role the community of believers play collectively in living out their mandate as a mission church. Healing was a collective work and not focused on one person, and healing was even understood as a function of elders or leadership team.

- The concept that healing is more than only a physical reality has been emphasised by Martin Israel (1984) in his book, *Healing as Sacrament*. He demonstrates that healing transcends physical wellness of the body and should therefore strive towards true healing, which encompasses restoration of the whole of humanity. The book is valuable as it defines healing in the context of God's whole creation, showing that fulfilling one's total calling in life is part and parcel of this healing process. Israel (1984:14) indicates the various dimensions of faith. The environmental issues and threat to sustainability of our continent are concerns for all citizens of the world. Israel (1984:14f) argues that healing should be inclusive of total restoration of whole creation, including preservation of our environment. As custodians of the earth, human beings must promote holistic health, as human health cannot be divorced from environmental restoration. What happens to our environment unabatedly affects the wellbeing of all her inhabitants, including human beings.
- Richard Mayhue has written a very insightful book entitled *Healing Promise* (1997), which advocates healing from the point of spiritual significance. His views are strong on spiritual healing and spiritual benefits of healing for believers today. Richard Mayhue indicates the fulfilment of healing in the cross of Christ. He reutes the flaw of what he (Mayhue 1997:27) calls the "contemporary confusion" in faith healing. He explains throughout his book the false application and misuse of scriptures on healing, and basically demonstrates that healing today is not physical but spiritual. Furthermore, he indicates that God provided spiritual healing in Christ's salvation

sacrifice at Calvary (Mayhue 1997:259). Torrey (n.d:5), commenting on Richard Mayhue's book, states that it deals thoroughly with the subject of divine healing, as it gives all sides of the truth in their scriptural proportions. Mayhue (1997:84-85) observes that some viewed only those passages that emphasise God's ability and readiness to heal diseases and what he has done to make such healing possible today; others are entirely occupied with those passages that make it clear that God sometimes does not heal or that God has different ways of working in different dispensations. Richard Mayhue's contributions broaden the concept of healing from mere physical exercise to spiritual dynamics. This is a vital contribution that opens up the concept of healing to reflect upon the spiritual components of healing.

- Similar viewpoints and articulation on healing concepts were also submitted by Ronald Kydd (1997) in his work, entitled *Healing through the Centuries*. Ronald Kydd (1997:85) argues that "alleged contemporary faith healing ministries fall embarrassingly short of the biblical pattern in time, scope, and intensity. On the other hand God at times acts in such a way that only His direct intervention is an adequate explanation for physical healing." Ronald Kydd (1997:86) confirmed and substantiated the perspective of healing as spiritual reality, confirming Richard Mayhue views as discussed previously. Kydd's book is technical and deals with comparative studies that cover healing perspectives from scriptural, theological, historical and experiential levels. The book brings to the fore the need to compare and contrast the concepts of divine healing and faith healing. The book demonstrates the widespread nature of divine healing in the twentieth century with affirmation throughout his book. Kydd's understanding on the impact of faith healing is similar to Raymond Flung (1989:1), who mentions that: "Quantitatively the number one means of evangelism today, of people coming to faith in Jesus Christ, is probably faith healing." Ronald Kydd's work comprehensively reflects on healing throughout the Church's life. He starts with an in-depth look at the life of Jesus and makes this the foundation for the rest of his research. He attests that the ministry of Jesus Christ becomes the barometer for the healing ministry today. The challenge that his book gives to the healing ministry is to be a ministry based on the tenderness and passion of Jesus to people, especially the vulnerable. It indeed speaks against what modern faith healing portrays in glamour, popularity and showmanship, as Jesus' model is a model

of servanthood. Kydd's work furthermore deals with healing in the Church through the centuries and how human vessels went about manifesting the grace of healing through the Church. The book deals with six models of healing, namely (1998:xvi-xx.): 1. Confrontational. 2. Intercessory. 3. Reliquarial. 4. Incubational. 5. Revelational, and 6. Stereological. The six models around which the book develops demonstrate the fact that healing has different facets that needs to be catered for to be effecient. The models highlighted the spiritual depth and dimensions of healing intervention that covers issues of forgiveness, repentence, intercession and restitution, to mention but few. All these elements must be taken into consideration, even when faith healing practice is officiated for physical ailmen.

- Keith Warrington (2005), in his book *Healing and Suffering*, explores issues related to suffering by asking some vital questions, such as: Should believers ever be ill? Is there a method for praying for healing that one should follow? What, if any is the association of demons with illness? Why do some people remain not healed after prayers? Can suffering have a positive outcome for a believer? Warrington (2005:6-8) discusses promises made in the Old Testament about healing and suffering and concludes that many of these promises were for Israel and of little reference to Christians who are not expected to keep the Mosaic law and who are not in danger of being exiled from their national land. In chapter 3, he deals with healing in the gospels. Warrington (2005:26,96) correctly concludes that: "Jesus' healings are uniquely linked to his mission to initiate the kingdom ... his role was unique and his mission, by definition, unrepeatable." In terms of implications for the modern Church, Warrington (2005:96) argues that Jesus "ministry is not to be viewed in line of direct continuity with today." His argument is that Jesus did not leave a healing pattern to be modelled for contemporary practice, although he has passion for the sick and suffering (2005:36). The researcher views this assertion as one-sided, as Jesus' way of doing ministry has valuable contributions for the Church's contemporary ministry. These contributions are not only for academic significance, but are also important for the practical ministry of the Church. Warrington's view that Jesus did not leave the modern Church with a healing pattern calls for some response. Although we cannot literally and word by word follow Jesus' healing methods, there are principles to apply from the way he dealt with the illness and the suffering of others.

Warrington (2005:123) alludes that Acts is not the place to look for a contemporary methodology on healing and suffering. Although he acknowledges the ongoing healing ministry of Jesus in the New Testament, Warrington (2005:128-48, 148-79) suggests that for a contemporary healing model in the New Testament, the works of Paul and James are of significance. The other important contribution of Warrington (2005:180-97) is on the role of the Holy Spirit in suffering. In this portion, he refutes any thought that Jesus' ministry was aimed at removing suffering. Warrington (2005:196f) rather demonstrates the ongoing empathy of God with human suffering through the presence of the Holy Spirit with the believers.

- Geoffrey Bingham (1980:xii-xiii) propagates that healing should be understood from the main discourse of God's Kingdom as the central theme of the Gospels. In his book, *The Wounding and the Healing*, he indicates the need to meticulously work through the purposes, methods and natures of healing throughout the Bible. He works with God's Kingdom as the central theme and shows that God is a healing God. He reasoned that sin has become the great defaulter, which brought sickness into the world. He supports this by many Scriptures that demonstrate punishment as a consequence of sin. He mentions, however, that not all sickness is as a result of sin. His conclusion is that God works divinely to heal, but also uses human healers to accomplish healing, according to Matthew 28:19f. There is a thin line between illness caused by sinful actions and vulnerability of human beings because of illness, as we live in a broken and fallen world. He tends to balance this view with his statement above, where he alluded that sin causes illnesses, but that all illnesses are not as a result of sin. He is both cautious in what he calls the *Princeton View*, which states that miracles were given to launch the Church and subsequently ceased, or are only operational where the Church is being planted, and the Pentecostal/ Charismatic notion of positivist view that advocated that God heals at all times through his servants to perform healing at all times. He is basically suggesting that the Biblical truth embraces both viewpoints and that they should be employed with wisdom and tactfulness.

The inputs by various authors on the question of healing have broadened the understanding of the researcher in the way the research study will develop. It has shown the relevance of the

research topic on faith healing practice as an issue the Church is concerned with in general. More than this, the literature review helps address the question of how to deal with those who are not healed through prayers despite being prayed for. After reviewing literature on the concept of healing, the following observations are worth noting:

- Firstly, that various authors have different understandings of the concept of faith healing, which are governed by the doctrinal positions of the authors. Varying viewpoints have to do with hermeneutical issues in the way scripture is used and applied by various groups (Hacking 2006:38).
- Secondly, most authors agree that healing is part of the Church's mandate from Christ. Healing is not necessarily understood by all in the physical sense however, but as a broad concept, also including spiritual dimensions of healing.
- Thirdly, it is important to note that God heals people in different ways; there is nothing evil about consulting medical doctors. Dualism, which separates things into spiritual and secular realms, must be avoided, as all good gifts come from God, the author of all life.
- Fourthly, inputs gained from the literature review will contribute theoretical perspectives that will enrich the study as a whole.

The next emphasis of literature review covers material related to pastoral care and counselling. The research title has two components to it; faith healing practice and pastoral care. The preceding review reflected on faith healing views, the focus now shifts to pastoral care and counselling.

#### 1.11.2. Literature on pastoral care and pastoral therapy

The literature review deals with the theoretical concepts that integrate both religion and psychology in its pursuit of dealing with illness and health related issues. The literature review further explores challenges of living with illness and effects of illness on physiological, spiritual, emotional, and social dimensions of human existence. A short review on work dealing with pastoral care and pastoral therapy is done by reviewing L. Weatherhead's and Edgar Jackson's integrated approach to pastoral therapy and Roger Hurding's and Daniel Louw's on pastoral care and counselling.

- Weatherhead (1952:461) has suggested an integrated model of pastoral care in his masterpiece, entitled *Psychology, Religion and Modern Era of Psychotherapy*. Although Weatherhead's contributions were made many decades ago, his understanding and approach to integrate the fields of psychology, religion and psychotherapy has far reaching implications. He is basically proposing an integrated approach to healing that makes use of both psychology and scriptures in therapy. His challenge is to not just accept sickness and diseases as the order of the day. Weatherhead (1952:461) states that: "God created the body to be the perfect instrument of the spirit. It is not His will that it should function imperfectly, or that man should assent to disease without doing everything possible to attain health." The book demonstrates that healing takes different modes and mediums to manifest. Weatherhead proposes a tough approach to illness, which seeks ways to overcome the debilitating effects of illness for productive and wholesome living.
- Roger Hurding (1998) has written an insightful book on *Pastoral Care in Postmodern Age*. He deals with all kinds of issues one should consider in the pastoral ministry today, and includes a large section devoted to the question of healing and how to go about making peace with your disease or sickness (Hurding 1998:217-226). Hurding works with an integrated model of pastoral wholeness that is of benefit to this research study. The contribution by Roger Hurding recognises the changing times and dynamics of postmodern times, but also demonstrates the relevance of pastoral counselling to people facing chronic and acute illnesses. This is an important contribution in the context of faith healing, which often seeks instant solutions without preparing people for living with the reality of illness.
- Edgar Jackson (1993) reflected upon psychosomatic effects of healing in his book, *The Role of Faith in the Process of Healing*. He has endeavoured to meticulously demonstrate the relationship of emotions to the body and how this affects the healing process. The book covers different dimensions of healing and practices as diverse as Oriental concepts to Western modes of wellness. The major part of the book explores faith and its expression through various scientific ways of healing. The benefit of Erick Jackson's work is in the fact that it realises the role and impact of psychosomatic diseases and their relation to emotional instability. The research study

has as one of its objectives the investigation of the role of psychosomatic factors in faith healing. This is quite vital when considering the parallels of psychosomatic manifestations with what one may call “African diseases<sup>5</sup>”, believed to be caused by witchcraft, curses and bad luck. Turner (1996:717f) states that many African Americans associate gastrointestinal disorders that cannot be cured by Western medicine with witchcraft or voodoo. He remarked that belief in voodoo often persists in Black culture. The whole chapter is dedicated to the question of psychosomatic diseases and their relation to African epistemology. The emphasis on body-mind relation and psychosomatic diseases will benefit the research on faith healing and pastoral care, as it gives proper emphasis to emotional dimensions of the subject matter. The role of stress as one of the major contributors of diseases and state of ill health is also demonstrated by Erick Jackson in his book.

- Daniel Louw has contributed a great deal to the field of pastoral care and counselling. The book *Pastoral Hermeneutics of Care and Encounter* (2000) deals in great detail with the different aspects of pastoral care and has many sections dedicated to healing in the pastoral context. The book reflects upon a theological basis of pastoral care and aims to develop a basic theory to work with. This is a comprehensive book that puts the triune God at the centre of human experience. On one hand, the book reflects upon God’s response and involvement in human realities and on the other hand, it suggests a pastoral counselling model that interrelates and integrates psychotherapy for the holistic treatment of hurting persons. The discourse on the relationship of counselling to psychotherapy is very helpful, as it benefits this research by explaining terms and relevant concepts. The importance of an integrated approach that responds to various situations in pastoral ministry should engage with other disciplines in the social sciences. The centrality of God’s involvement in human suffering must inform any situation analysis and treatment strategies.

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<sup>5</sup> African people have the understanding that some illnesses and diseases are caused by things such as witchcraft, sorcery, curses and being disobedient to ancestors. These conditions usually manifest through mental and spiritual disequilibrium, infertility, unknown illnesses and evil spirit possessions. These are the so-called African diseases, which are untreatable by Western medicine, as symptoms cannot be diagnosed. They are believed to be treated through offering rituals, sacrifices, and the consultation of traditional doctors.

- The final review of literature on pastoral care engages important work published by Daniel Louw in 2008 concerning issues related to illness, coping and health. In *Cura Vitae*, Daniel Louw deals with complex issues of health and illness from a pastoral care perspective. Louw (2008:11) indicates that “Cura Vitae is about a theology of life and the healing of life from the viewpoint of Christian spirituality. It is about how new life in the risen Christ and the indwelling presence of the Spirit can contribute to the empowerment of human beings. It is about hope, care and the endeavour to give meaning to life reality of suffering, our human vulnerability, and the ever-present predicament of trauma, illness and sickness.” Louw (2008:11) further indicates that “Cura Vitae is a theological attempt to create a paradigm shift in care giving from a predominant focus on our ‘knowing and doing’ functions to our ‘being’ functions.” The first chapter of the book defines the parameters and gives the rationale of the book as it engages in practical theology and pastoral care from a pneumatological approach, with inhabitational theology as the springboard (Louw 2008:16). The book further develops the concept of human experience of health and illness with related concepts from empirical experience and from an African perspective. The “ubuntu” concept and African epistemology in dealing with forces that cause ill- health and sickness are sufficiently dealt with. The book takes cognisance of biblical views on suffering, healing and illness, but also deals with the psychological and psychiatric effects of these conditions on those affected. The trauma that results from such situations is looked at and practical solutions are suggested for coping with shock, trauma and illness. The author further dedicates half of the book to specific conditions of illnesses and diseases. He devotes considerable time and space to the whole question of sexuality and HIV and AIDS, as well as the question of the stigmatisation of HIV positive or infected persons. The book covers various aspects of sexuality and promiscuity, as well as issues of homosexuality, gender sexuality and male abuse. The issue of sexuality and promiscuity is handled from a theology of resurrection and ways to deal with it are suggested. Cancer and various skin infections, and psychological and physical struggles related to these conditions, are further discussed. The book also includes issues such as a mastectomy, suffering from a stroke, coping with ageing, dying and trauma around parting and grieving the loss, and the whole issue of mourning. These are all different conditions that cause some identity crisis and crippling fear. The whole purpose of the work is an attempt to give theoretical

reflection, pastoral response and practical application to various situations; although the author admitted that he is not creating a manual on how to manage life (Louw 2008:15). The book is a good tool for every minister and Christian practitioner as a basic reference material on issues dealing with human frailty and life's unwanted realities. As it covers different issues in the context of meaningful and productive living in the midst of challenges, it may serve as an introductory reading to various practical disciplines. It forms an integral part of the research study in dealing with the question of illness and ways to help people to a meaningful and productive life in Christ.

Pastoral care and counselling are important interventions for people suffering from illness, as these create opportunities to converse and engage them around their anxieties, fears, hopes and aspirations. The questions of fear, doubt and uncertainty are dealt with by pursuing a comprehensive strategy of treatment. The predicament emanating from illness, necessitate a special approach to ensure equilibrium or healing from illness situations. Counselling and pastoral care are major parts of such interventions, as illness affects mental, spiritual, social and physical dimensions of an affected person. This is substantiated by the fact that illness affects the totality of a person and need to be treated with systems that respond to spiritual, emotional, social and physiological needs of people facing ongoing illness.

The last focus area of literature review gives a short discussion on observations and problems that emanated from literature review process.

#### 1.11.3. Main observations from the literature review

The literature review has endeavoured to reflect on various perspectives of faith healing and pastoral care and counselling in relation to people's experiences of illness, suffering and healing. Thus, the review contributes towards a better demarcation of the research area and also serves as an indicator for the direction of this study.

The faith healing practitioners claim that the Church is still mandated at present to heal the sick, whether this is by means of individually gifted healers or by the corporate ministry of the elders. Healing is seen as normative to the church today and as a way that demonstrates the gospel's power to the world today. On the contrary, the viewpoint that doesn't make

healing the focus of ministry rather emphasises the spiritual significance of healing. Those upholding this viewpoint deny that God still uses human agents for healing; however, they are open to the fact that God may divinely intervene and bring about physical healing. The main argument here is that the Christ has brought fulfilment of healing on the cross, which has ultimately found its expression in spiritual manifestation of healing from sin and its consequences.

The problem with the aforementioned viewpoints on healing is that they are based on different and sometimes opposing interpretations of scriptures (Asamoah- Gyadu 2007:307). The pro-faith healing views that advocate that physical healing is part and parcel of church's mandate and mission today, and the anti- faith healing stance that are more prone to dispensationalist viewpoint, which advocates that physical healing has phased out with the twelve apostles and the first Christians, both claim a valid understanding of the scriptures on the topic of healing. Different interpretations are articulated however, as a result of differing doctrinal perspectives that are based on certain biases. Reflecting upon the hermeneutical approaches of Pentecostals, Asamoah-Gyadu (2007:307) states that "Pentecostals will have none of the historical-critical approach to text. The Bible for them is the authoritative word of God, and what it promises the believer must be appropriated for the expansion of God's kingdom." Although healing practices are quite popular in Pentecostal and Charismatic churches, there is virtually no material dealing with the emotional and spiritual impact of faith healing on people who are not healed through faith healing prayers.

The research project is based on the understanding of the need for serious engagement with the hermeneutical process, while trying consciously to deal with researcher's own biases. A conscious effort will be made to reflect on scriptures dealing with both historical context and the cultural setting of the contemporary world. Thus, scripture as a normative source and the culture as dynamic process will be engaged in a dialectic relationship to establish the framework required to interpret the results of the study.

The literature review on pastoral and counselling approaches has underscored the fact that illnesses affect people on various levels ranging from spiritual, physical, psychological, and cultural. It has further emphasised the fact that illness causes a predicament, and subsequent

need for counselling. The need to create a model that will address theological, practical and psychotherapeutic dimensions in responding to the plight of the sick and hurting.

The general problem or challenge is the fact that there is a lack of enough academic material or research on issues related to faith healing practice and counselling by Africans. The available material is mainly American or European based, and although knowledge is globally accessible lacks the context and cultural dynamics of African realities.

### 1.12. Chapter outline

The research study consists of seven chapters, which are outlined in the following way:

Chapter 1 covers the introduction, background and motivation of the research study. It further deals with the literature review related to faith healing and crisis counselling and a research design, which briefly gives the background to research methodology.

Chapter 2 covers African perspectives on healing: Description of socio-economic realities in Africa and their relation to illness, the growth and impact of AIC's and Pentecostal Churches. The role and function of African cosmology and culture are discussed and the community ("*ubuntu*") concept and African spirituality are studied in view of illness. Further biblical images and how they relate to illness and health are looked at. These are done in relation to Christology and how it affects views on illness and health.

Chapter 3 covers research methodology and empirical research outcomes: Technical aspects of data collection, sampling and selection, data coding, transcription and interpretation are discussed. Atlas.ti computer software is utilised for data coding and analysis. Field research outcomes and conclusions are presented.

Chapter 4 covers psychosomatic diseases in relation to faith healing: The interrelationships between body-spirit functioning and psychosomatic issues are discussed. Wilber's four quadrants of knowledge and various stages of trauma are also handled. The different variables of psychosomatic diseases, such as somatization, placebo effect are highlighted.

Furthermore, practical outcomes from the Harvard study on prayers are indicated and a biopsychosocial model introduced.

Chapter 5 covers a theological perspective on healing, both from the Old and New Testament scriptures and the life and ministry of Jesus Christ. Theoretical and philosophical perspectives on the concept of a suffering God are reviewed and implications for healing ministry discussed. Different facets that relate to healing concepts are introduced and discussed. It further covers healing in the early Church and the place of healing in the modern Church.

Chapter 6 covers a pastoral ministry in relation to people suffering with illness. A pastoral approach that is based on hope and compassion are introduced to deal with ongoing illness.

Chapter 7 covers outcomes, conclusion and recommendation of the research study.

### 1.13. Conclusion

The faith healing practice is an important exercise for AIC's, Pentecostal and Charismatic Churches in Africa. It has bolstered the growth of these churches immensely, as many people have turned to them for answers to challenges they face in African reality. Unfortunately, little reflection has been done on the impact of healing practice on the spirituality and psyches of those seeking healing.

Another reality is that faith healing practice cannot be evaluated in isolation from the socio-economic realities and African culture and epistemology. The high poverty levels and subsequent vulnerability to life-threatening situations have created a breeding ground for the growth of churches that emphasise miracles and healings in Africa. People who struggle with ongoing illnesses of which some are chronic, like HIV/ AIDS despite prayers, and the realisation that healing may be a process, need a holistic and integrated response to illness.

The faith healing practice is mainly prayer based, with the anticipation of instant results. It is therefore lacking structures to enable people to be guided through the process of healing. These lacking processes are in the areas of counselling, teachings and other practical ways to assist ill persons. The literature review has dealt with the broad concepts of physical healing

and their implications for the modern Church. Varying authors' viewpoints were discussed on faith healing and pastoral care and psychotherapy.

There is a serious lack of good African sources that deal with the impact of the faith healing practice and crisis counselling interventions on healing seekers. Most sources are written by authors from America and therefore do not uniquely address issues that contribute to illness in Africa. In the light of these factors, the envisaged pastoral support system should demonstrate understanding of an African worldview; especially in relation to illness and health issues, and also employs psychotherapy in designing pastoral strategies.

The next chapter deals with the question of “what is going on”, as suggested by the practical theological methodology as described by Richard Osmer. To seriously make inroads and be rooted in Africa communities, theology or Christian practice must look, listen and learn from an African worldview and epistemology.

## Chapter 2: African epistemology and views on illness and health

### 2.1. Introduction

This chapter engages various practices and perspectives on illness and health from African perspectives. Healing is part of African epistemology and the growth of healing movements within the Africa context is therefore comprehensible. The chapter strives to integrate important aspects of African realities with healing functions, in order to respond to people suffering with ongoing illness who desperately seek healing from Christian faith healers.

The structure of the research follows the four task approach of practical theology methodology as proposed by Richard Osmer's model (2008:4f) and discussed in chapter 1. Thus, chapter 2 and chapter 3 employ elements of task one of practical theological methodology, according to Richard Osmer's approach, to address the question of "What is going on?" in relation to the impact of faith healing practice to healing seekers. The focus of task one is primarily a descriptive-empirical task that explores behaviour, beliefs and conduct of people seeking healing for illnesses through faith healing practices. This chapter links with the question of what is going on, as it reflects on African epistemology and a worldview that is based on a close relationship between the material and spiritual worlds. In that sense, illness and misfortune are unwarranted realities that affect the physical dimensions of human existence. In fact, illness and misfortune are understood to have spiritual causes and therefore need spiritual remedies. In pursuit of healing from illness, African people involve themselves in offering sacrifices and rituals to ancestors and consultation of healers of all kinds; traditional healers, faith healers and medical doctors. Therefore, what is going on relates to African epistemology and African culture and its expression during illness and misfortune. This chapter further focuses on how Jesus' healings relate to faith healing practices in Africa and the effect of healing services on African Christians who are seeking relief from their ailments.

The choice to engage in chapter 2 with African epistemology, and not with the empirical research that is covered in chapter 3, is the recognition that the question of "what is going on?" is an engagement that is interpreted by traditional African people through their worldview and cultural realities. In other words, illness and health issues are daily realities that are perceived from African cultural perspectives, both in what causes illness and

misfortune and how to treat or respond to illness and misfortune. Therefore, the research topic on faith healing practice in pastoral care is firstly to be understood from African reality and epistemology, before employing alternative views of illness and intervention methods in pursuing healing.

The envisaged goals of the chapter are:

- To reflect upon the socio-economic situation in Africa and how it impacts the faith healing practice in Africa.
- To assess the role and impact of the faith healing ministry to healing seekers in Pentecostal and Charismatic churches.
- To highlight and engage African cosmology and epistemology in ways it relates to illness and health, with special reference to the significance of Jesus Christ for healing ministry in Africa.
- To discuss and integrate biblical images with African culture and practice in relation to illness and health dynamics.

The African worldview is anthropocentric and based on strong interdependent networks of cultural, social and spiritual relationships. The goals of an African worldview as set out, engage with the question of illness and healing by reflecting on African epistemological perspectives. The strong spiritual and mystic undertones of the African worldview form the basis by which connection is made possible between the living and the divine beings (Magesa 2004:81). Harmony and peaceful co-existence are virtues cherished greatly, both within the community and with the ancestors. Thus, illness and disasters are undesirable misfortunes that need to be atoned for through various rites and rituals.

In this context, healing and protection constitute the greatest attractions for Africans (Lugwanya 2000:30). This fact is also confirmed by Nürnberger (2007:47), who states that people visit diviners primarily to obtain protection, healing, fertility and strength, and that for these reasons African Independent Churches (AIC's) are quite attractive, as their leaders respond to these needs. This is understandable when it is considered from African cosmological perspectives, which will be discussed later in this chapter. Harding (2008) argues that these attractions are quite evident in the way AIC's draw a large number of converts, as emphasis is placed on healing as the very core of the gospel. This is in

consonance with the African belief in the supernatural; healing methods, however, must not contradict standards of the scripture.

Msomi (2008:238) attests that theological studies in general and practical theology in particular have supported the fact that the healing ministry is embodied in the commission of Jesus Christ to his church. He further states, however, that church history has shown the dramatic decline of healing praxis within the Church. Msomi (2008:239) concludes, considering illness from a cross-cultural perspective, that it becomes clear that societies that have neglected the social and spiritual aspects of illness are poorer for it. The whole human existence on earth was and is still characterised by illness, diseases, accidents and calamities, which ultimately result in death. In the modernised world, the normal way for many people to treat illnesses is by medical care, experimental remedies like use of herbs, and diagnosing and treating of diseases (Brown 1995:39). Many Africans, however, respond to these plights of illnesses and diseases throughout the centuries by prayer and appeasement of a divine being and ancestors; sometimes magical rites and incantations are involved. This is an important observation as the African philosophy of peaceful co-existence is to maintain a healthy and appeasing relationship with both the living and the departed ancestors.

As old and real as human existence is, so are also the reality of illnesses and various ways African people have gone about responding to illnesses. Restitution needed for misfortunes was through different rituals and ancestral appeasement (Gundani 1999:44). Illness was never understood as an isolated entity, but was viewed from spiritual, social and cultural perspectives. In that sense, Lambo (1964:446 cf. Augsburg 1986:320) states that:

In the mind of the African, there is a more unitary concept of psychosomatic interrelationships; that is, an apparent reciprocity between mind and matter. Health is not an isolated phenomenon but part of the entire magico-religious fabric; it is more than absence of disease. Since disease is viewed as one of the most important social sanctions, peaceful living with neighbours, abstention from adultery, and keeping the laws of gods and men are essentials in order to protect oneself and one's family from disease.

There are deeper issues that affect ill health in African life and unless such issues are addressed, the attempts of healing mediums may not meaningfully address the misfortune and illness (Berinyuu 1989:71-72).

One of the key issues highlighted in the chapter is the serious challenge of poverty to human health and well being, both from productivity and health related spheres. This is a serious challenge in the African context, as it serves as the breeding ground for many social evils, including illness and diseases. Poverty poses serious challenges that impact various structures of African living. Effah (2006:71) suggests that the definition of poverty should be made much broader. He points to the fact that the human development perspective further expands poverty to include poor health, lack of good education, lack of decent standard of living, denial of political freedom, lack of human rights, vulnerability, exposure to risk, powerlessness and voicelessness. Thus, as poverty has various dimensions as stated above, it needs to be tackled from these broad dimensions and realities.

Already in 2003, Van der Walt (2003:40) stated that all aspects of human life are touched by poverty, such as the economic, spiritual, judicial and ethical spheres. The multidimensional nature of poverty is also confirmed by Mowafi and Khawaja (2005:59, 262). In that sense, the researcher conferred that poverty is a disease, an illness that is very destructive to Africa's vitality, productivity, dignity and identity. The concept of poverty is employed in a broad perspective that encapsulates all the aforementioned dimensions. The reality is that without recognising the socio-economic factors and their effect on health, any healing attempts will not effectively address the question of illness and health in African communities. The twin challenges facing Sub-Saharan Africa are poverty and diseases. These impinge both on economic productivity and health output of the continent. Therefore, the next focus area discusses the role of poverty as economic and health issue and how this relates to illness and healing efforts in Africa.

## 2.2. Africa's poverty and poor health necessitates a holistic response

The World Health Organisation defines health not merely as the absence of disease, but a state of complete physical, mental, spiritual and social well-being (Woodward 1995:79). Different cultural views and challenges of modern pluralistic societies have necessitated the widening of views on health that are inclusive of forms other than only the Western biomedical viewpoint. These have resulted in a greater openness of Western medical practice to other healing paradigms (Woodward 1995:83).

The broad definition of health has great significance for the African context that has faced immense socio-economic challenges for a very long time. There has also been a significant change in the map of world Christianity over the last century. A hundred years ago, 95% of Christians lived in the Western world; today 70% of believers live in Africa, Asia, and Latin America (Claydon 2005:118). Out of 700 million people who live in Africa, 397 million are Christian believers (Claydon 2005:118). The shifting of Christianity to the South is also confirmed by Samuel Escobar (2003:15), who attests to the fact Christianity is growing rapidly in the developing world, such as Africa and Latin America, while it is decreasing steadily in the Western world.

The socio-economic realities of Africa, such as the threat of the AIDS pandemic, drought, poverty, and civil wars are also challenges the Church in Africa has to grapple with. The high HIV and AIDS prevalent rates, especially in Sub-Saharan Africa are causing many deaths in Africa on a daily basis. Sub-Saharan Africa remains the most heavily affected region, accounting for 72% of all new infections in 2008 (UN Report 2010:40). Numerous awareness and treatment campaigns have been launched, but it seems that the fight against HIV and AIDS is far from over, as infection rates do not come down in many Southern African countries.

Political conflicts<sup>6</sup> and wars are also a big destructive factor to economic and social development in Africa. The wars and conflicts of the last few decades have left many Africans as refugees still today and many of these refugees are displaced, leading to poverty and violation of human rights (UN Report 2008:7). Thus, the continent is clearly ravaged by all kinds of social, political, health and economic realities. This situation is confirmed by recent studies of United Nations Human Development Index that show Africa as the least developed continent (United Nations Development Index 2009:n.d.). This is also reflected by Africa's income per capita or Gross Domestic Product (GDP) per capita, which is extremely low despite the wealth of natural resources. The GDP is less than \$200 and is still dropping in many African nations; although a slight growth is recorded it is still far lower than other developing countries in the same category as Africa, such as Argentina, India and Brazil. Msomi (2008:146) indicates that poverty is a social pathology, as it has the potential to erode

human personality, in the sense that at worst it leads people to devalue life psychologically. In an emphatic way, Msomi (2008:146) further states that the devastating effects of poverty sometimes manifest as incidents of depression, violence, alcoholism and many cases of illegitimacy. According to UN Millennium Development Goals Report (2008:6), little progress has been made to reduce extreme poverty in Sub-Saharan Africa.

The Christian Church is not immune to these challenges; despite these challenges however, the Church in Africa reflects the vigour and energy of the continent. In order to minister in this continent of many faces with high spirituality, the gospel must infiltrate African cultures in word and deed with the power of the Holy Spirit. Africans view life as a struggle, *inter alia* as a struggle in the realm of power (Msomi 2008:240). This is quite an important fact, which should underscore pastoral ministry in the African context. Msomi (2008:240) surmises this by saying “healing in African context would need to take seriously the question of exorcism-confronting power with the power.” This confirms the words of Jesus Christ in the gospel of Luke (11:21-22): *When a strong man, fully armed guards his own house, his possessions are safe. But when someone stronger attacks and overpowers him, he takes away the armour in which the man trusted and divides up the spoils.*

Arnold (2001:421) remarks that the picture is one of warfare, with the lords battling over a castle estate. Through his exorcisms, Jesus is disarming Satan and taking the spoils (people bound by him) from his castle. The reference to “dividing the spoils” may be an allusion to Isaiah 53:12 and the ultimate victory of the Suffering Servant of the Lord. These words of Jesus make more sense in the African context than in any other place. Luke’s expanded version of the way he talks about the strong man shows that Jesus is God’s stronger man who invades Satan’s palace (Mathew and Mark read “house”). This is also an expansion of Isaiah 49:24-25, in which the question and answer style showcases the strength of God as he advances into the territory of the mighty foe. The rhetorical question is whether Israel will join in this victory march or will oppose him (Tiede 1988:217-218). The text here depicts the stronger man as relying on his possessions, which are just an illusion; he needs protection for his property to be safe. A stronger ruler than Satan made war on him, overcame him and shared his spoil and established his sovereignty (Johnson 1991:183).

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<sup>6</sup> Africa is still among the hot spots of conflicts, with long standing civil wars such as in Somalia and some volatile and unstable nations such as Democratic Republic of Congo, Ethiopia, and Eritrea

The power of the gospel takes control and reigns over domains and discards evil, while it advances what is good. In fact, the awareness of spiritual forces and the effect of the invisible world on African existence play a central role in African living and peaceful co-existence. Thus, the Christology that views Christ as supreme to all destructive forces is attractive to African people. This is one reason why the signs and wonders crusades of faith healers are quite popular in Africa and many people are fascinated by these gatherings. The socio-economic realities have taught Africans to look for ways to cope with poverty, diseases and all associated evils. People suffering with ongoing illness consider different treatment alternatives, from Western to traditional ways of treatment. Dunn (1997:26) attests that “some alternatives may prove valid- even miraculous. Others may flirt with quackery, but at least they are something to do and try.” The healing ministry could become controversial, as many claims for healings and also counter healing claims are regularly made (Bates 1995:15):

On the one hand, many people genuinely claimed to have been healed through this ministry. Many conversions to Christ have also occurred. On the other hand, some people claim they have been hurt by the traumatic experiences they have undergone- especially when there was no healing. Some committed Christians consider the whole process of faith healing to be emotional and psychological manipulation and money making racket. This is especially seen in the case of the ‘healing churches’ which have emerged recently.

This is an important quotation, as it confirms research hypotheses (1.9.1 on page 30) that alleges that people suffer emotional hurt and pain when they remain unhealed after high expectations of healing due to promises made by healers.

The real liberation for African people can only be achieved when Africans are made whole again. This involves more than relief from illness and other socio- economic hardships, as mentioned previously. The real quest is for the soul of Africans and their participation in the fullness that links them to the unborn and to the ancestors, as well as to the living communities around them. It is in short, about reconstructing African cultures and self-esteem (Schreiter 1989: ix). The state of Africa’s social and economic condition suggests a grim picture for the continent, and this could also be a reflection of the real spiritual condition of the continent despite the proud history of the Christian Church in the continent.

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([http://en.wikipedia.org/wiki/Poverty\\_in\\_Africa](http://en.wikipedia.org/wiki/Poverty_in_Africa) 06 June 2010).

This leaves a serious question as to what the real impact of Christianity on African societies is. This question is further augmented when one takes into consideration the alarming growth of African Independent Churches (AIC's) because of their emphasis placed on healing (Kalu 2008:263). Why does the continent remain sick on social, economic, and spiritual levels, while healing is proclaimed and received so well in the major parts of Sub-Saharan Africa? Jesus Christ is perceived by many Africans as the great physician, healer and Victor *par excellence*. The understanding is that he came to give life abundant. Appiah- Kubi (1987:76) ironically enquired more than twenty five years ago, however, "where this abundant life is? All we see around us is suffering, poverty, oppression, strife, envy, war and destruction on the continent." Similar concerns were raised by Cécé Kolié (1991:128), when he alludes "to proclaim Jesus as the Great Healer calls for a great deal of explaining to the millions who starve in Sahel, to victims of injustice and corruption, and to the poly-parasitic afflicted of the tropical and the equatorial forest." These are serious concerns raised by Appiah- Kubi and Cécé Kolié, but they do not nullify the fact that African culture is a culture of mysticism and spirits, where protection from harm, suffering, and healing of the afflicted are of great significance.

Modern medicine has achieved great wonders for the general health of human beings, especially in the areas of scientific and technical knowledge. Many illnesses and diseases that caused a great deal of suffering and even death to our ancestors in the past are now easily diagnosed, prevented and treated. This progress also has its own limits, however, not so much in medicine itself, but mainly in the underlying assumptions within which they operate. Modern medical science views illness primarily from a physiological point of view, which is detached from the person suffering. This results in treating of illness or organs, rather than the sick person. Aldridge (2000:9) has alluded to the fact that natural science based its treatment mainly on medicine for illness treatment and has little regard for spiritual factors associated with health. Aldridge (2000:9) also further states that virtues such as patience, hope, grace, prayer, meditation, forgiveness and fellowship are as important as medication, hospitalisation or surgery in many health initiatives. These spiritual inputs help the patient to find purpose, hope and meaning in the midst of the prevailing suffering.

### 2.2.1. Poverty constrains wholesome and meaningful living

The extent of poverty touches all aspects of human life (Van der Walt 2003:40). To express the difficult conditions associated with poverty, Coetzee (2002:5) uses the word “vulnerability” with regard to poverty. He compares poverty to “vulnerability” to indicate the general interdependency and distress a poor person endures. Every individual experiences periods of problems and life pressures difficult to cope with. This is very true of people in the low socio-economic group, given that for them, stress is virtually constant (Chandler *et al* 1985:743-744). The poorest of the poor face many stressful life situations that are caused by low income and substandard health care; this creates a situation where crisis is highly prevalent among those in this category. Poverty and health are intrinsically linked. Not only are the poor more likely to suffer ill-health and premature death, but poor health and disability are themselves recognised to be causes of poverty (Blackburn 1991:7). In this regard, Vester (2012:4) states that poverty south of the Saharah is endemic. It is like an incurable disease. Furthermore, Wood (2007:5) mentions that in 1998, the World Bank estimated that 291 million people in Sub-Saharan Africa were living in absolute poverty. More than ten years later, the situation is more desperate according to African Progress Report of 2010 (2010:23). People in the lower social grouping are more prone to higher rates of illness and death than people in wealthier social groupings (Blackburn 1991:33). The report of Namibia Household Income and Expenditure Survey (NHIES) 2003/04 has demonstrated that poverty, and in particular severe poverty, was much more prevalent than previously thought in Namibia. More research based on the new approach has since been undertaken by the Institute for Public Policy Research, however, which shows that while poverty appears to be more prevalent, the declining trend over time is also more pronounced (Schmidt 2009). The latest Namibia Household Income and Expenditure Survey (NHIES) survey of 2003/2004 estimated the poverty rate in Namibia on 38%, which is a sharp decrease from the 58% indicated in NHIES survey of 1993/1994 (Schmidt 2009). The consequence is that large numbers of people are caught up in the cycle of poverty and social exclusion.

Historically, colonialism contributed to poverty as Africa’s resources were plundered, but equally, African governments are their own contributors to poverty through corruption, nepotism, tribal conflicts and military rule (Vester 2012:7). In the same vein, Mills (2010:10, 12) argues that bad choices African leaders have made also have contributed to poverty in Africa.

The situation of poverty is further aggravated by the fact that in many African countries unemployment rate is quite high. For example, Mohr *et al* (2008:79,499) indicate that the unemployment rate is estimated at about 37.3 % in South Africa. Census 2011 results as released by Statistics South Africa (2012:50) indicate improvement in employment rate however; 29, 8% of the population are unemployed. In Namibia, the focus area for the study, the unemployment rate according to the Namibia Development Plan (NDP3) stands at 51.2% in 2008 (Namibia's Fourth Development Plan (NDP4) 2012/13 to 2016/7:15). The situation has not change much since then. The poor who have some sort of employment get low salaries and wages and cannot follow a proper diet or live in conditions that are conducive to general health. Poverty and racism are health issues and these have psycho-spiritual consequences (Dreher 2001:1ff). Poverty breeds many social problems such as crime, disease, drugs and substance abuse. One important area, that is often overlooked, is the emotional crisis that comes about where there is lack of support mechanisms as a result of extremely difficult problems. These realities are very common for people in the low socio-economic strata.

Couture & Milner-McLemore (2003:53) highlight the fact that there is a link between poverty and high HIV infections in the poorest communities in South Africa, especially among women. The vicious cycle of poverty and HIV infections is emphatically demonstrated by Vester (2012:10), who indicates that "poverty has an impact on people's total view of living and the way in which the world is perceived. The struggle to survive becomes absolute and eventually has an impact on the moral existence of humanity. Not only does it direct the manner in which living resources are obtained, but it may also lead to serious ethical crisis."

It is clear from observations made by Vester that poverty is directly against human dignity and value, and thus becomes catastrophic when coupled with the inevitable reality of illness and diseases. This is further explained by Blackburn (1991:41-47), who made the important observation that social circumstances determine who gets ill, what the nature of illness is and what type of treatment is available to combat it. Furthermore, as stated previously, the levels of social standing define illness and recovery strategies for many people. A person's position on the social scale impinges on his/ her condition of health and the treatment available to that person. The HIV and AIDS prevalence rate is therefore high among the poor, with its

devastating effect on life expectancy and on young adults who should be the productive sector of the community (Mash *et al* 2009:5). The impact of socio-economic realities on health outcomes are also confirmed by Mark Tomlinson *et al* (2010:974) by stating that:

Poverty and socio-economic equality are both linked to the spread of HIV infection and to questions of individual and group power. Socio-economic inequality results in social exclusion and powerlessness for people living under conditions of poverty. Individuals living in poverty may not have access to the social and economic resources that contribute to health and a sense of wellness such as access to health care. Poorer sections of a society often have lower indices of health than socio-economically advantaged sectors.

As demonstrated previously, there is a strong relationship between the social class and health. Furthermore, Ross & Deverell (2004:8) through occupational class research brought to light that reproductive and mortality rates increase regularly with decrease in occupational class. Disparities in illness, especially in chronic illness, can be grouped according to occupational class. Poverty as a social evil leaves many Africans in dire conditions, with little option for proper health care. In that light, the faith healing practice is heartily embraced as a quick and economic alternative for healing (Kalu 2008:263). Unfortunately, however, the vulnerability of the poor is further exposed through faith healing, as they may hope for the promised healing that doesn't materialise. Pain, hurt and sometimes guilt accompany such disappointments, and these could result in various psychosomatic manifestations.

This is even true when considering the causes of poverty as indicated by Myers (2008:83-86): There are four impact areas of poverty, namely physical causes, social causes, mental causes and spiritual causes.

- The physical causes address the lack of basic amenities such as water, housing, food and health. The majority of Africans are desperate for these basic needs and remain poor as they are unable to cater for them.
- The social causes deal with social and cultural practices that are accepted by societies, but perpetuate injustice and misery. An example of this is that in many African tribes women do not own property and therefore, if the husband dies, the wife cannot inherit property or the estate. The practice of Ukutwala, whereby young Xhosa girls are forced into marriage, is also another demeaning and disempowering phenomenon.
- The mental causes of poverty are lack of knowledge and technical skills. Poor people especially develop a mentality of worthlessness, anger and disillusionment when they

lack these things. All the problems mentioned previously, coupled with lack of nutrition, illness, drugs and alcohol, also create and sustain poverty (Myers 2008:84).

- The spiritual causes of poverty deal with the battle many Africans engage in to safeguard against witchcraft, evil spirits, misfortune and bad luck. For example, Vetser (2008:86) indicates that people will spend money on charms for protection and time is lost to feast days, all in the attempt to manage these power relationships.

As a result of all these pressures and stresses, there is a great need for psychological counselling among those who are economically disadvantaged (Romeira 1992:247). Focussing on people grappling with illness, who in many instances are poor, indicates that healing ministry should also be based on issues of social justice. Such a system will “certainly mean becoming actively involved in the grey world of politics, social structures and competing interest and might well be more costly and lack the gratification of personal healing ministry” (Pattison 1989:75). Focusing on issues of social justice in illness and health opens the possibilities to employ interventions that are sensitive and embracing to poor and vulnerable people in treatment. Roberts *et al* (2002:424) state that “the rationale for incorporating counselling in overall treatment regimens seems to be scientifically grounded, holistically based, and most optimally effective use of health care services. The question then becomes which issues are most relevant in helping people to cope with chronic and/or serious illnesses and which counselling strategies and interventions are most efficacious?”

The role of the Church in response to challenges of illnesses in Africa, including poverty, is important to reflect upon. Special emphasis is drawn to the impact of Charismatic and Pentecostal aligned churches, as they have benefitted a great deal from the emphasis on faith healing practice.

### 2.3. The rapid growth of Charismatic and Pentecostal churches in Africa

The main focus of the Pentecostal movement is health and healing, which is also an important aspect of religious life in Africa and therefore a plausible explanation of the growth of both AIC's and Pentecostalism in Africa (Kalu 2008:263). The impact of the Pentecostal movement in Africa is massive and has made great strides. Asamoah-Gyadu (2007:310) observes this phenomenon as follows “the emphases of healing and exorcism as tools of

evangelism account in part for the rapid growth of Pentecostal Christianity in Africa and its impact on the older historic mission churches. This impact has been so profound that there is currently an ongoing ‘Pentecostalisation’ of African Christianity in which historic mission churches consciously incorporate pneumatic phenomena, particularly healing and exorcism, into their worship and spirituality.”

Although this research is not about the growth of Pentecostalism in Africa, it becomes evident that healing practice has contributed to growth of Pentecostal churches in Africa. This should be understood against the background of what Laurent Magesa (2004:81) observes, that “if the instinctive cultural impulse of most Africans leads to the belief that being a community is healthy, then it also implies that any lack of community harmony is ‘dis-ease’. Specifically, lack of physical health is understood to be symptomatic of a lack of spiritual, emotional or moral health; it is physically and morally harmful to the society and the individuals concerned.”

The immense growth of Pentecostal churches in Africa is worth noting. There are several reasons for the rapid spread of Pentecostalism in Africa:

- People are dissatisfied with the mainline churches that they experience as maintaining only rules, hierarchy and doctrines, without encouraging strong personal spirituality, liberty and participation in the church service for all laity (Igwe 2005).
- The fact that Pentecostals emphasise miracles and faith healing seems to draw people to them. The continent hungers for miracles and quick fix solutions because of social-economic challenges. Faith healers promise instant healing and instant wealth through prosperity preaching. In fact “faith healers, prophets and sangomas all claim supernatural contact and sanctions” (Bührmann 1989:33).
- Western donors, especially Americans, pour out a lot of money and resources on their protégées in Africa. Prosperity gospel is the order of the day and victorious Christianity is proclaimed, which is associated with health and wealth (Igwe 2005).
- Bührmann (1989:33) indicates that the independent churches claim that they are able to answer the “how” and “why” of the troubled person by divination, and because of this, they integrate the physical and mental suffering with a myth they and the afflicted believe. Thus, they heal a breach. In a similar manner an African theologian,

Philomena Mwaura (2004:105), states that Western missionary Christianity was perceived as failing Africans, especially in the ways it fails to address sickness and health. Mwaura (2004:105) further remarks that this perception was exploited by prophetic and Pentecostal movements, which emphasise the working of the Holy Spirit in manifestation of healing, exorcism, deliverance and prosperity.

Healing practices are a prominent phenomenon within the African Churches and attract many people as a result of the socio-economic hardships African people encounter (Kalu 2008:135). Any religion that endeavours to bring a gospel that gives hope for physical healing and material prosperity will flourish in Africa. The following examples about the growth and impact of AIC's, Pentecostal and Charismatic churches in South Africa are typical of the situation in most Southern Africa countries. In the South African Christian Handbook, Hendriks (2005:27-85) discusses the significant impact and growth of African Independent Churches and Pentecostal churches in South Africa. This is noted against the backdrop of declining membership in the mainline denominations. The South African Christian Handbook (2007-2008:77) also confirmed the decline of mainline churches and growth of AIC's, Pentecostal and Charismatic churches with a majority of Black members. Le Roux (2011:127) alludes that according to the latest estimates in 2010, the Zionist Christian Church has over four million members, and all AICs have a combined total of over ten million people. The fast growth of AIC's and Pentecostal churches' membership is not unique to the South Africa situation, but a phenomenon all over Sub-Saharan Africa. In fact, the growth of Pentecostalism is a worldwide phenomenon. The fast growth of this movement has made it to be on the cutting edge of global missionary enterprise (Asamoah- Gyadu 2005:351; Kalu 2005:388-445).

Lugwanya (2000:32) notes that the Christian Missions in Africa has employed many strategies, but in his opinion, the most dynamic of all were healing and the promise to eradicate the causes of suffering and disease. Lugwanya (2000:32) further alludes that this option is still the most viable one in Africa; as missionaries and evangelists who succeeded in offering healing and protection for the people won many converts. Kay & Dyer (2004:xxv) indicate that historically, Pentecostal churches were started among the poor masses and grassroots people of various societies in the major parts of the world. This may have contributed to the fast growth, as well as the indigenisation of these churches to some degree.

More than these, the growth of Pentecostalism worldwide and especially in the developing world have been through vigorous evangelism and healing practices (Kay & Dyer 2004:192). Emphasis on faith as a healing tool is at the centre of these healing services. The healing ministry becomes in itself a social response and means of remedy to social and spiritual bondages that Africa's poor majority are gripped with. This is only possible if the faith healing practice takes serious consideration of African cultures and worldview (Moila 2002:20).

The implications of the Pentecostal and Charismatic explosion are dramatically stated by Fragell (2000) as "we are now facing the fact that Pentecostals within a period of time also may outnumber the Catholic Church, which today is the world's largest denomination, with 1 billion members. The number of Catholics will increase to 1.3 Billion in 2025, while Pentecostals would over the same period grow from 500 Million to 1.1 Billion. At these rates, by 2030 Pentecostals would become the world's largest denomination."

The reason for these growths are that Africans are attracted to churches that emphasise healing and deliverance from unwelcome powers that often torment people (Magesa 2004:82, 236). Healing practices in Africa are as ancient as the African cultures, as different spirit mediums were used for various deliverances and other exorcisms. African people had their diviners and healers all along. African traditional cultures do not maintain dualism and therefore do not differentiate between spiritual and physical causes of illness. Lartey *et al* (1994:15) are sceptical of a type of spiritual dualism that is abstract to the needs of the poor, as this spiritual dualism is self-satisfying individualistic pietism, which is geared to economic exploitation and the political domination of the poor. The danger of the faith healing practice is that it imposes particular American models and practices of healing on the African people. Escobar (2003:59-60) states that this is "culture Christianity, which makes use of American marketing principles, American nationalism and patriotism." The success of healing outcomes should not be measured by sensational and spectacular healing services, but rather how they transform people towards effective and productive living. Moila (2002:20) argues that the African perception of health, sickness and healing, as well as African experience of the biblical God should be in reciprocal engagement. He argues that once this encounter has taken place between the biblical message and African perceptions of health, a shift of the African worldview is bound to happen. The result of this encounter is a different look and

perspective on issues of reality. Moila (2002:20) states that it is, however, important to note that this encounter does not eradicate the African worldview, but rather introduces something new into it and calls for the reduction of some of its aspects. The newness suggested by Moila through biblical and African worldview gives deeper meaning and better appropriation of experiences of illness and health in African worldview. It enriches already held views on illness and misfortune in African worldview, but also enables critical engagement of African worldview with biblical revelation. Therefore, engagement in some detail with the African worldview and its relation to issues of illness and health is warranted.

#### 2.4. The main components of African Cosmology

It is necessary to provide the basic framework of the traditional African worldview and how life and all its facets are viewed from this vantage point. The modern African worldview, especially in the city of Windhoek (the research focus area), is not easy to define, as Westernisation and a Christian worldview have a great influence on African cultures and perspectives. The residents of Windhoek are people of different races, tribes and nationalities, with different cultural impositions. Even among Black races, there is no one culture that fits it all, as each tribe has distinct norms, customs, traditions and practices. Nürnberger (2007:v) remarks that: “Culture is not something static. Neither African nor Western culture is what it used to be during the colonial and post- colonial era.” Notwithstanding the tribal distinctive and cultural dynamism, there are generally held African customs and practices that form part of what our people used to believe and still uphold generally or broadly across cultures. Therefore, it is justifiable to discuss African cosmology as recognition of all African roots and as a means that gives African identity. In fact, there are all kinds of beliefs Africans hold to when it comes to misfortune, illness and death.

Thus, African philosophical framework and African cosmology are firstly discussed and then related to African views on illness and health issues.

##### 2.4.1. African philosophical framework and African cosmology

Understanding of the theoretical premise upon which African cosmology functions is imperative to better appreciation and engagement with the African worldview. In this regard, Kalu (2000:56) remarks: “Africans operate with three- dimensional perception of space: the

sky, the earth, and the ancestral world, which is located under the earth ... Each space dimension is imbued with divinities, territorial spirits, and a host of minor spirits.” This understanding is also highlighted by Gerhard Buys, a Namibian theologian, in his analysis of an African worldview. He outlined in his paper the "dynamic worldview of Africa", eight integral elements of African cosmology, namely (Buys 2000:12-14):

- Plurality of spiritual beings: In the African worldview, there are many dynamic beings influencing and impacting daily living of whole groups, tribes and clans. The two forces operating in the world are understood to be evil spirits and good spirits. Evil spirits are held at bay by good spirits. Ancestors are an example of good spirits and may be called upon to help the living against the onslaught of evil spirits.
- Holistic creation: There is an equilibrium, unity and balance between and among all creation. The disruption of such balance would bring about catastrophe for the community.
- Human beings: The African worldview does not separate sacred things from human life. There is no distinction of the sacred and the supernatural from the worldly or secular things such as politics, economy, science, art, etc.
- Semi-fatalism of religious interpretation: The fact that spiritual forces precede and rule over all facets of life may tend towards a semi-fatalistic worldview. Human beings are not in control of their lives, as outside forces control them. This stifles personal initiative and self-enrichment. The religion is mainly there to control the influence of the evil.
- Centrality of humans: An African worldview puts human beings at the centre of creation and perceives God as being distant from his creation. The belief is that God created the earth and then departed from his creation. As God is not involved, the importance of ancestors as mediators between God and humans are maintained.
- Cosmic struggle between good and evil: The religion is directed to getting ways to avoid evil forces and to appease spiritual forces through prayers and rituals. The flow of power in a traditional African mind could be directed towards causing good or evil. The power is channelled for beneficial purposes through rituals performed in public by authorised representatives of the community. This dynamic power can also be used

for detrimental purposes to the community, however, through the secret and wilful manipulations of witches and sorcerers (Nürnberg 2007:22).

- Utilitarian nature of African Traditional Religions: As we have noted previously, the benevolent spirits are there to fight and evade evil forces. The followers of African traditional religions recognise only those who possess spiritual gifts to exorcise evil spirits and deliver people from all kinds of bondages as true spiritual leaders. Other leaders, who only preach the gospel message without demonstration of any visible spiritual sign, are not taken seriously. This tendency is called utilitarianism.
- Concept of time and history: The African worldview works from the past to the future; the present is viewed from the past. History is seen as cyclic movement, where things happen according to natural phenomena. Time is never viewed in a progressive and linear way, as it is in Western culture. The African life is categorised by life cycles or rites of passage. The time is described in reference to sunrise, midday, twilight and night and not by the clock, as in the West.

The eight elements of African worldview as described in the aforementioned, demonstrate the close connection between the physical and the spiritual dimensions of African life, illness disturbs this harmony and relationships, both on spiritual and physical levels. In pursuit of healing, contact with ancestors and spirit beings through communication is important. Traditional African worldview is based on oral tradition; therefore, words take prominence in African communities, as power is conveyed through communication. Words, names, greetings, expressions and gestures are loaded with power and may have beneficial or detrimental consequences. Verbal communication is therefore largely formalised (Sundermeier 1998:21ff).

The way African cosmology is constructed and built on spirit reality and the dynamic power concept in itself is fertile ground for healing practice and invitation to spirit mediums to appease in situations of misfortune and ill health. African people understand the influence of the invisible world on the affairs of mankind. This is again the reason why the faith healing practice draws people; faith healing is about the power of words and putting faith in God's power to affect nothing less than positive outcomes. African cosmology is engrossed in the realities of people's experiences and is so rich in aura and mysticism, which is expressed in cultural-religious modes of expression. Christianity that will bring transformation to lives of

people must engage and inculcate itself in African realities. The faith healing practice seems to emphasise certain ‘truths’ Africans respond to in pursuit of health and wellness through the faith healing practice.

Based on the aforementioned reasoning, it is therefore of the utmost importance to have a closer look at how illness and health relate to African worldview, and how these factors could be a catalyst for a responsive healing ministry in Africa. Therefore, a broad discussion on African epistemology with special focus on healing practice is undertaken. This is important for consideration as Africans view illness and health from their own epistemological framework (Moila 2002:20). To seriously engage with the healing practice in Africa requires a better understanding of the African worldview and how African people operate within it.

#### 2.4.2. African epistemology and views on illness and health

The African cosmology and views on illness make it very difficult to just come and treat any condition from a Western perspective. There are implications, even for religious rites such as prayers, which needed to be employed with sensitivity and cultural understanding. Ezeh (2003:37) indicates that “African religion and culture are inseparably linked, for many Africans their culture is their religion and their religion their culture. In most instances, the best way to know an African is through his/ her religion.”

Worldview plays a significant part in the construction of any culture. In essence, worldview has to do with people’s beliefs and attitudes concerning their origin, structure and organisation of the universe and of the laws governing the interaction of the beings in it, especially as it relates to humanity (Ikenga-Metuu 1987:61). A better understanding of one’s own worldview<sup>7</sup> is instrumental to one’s perception of social, political and psychological realities. An African worldview embodies both the visible and non-visible spirit realities. Ezeh (2003:38) attests that “the earth is the visible world. It is the world of a man and all the material surroundings known to man.”

The African worldview sees life as an integrated one, which is in constant relation with the visible and the invisible world. Human beings completely depend upon those invisible powers and beings. The quest is to seek harmony and balance, as breaking of this equilibrium

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<sup>7</sup> A particular worldview of a people’s group is more than a mixture of attitudes and behaviours of a social grouping; it centrally reflects the underlying thought patterns or logical framework that holds together a group in unison.

causes serious disturbances. Any illness is ascribed to a disturbance of the balance between humanity and spiritual or mystical forces, and the aim of health seeking is to restore equilibrium (Bühmann 1989:30). In African understanding, life is a central figure and perceived as sacred. Many African authors have articulated this fact as the central and fundamental point of all theology (Stinton 2004:54-55).

Life is viewed in a hierarchical order. This is confirmed by Bujo (1992:20), stating that “life is participation in God, but it is always mediated by one standing above the recipient in the hierarchy of being. The hierarchy belongs both to the invisible and the visible world.” Sickness in an African understanding is a complex reality and cannot be seen in isolation; it affects both the individual and the community. In African life, concepts of ancestors, witches, and sorcerers take central place. Illness is viewed quite widely and there is no clear distinction between psyche and soma (Bühmann 1989:29). This fact is also supported by Thesnaar’s finding in his study among amaXhosa people of Eastern Cape (1993:37); he argues that “*siekte is by die Afrikamens van sosiale belang, met sosiale oorsake en sosiale gevolge. Wanneer ’n person siek word, kan die siekte nie los van die gemeenskap gesien word nie. Die rede hiervoor is omdat die gemeenskap ’n terapeutiese funksie het.*”

Thus, Thesnaar argues that illness is a social issue with social complications for African people. This by implication means that illness of an individual cannot be divorced from the community, as community fulfills a therapeutic function.

Msomi (2008:99), for example, says that Zulu people understood the causes of illness to be either natural or supernatural; the natural or ordinary falls into what is called the *umkhuhlane* group. These are illnesses that just happened and for which nothing can be done. They are as simple as the common cold, and as serious as epidemics such as smallpox, measles etc. On the other hand, illnesses said to be of supernatural origin need to be taken seriously. These illnesses are called *izifo zababantu* (African disease), with sorcery and witchcraft at their heart (Msomi 2008:107). Zulu people, like most Africans, believe that these supernatural illnesses cannot be treated by Western medicine. “Disease of this category includes the following: *umbhulelo*, *umego* (literally: to jump over). These are illnesses believed to be caused by *muthi* which is spread on the ground. If crossed, this *muthi* makes the person ill. Western doctors may diagnose these conditions as rheumatoid arthritis, tuberculosis of joints, genito urinary infections, etcetera” (Conco in Msomi 2008:107).

The faith healing practitioners work within a cultural vacuum which is devoid of cultural sensitivity and lacks understanding of the worldview people come from and live within. The danger is that people undergo faith healing practice and are expected to receive healing by faith, without really unlocking the deep-seated belief systems they hold about causes and reasons for being ill. Wrong understandings of a situation lead to wrong application and ultimately result in wrong conduct. Healing must therefore take serious note of these philosophical perspectives people grapple with during illness. The fact that faith healers come with Western models that are based on positive confession and “name-it-and-claim-it”<sup>8</sup> theology or positive theology of prosperity preachers is imposing a peculiar philosophical framework based on Western individualism.

Healing and illness are inseparable from each other, as illness is broader than only physical ailment; it deals with the whole imbalance within a human being or the community at large. Therefore, healing should be approached holistically in pursuit of restoring a human being to his/ her relationships on all levels, from spiritual, social, physical, psychological, economic, political and so forth. These community illnesses are multiple: They could be related to ancestral wrath, witchcraft and natural circumstances (Lutheran World Federation 2004).

The concept of illness carries with it both individual and cosmic dimensions. In this sense, illness is never viewed in isolation of community and relationships. For example, if one gets ill there must be some disturbance in a relationship, either with the living or with the ancestors (Berrinyu 1989:71). There are at least three causes of illness in African understanding:

- The first is personal responsibility. Here, sickness results from an individual act of disobedience to communal norms or not appeasing ancestors by neglecting to maintain the relationship with the ancestors.
- The second is generational curses. These were handed down by ancestors as a result of the sin of a close relative in the past.

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<sup>8</sup> This theology is based on the positive thinking philosophy of the late Norman Vincent Peale and was taught vigorously by people such as Robert Schuller and Kenneth Hagin. The teaching states that through the crucifixion of Christ, Christians have inherited all the promises of God made to Abraham, which includes both spiritual and material well-being. The only problem according to this doctrine is that Christians have too little faith to appropriate what is rightly theirs. What they need to do is to state that claim loud and clear. This is the so-called “name-it-and-claim-it” theology, which became both popular and controversial in Pentecostal circles (Cox 1995:272).

- Third is African cosmology, which involves belief in involvement of protecting spirits, evil spirits, supernatural and magical forces that interrupt life for good or bad purposes. The general understanding is that the the invisible world and the physical world are in a reciprocal relationship to each other and communicate continuously, and that there is no demarcation between the worlds of the material and the spiritual, or between the visible and the invisible worlds. The human experiences are connected by constant interaction and communication with other organisms such as spirits, animals, and plants. This relationship gives a sense of cosmic oneness and is perceived as a closed relationship of material and spiritual realm. The world is viewed as a spiritual and historical reality, thus a cosmotheandric vision where God, men and the world are in a symbiotic relationship. Cosmotheandric<sup>9</sup> consists of three main Greek words, *cosmos*- world, *theos*- God and *anér*- human beings. In other words, the African worldview has a strong connection between the divine, nature and humanity. Things are understood to be in a closed, controlled system where everything has a bearing on the other.

This kind of outlook explains the reason why illness and any misfortune cannot only be viewed primarily from a medical point. Spiritual interference in daily living is a concrete reality, and just as illness is perceived as more than mere physical and biological, so treatment is also to have spiritual dimension. Life is perceived as beyond death and death is seen as a necessary passage to life. The life cycle is understood to be a process of perpetual regeneration through various phases of birth, death and rebirth. This phase is reckoned to be of a higher order, which connects individuals with God, human beings and the nature. Nyamita (in Mugambi & Magesa 1998:18-19) attests that “one sees here a kind of ontological process whereby the human subject is accomplished within a cosmotheandric relation implying a necessary relationship between the Supreme Being and the socio-cosmic universe.”

The African belief on the causes of illness has a direct correlation to dying and death, as illness is always understood to be an invader that comes mostly through rebellion and disobedience to communal orders, or a misfortune caused by others through witchcraft and so

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<sup>9</sup> Cosmotheandricism is a concept in which God, human beings and the whole creation are interwoven together without lapsing into pantheism. It illustrates the intimate and complete unity that existed between the divine, human and creation as realised pragmatically in Christ, and demonstrates the goal towards which everything on earth is directed in Christ and the Spirit (Brinkman 2007:151 & Panikkar 1993:72-77).

forth (Appiah- Kubi 1981:14). In fact, there is no clear perspective on how to handle death and how to live with it. This point is better served by the ambiguity death causes, both as a curse and misfortune on one hand, and as an opportunity for growth and celebration on the other hand. In African mythology, death is seen as a mistake or an accident. Death is blamed on either people themselves, animals or on spirits. An African worldview has no sufficient explanation for sickness and misfortune; therefore the beauty of Christ, the healer, is to liberate Africans from fear, deception, victimization or scape-goating (Turyomumazima 2009). Death is perceived as a passage or a journey from this earth to a better spirit world. The dead become spirits and enter the spirit world. From one perspective, the African cosmic-view comes into play in the African thought that at death one joins the ancestors. This means that it is not a radical break, but a continuation of the mysterious life force (Healey & Sybertz. 1996:217).

Knowing that even in death there is still some connection between the living and the dead as explained previously is affirming; this doesn't deny the fear and uneasiness that death brings, however. Death is never welcomed and everyone tries to avoid it at all costs, as it brings untold misery and discomfort. The uneasiness is further enhanced by the very understanding that death causes inevitable separation between the deceased and the living. In the context of how the departed one is viewed, to partake in the Lord's Supper therefore carries great significance for African Christianity. The Lord's Supper becomes a meal remembering the "living dead" person, as Jesus Christ viewed in African Christianity (Brinkman 2007:222). The funeral meal in the African context seems to carry the same significance. The fact that Jesus died an innocent death after living a good exemplary life, qualifies him in African understanding to be part of the ancestors. Jesus Christ becomes an ancestor in a very high order as any human ancestor. This point will be dealt with in broader sense under the ancestorship of Jesus Christ. As noted before, African cosmology views any misfortune or illness as ancestors that are unhappy and therefore bringing hurt to an individual or a family.

The African worldview doesn't have an idea of personal sin, because of its cosmological viewpoint that seeks causes of wrong either in disturbance of natural laws or within the community as a group. Subsequently, there is no reference to personal sin. The only way to restore the healthy relationship is understood to be through sacrificial rites to keep ancestors happy and content. A senior member of the family is responsible to call upon the ancestors on

behalf of his family. Ancestors are believed to have the power over the living and can cause harm or bring prosperity. Jesus Christ, by virtue of being God's son and being the elder brother is understood to have the senior status as the mediator between God and the human race. Brinkman (2007:222) explains that "he will never stop being one of the 'living dead' because there will always be people who know him, whose lives have been irrevocably influenced by his life and work. He is the one whom people can call on for help and to whom people pray, just as seats and staffs, among other things, are the symbols of the presence of the ancestors, so the wooden cross is the symbol of Jesus, the ever-living."

The Pentecostal preachers emphasise the fact that Jesus Christ is supreme over every condition and that his name is higher than any other name, including names given to all kinds of dreaded illnesses, such as cancer, HIV and AIDS etc. This doctrinal position gives hope to many African people facing life-threatening situations and challenges through hardships caused by socio-economic realities, including poverty and poor health. Faith healers often have such a bold faith in the power of God that they boast about the abilities God has given them to heal all kinds of diseases. African people are pre-occupied by the impact of the spirit world and the struggle of evil and good that constantly battle for supremacy over their lives. Therefore, they are drawn by faith healing messages that proclaim victory over enemies to their wellbeing and harmonious living.

There are various types of illnesses in African understanding, some psychosomatic, which have to do with mental disorders and others cultural such as witchcraft, sorcery, spirit possession and hysterical psychosis, poisoning and pollution (Maboea 2002:66-68). African traditional religions perceive mental disorders such as insanity and schizophrenia to be caused by disharmony between people and the supernatural powers. The major cause of insanity is understood to be attacks of evil spirits (Maboea 2002:66). African understanding of healing has to do with having healthy bodies that enable a person to execute tasks and rituals required by communities.

Illness and healing are important components of human existence, as a healthy person has the potential to achieve much more. Religion also plays a big role in illness and health, as this is a time when many people actualise their faith. Faith healing services are in many instances man-centred; they are about the faith healers who do the healing and showcase it to the

onlookers. Unfortunately, the focus from Christ is lost and shifted to the miracle and the miracle worker. This is where the opportune time is missed as so many people are drawn by miracles to healing crusades but are not pointed to the giver of the gift, Jesus Christ. Salvation is a holistic concept that embraces healing, but the methodologies employed in faith healing often do not exalt Christ as much as they portray the faith healer as the wonderful man/woman of God.

There is no need to explain every illness with causality. The fact is that as a result of the Fall of Humanity, we are susceptible to illness and degeneration. “Moreover, one explanation to the puzzle of sickness is that God has a purpose even in suffering, e.g. see Heb 12:13” (Turyomumazima 2009). This was shown by the suffering and agonising death of Christ on the cross, which ultimately brought good news to sinners, by the vicarious atonement established by Christ’s death. Johnson (2006:317) indicates that “by the mystery of God’s will, the shameful cross is the instrument of entry into the authentic glory and honor with which God crowns Jesus.” The focus was not on the physical agony of the cross, but rather on the joy that was beyond the suffering and hostile opposition.

A person, who has a proper grasp and attitude towards suffering, will be strong to fight calamity in his/ her life with intrinsic motivation, firm faith and solid hope in God who is in control of all life. The question should be about how to enhance the spirituality of the healing seeking believers so that they become more whole and complete in their understanding of Christ’s purposes for them as they seek healing from illness.

African people give expression to their daily experiences through music and dance. The use of African instruments for various events, such as rite of passage, naming ceremony, wedding ceremony or burial, bear witness to the fact that music and dance repertoire are integrally linked to African cultural and religious realities (Mtetwa n.d.). Thus, use of drums, ululating sounds and going into trances during exuberant singing and dancing are all indicators that African people have their ways to connect to spirituality. Coupled with these are the offering of sacrifices and other rituals at various important rites, such as birth of a child, at death, initiation to adulthood and even to cast off evil and curse from a household. These are African practices that are widely practiced in traditional African societies as vital sources of spirituality and religious expressions. Before dealing with African spirituality in its relation to illness and health, a brief reflection is engaged on the importance of inculturation in healing

practice. The dilemma for the Christian Church since the advent of Western missionaries has been the failure to contextualise the gospel in the life-experiences of Africans. As such, any healing function would not have lasting impact without engaging African worldview and practices with the gospel message (Kanyandogo 2001:95-105). Inculturation of the gospel would acknowledge that Africans have their own religious experience and consciousness that need to be built upon for a culturally relevant and culturally responsive healing practice (Kanyandogo 2002:118). Inculturation is an important concept that needs to be addressed when dealing with issues related to African perspectives in response to illness and health realities.

#### 2.5. Inculturation: a challenge for faith healing practice in Africa

Louw (2005:151) defines inculturation as a process whereby the gospel is incarnated and embodied within the paradigm of a specific local culture. This happens without losing the awareness of multicultural pluralism, i.e. the reality of different cultures (identities) within a system of dynamic interaction and inter-dialogue. If the cultural dynamics of a given community are ignored or overshadowed by Western modes and approaches of faith healing practice, then such practices do not really contribute to meaningful and significant living as African Christians.

Although healing is a core emphasis in AIC's, Charismatic Churches and Pentecostal Churches, there is also ambivalence to it. There is a fear of syncretism between biblical and African practices of healing (Jenkins 2011:45). This may result in a healing practice that looks Christian in name, but in nature and approach is only a replica of traditional healing practices. Jenkins (2011:46) disputes such a notion about syncretism in African Independent Churches, such as the Zionist Church (ZCC) by arguing that they are authentic Christian and contextually African churches. In fact, there is not a problem with syncretism *per se*; the real challenge is to seek a proper inculturation of the gospel and culture. "In the realm of healing, bringing the African religious customs, orientations, and rituals, to his presence is not syncretistic. It is an ecumenical movement; a process of integration" (Turyomumazima 2009).

The fact is that the gospel cannot be divorced from the culture. The term ‘culture’ has to do with structured customs and underlying worldview assumptions that govern people’s lives. Charles Kraft (2009:401), a professor of anthropology, states that “culture (including worldview) is a people’s way of life, their design for living, their way of coping with their biological, physical and social environment. It consists of learned, patterned assumptions (worldview), concepts and behavior, plus the resulting arti-facts (material culture).” As a worldview is not static, anything that affects it will ultimately affect the whole culture of a certain people and everyone that operates within that culture. Jesus knew this and therefore aimed at one’s worldview when he wanted to put across some important points. For example, when someone asked “Who is my neighbour?” Jesus then told them a story and asked who was being neighbourly? (Luke 10:29-37). Kraft (2009:403) indicates that “he was leading them to reconsider and, hopefully, change a basic value deep down in their system.” This was clearly demonstrated by the fact that Jesus never abolished Jewish roots, but worked with it to transform it positively. Turyomumazima (2009) remarks that: “Jesus does not destroy everything of one’s former education or formation upon conversion. Instead, Jesus inspires the person to find out ways in which he or she can make use of his/her own heritage. Conversion is not an experience of demolition but of resurrection.”

In reality, the contextualisation or indigenisation of the gospel is a necessary and indispensable reality. By doing so, the gospel becomes culturally relevant and bears much fruit. Richard Niebuhr (1951:6-16) illustrates that throughout the history of the Christian Church, five different models have been used as the gospel encounters culture. Clement Chikambo Majawa (2005:10-11) engages with these five models of Niebuhr in the following manner:

- The first model advocated Christ as against culture. This model was represented by people such as Tertullian and Tolstoi in the modern period. The emphasis was on the differences between the gospel and any human culture. The understanding was that the Christians were called to build a different society in accordance with divine laws and there to safeguard the Church from negative worldly influences.
- The second model propagated the Christ of culture. This has a different or opposing approach to the first one. Christ is viewed as the fulfilment of universal human aspirations, and therefore Christians must positively engage in available human achievements. The understanding was that such achievements would only finally

reach their highest goals through conversation with the gospel. The wellknown examples of these liberal theological positions are Gnosticism in the 1<sup>st</sup> Century and Schleiermacher in the 19<sup>th</sup> Century.

- The third model puts Christ above culture. This is a model of synthesis. The gospel and culture are believed to share fundamental affinities, although they differ on important points. The understanding is that the relationship could be complementary and therefore synthesis possible. This was typically the Catholic Church's position for many centuries and was also propagated by the neo-scholastic movement of last century.
- The fourth puts Christ and culture in a paradoxical relationship to each other. This model, that reflected the gospel as paradox to culture, was associated with Martin Luther and existentialist thinkers such as Kierkegaard. It is similar to the first model, as it views irreducible differences between the demands of Christ and human aspiration. It doesn't go for confrontation, however, but accepts the basic situation in which faith emerges and forgiveness of God is received (Majawa 2005:11).
- The fifth model propagated Christ as transformer of culture. The gospel is seen as the final transformer of culture. Human culture on its own is part of the fallen world, but the death and resurrection of Christ has ushered in a new era and culture could be established on a new basis. Majawa (2005:11) remarks that Christian society is not established by withdrawing from the world as in the first model, or by arriving at synthesis as in the third, but through a radical transformation. A classical example is Augustine's theology. These models have important implications for how inculturation is done, even in modern day Christianity. The researcher agrees with the fifth model, which demonstrates that Christ transforms any culture, thus doing inculturation is not necessarily approving everything of a culture, but rather to engage culture in a transformative manner that illuminates the best of such culture and critically engages with negative aspects of it.

The Niebuhr's models have demonstrated the fact that Christ is not against any culture, nor does he impose or distance himself from it; in fact he uses the good in any culture and transforms it for the greater purposes. Transformation of any culture will only effectively happen, as Kraft (2009:404) indicates, when the gospel is "planted as a seed that will sprout within and be nourished by the rain and nutrients in the cultural soil of the receiving

peoples.” There are important implications to understanding culture, as it leads towards contextualisation. Kraft (2009:405-406) mentions important issues that emanate from understanding culture as follows:

- That God loves people as they are and that the gospel should be brought in the culture and language of the receiving people.
- That God works with his people in culturally appropriate ways. Churches should therefore be culturally appropriate, using people’s customs but attaching new meaning to them for God’s purposes. In this way, people are changed at worldview level, as well as at the surface.
- That God’s work within a certain culture never leaves that culture unchanged. God changes people first, and then through them their cultural practices. These are not enforced changes; but people change as God works in them and as they understand scriptures better.

The remarks of Kraft confirm the viewpoints that Niebuhr stated, especially the fifth model that demonstrates the transformatory power of Christ to any culture. The researcher also endorses Kraft’s viewpoints and argues that any engagement of Christian mission, whether through healing or other ministry must not lord over nor despise culture; but rather with due recognition seek to transform it through meaningful and credible engagement with the gospel.

#### 2.5.1. Reviewing modern healing practice in view of inculturation

The independent churches, especially of Charismatic and Pentecostal background, have unabatedly been involved in healing services and have invited the public to witness the healing power of God through their ministries. The danger has always been that at such services the person with the gift of healing becomes the focal point and centre of attraction, which may easily lead to idolising of an individual. The other danger, as already discussed in depth in this section is not being culturally sensitive and contextually relevant. Hence, the need is to address the concepts of African cosmology and how these relate to and inculcate Christ as the “big brother” and “first ancestor”, who fulfils a significant ancestral role (Brinkman 2007:225). He is different in the sense that he died like all other ancestors, but triumphantly arose from the grave and now reigns in glory. The Apostle Paul says, “but Christ has indeed been raised from the dead, the first fruits of those who have fallen asleep”

(1Cor. 15:20). Paul demonstrated that Jesus' resurrection was the "first fruits," a phrase that means the actual beginning of the harvest (cf. 16:8, Ex 23:19, Lev 23:10). This carries the idea of a first instalment (Keener 2007:127). This idea is amplified by Ciampa and Rosner (2010:761) when they indicate that "first fruits" is a metaphor used in the Old Testament to denote the first portion of the crop or flock, which is offered as thanksgiving to God.

Ciampa and Rosner (2010:761), in referring to 1 Cor.15:20, state that Paul made the connection between our fate and the fate of Christ by showing that Christ's resurrection is not an isolated event, but guarantees something even more stupendous. This idea also goes along with the African concept of Jesus being the big brother. Maintaining this critical balance between cultural engagement and biblical hermeneutics is necessary for healing ministry. Most faith healers seemed to be copy cats of American television evangelists (Anderson 2002:529), and seem to ignore African life issues, beliefs and worldview (Kalu 2008:255). The power of media, especially television, is very prominent within the African context. There are various gospel television channels broadcasting into our homes at present. Anderson (2002:530) observes that those TV evangelists of North America have infiltrated African homes through their television broadcasting and have garnished a large following. Thus, not only is a culturally irrelevant gospel brought to homes, but also many African evangelists copy the techniques of these TV evangelists as a way to preach and discharge healing services. The Americanisation of the gospel, especially through prosperity preaching, becomes the focal approach of preaching. Kalu (2008:256), in view of a prosperity gospel in Africa, states: "Some allege that the theology engages God in a spiritual *quid pro quo*; lurches toward full-blown American materialism; bows to the American dream and mainstream culture; and makes God little more than a celestial ATM."

The challenge for the faith healing practice is to detach itself from American hermeneutics and build on African relevant and contextual hermeneutics of healing. Woodward (1995:92) makes an intriguing statement when he says that "there are choices to be made in the way we construct our shared framework of meaning and values in relation to healing, and in our ways of acting within it in order to promote it. Specifically, what models of God and pastoral care undergird the practice of Christian healing?"

A similar challenge is highlighted for Western missions in Africa, which failed to inculcate cultural dynamics and African worldviews for the benefit of the gospel. Petersen (2009:145-146) indicates, in his review of Dutch Reformed Church mission work to the Ovahimba people of North West Namibia, that Christians in the Ovahimba community were disillusioned because they were encouraged to reject their roots. He further echoes the words of a certain interviewee, Maria, who became a Christian and was later lamenting the fact that she lost vital connections and relationships with her pagan family, saying that, “we were not trusted to practice Christianity with our families.” This has brought about situations where churches were planted that are very Western in style, format and architecture and Christians converted more to Western culture than to Christianity. The answers given were also very irrelevant and not really dealing with the real, deep and profound issues that matter to Africans, such as deliverance from evil spirits, sickness and all kinds of taboos. “African universe is a spiritual universe, one in which supernatural beings play significant roles in the thought and actions of the people” (Kwame 1995:69). The challenge today is to engage with forces of darkness in African epistemology and to create a theology of inculturation (Ndegwah in Kwame *et al* 2004: 85) that would answer questions Africans ask and grapple with.

The African perspectives on healing are a crucial basis for critical analysis of the psychological and spiritual impact of faith healing in the African context. In order to assess the spiritual and psychological impact of faith healing on healing seekers, there is a need to first understand what traditional African worldview is. There is recognition, however, that as a result of colonisation and missionary influence over the centuries, many communities in Namibia have embraced both Christian and secular worldviews, and therefore do not necessarily maintain a pure African cosmology.

African people are spiritually inclined because of an African worldview that is intrinsically aware of supernatural powers and the effects of invisible powers. Spirituality is an important reality from whence healing practices and healing rites derive their manifestation in African setting. It is an expression of a person’s beliefs, norms and values which come most to the fore during trying circumstances, such as facing illness or misfortune. Hence, a reflection on various aspects of African spirituality follows.

## 2.6. The role of spirituality in African experiences of illness and health

The research question deals with the spiritual and emotional impact of faith healing, which in itself has strong spiritual undertones. It is unimaginable to think about healing within the African context without reflecting on spirituality. The way spirituality is defined and explained within the African setting shows the all embracing nature of spirituality on all cultural and religious lives of Africans. There is a need to explore the philosophical undertones of African spirituality with its various components, and to reflect on how Africans deal with issues of illness and health through spirituality. Firstly, the topic on what is African spirituality is discussed, then a reflection on main features of African spirituality given, and finally an assessment is made on the role of spirituality during illness.

### 2.6.1. What is African spirituality?

Defining spirituality is not that simple, as different religious traditions have different understandings of it. In essence, it has to do with religious experiences and religious practices. Spirituality could best be described as a lived experience, which refers to the function and impact of the content of faith or belief systems on religious experiences (Louw 2005:49). The definition given by Stevens and Green (2003:x) embrace experiential aspects of spirituality, but broadens the scope to a wider framework that includes the whole human existence and various relationships of such existence. They argue (2003:x) that spirituality is about vibrant experiences of God in multiple contexts of life. Such experiences of life help human beings to discover the transcendent meaning of everyday life, which has to do with all aspects of living, such as work, relationship, life in church and in the world. Biblical spirituality<sup>10</sup> is a social spirituality about God's Kingdom and God's people who are on a journey towards maturity.

The African conceptualisation of spirituality may be different from the Christian understanding of spirituality; this doesn't mean that Africans never had any idea of spirituality

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<sup>10</sup> The essence of this spirituality is love as the central focus of the New Testament virtue for dynamic Christian living. Jesus, in the gospel of Matthew on responding to the question by a Pharisee, showed the essence of true spirituality as: "Love the Lord your God with all your heart and with all your soul and with all your mind. This is the first and the greatest commandment. And the second is like it: "Love your neighbour as yourself." All the Law and the Prophets hang on these two commandments" (Matthew 22:37-40).

before missionaries came, however. Mtetwa (1996) observes that “the praxis of African Spirituality was fully-fledged in the pre-modern world and will probably endure the post-modern world, even if this means re-emerging in a transformed or modified way.” There is a close relationship between the spirituality and culture of a person. In fact, Nketia (2010) states that "culture determines the manner in which spirituality manifests and the expressive forms that encapsulate, trigger, invoke or sustain it. Hence while the ultimate source of spirituality may be invisible, its context and manifestations in contemplative, meditative or intense behaviour or expressive forms are culturally defined".

Spirituality<sup>11</sup> is about the spirit and life view of a specific culture. This means that a person or a group has an underwriting common concern or drive that governs such a person or group. This is expressed in thought patterns, ways of thinking and in behaviour. Spirituality touches the whole of a person and not only the religious or moral consciousness (Louw 2005:158). In other words, spirituality can be institutionalised in ways that enables it to be expressed in visible forms, such as use of drums and other instruments in some African societies. Bellagamba (1987:99) calls for the development of a new attitude towards spirituality, when he suggested that attitude is to be "inculturated attitude."

According to Bellagamba (1987:99), the advantage is to "avoid the danger of uprooted spirituality, cerebral spirituality, a spirituality which is apart from, and not part of, life." There is a need to make spirituality relevant to the needs of people it serves, and not to have an abstract concept of spirituality that stands aloof from real issues people are concerned with. Therefore, African spirituality is built around the cultural and religious realities of African people. Lartey (1997:113-123) propagates a spirituality that makes room for "a human capacity for relationship with self, others, world, God, and that which transcends sensory experience, which is often expressed in the particularities of given historical, spatial and social contexts, and which often leads to specific forms of action in the world." In further exploration of this point, Lartey (1997:113-123) outlined the "characteristic styles of relating" in five dimensions:

- Relationship with transcendence. The notion here is that spirituality is experienced universally by human beings in relation to divine power, which is transcendent to

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<sup>11</sup> Spirituality is the very life force or motivation that gives meaning to life and enables people to cope during hard and trying times of lives.

human everyday life, but also part of such human life. People respond to this transcendence through culturally appropriate religious practices and rites.

- Intra-personal relationship, which deals with how one relates to him/ herself. The understanding is that better appreciation of self in itself brings out dynamic spirituality.
- Interpersonal relationship, which deals with relating to others. The spirituality is expressed by cultivating an I-Thou relationship with others where virtues such as respect, accountability and friendship are fostered and maintained.
- Corporate relationships among people. This is about building solidarity and meaningfulness by participating together and belonging together. Africans have many rituals and festivities which bind, unite and form spirit of communality among people.
- Spatial relationship, which deals with place and things. Human beings are in a mutual relationship with nature and their environment. There is a great sense of spirituality in nature and universe. The danger is when we turn worship that is due to God to created things. African culture has many tokens, as well as life-cycles revolving around nature that enhance the spirituality of the African person.

All these observations by Lartey are indeed a vindication of African culture which, by virtue of *ubuntu* spirit, is grounded on relationships. Kasambala (2004:44) remarks that “Lartey's five dimensions of spirituality are helpful for understanding African spirituality, especially when compared to other spiritualities in different contexts of the world. The outstanding feature that has important significance for spirituality in Africa is his emphasis on the corporate (relationships among people) dimension.” It is quite clear that African spirituality is the gem that binds together different facets of African living. It is like glue that holds everything intact. This spirituality finds its greatest expression in relationships at various levels: Relationships with God, ancestors, fellow human beings and nature. Spirituality revolves around the experiences of an individual and community together. It creates an opportunity for communities of faith to cultivate a sense of Christian unity and a brotherly/sisterly spirit that fosters greater unity that would be the basis for Christian witness and solidarity. In fact, spirituality has the power to draw an ill person beyond his/her pain and discomfort to a reality that transcends these physical challenges. It is about discovering the value of sustaining hope from which to draw some meaning and significance. This, by any

imagination, is not the denial of illness, but rather a quest for healing and hope to become normal again. Therefore, spirituality could enable a person grappling with illness, who is emotionally and spiritually drained as a result of prevailing illness and the seeming silence of God, to draw comfort and be hopeful in praying for healing. Kalilombe (1999:216) states that African spirituality is about "examining the way of life and following up those attitudes, beliefs and practices that animate people's lives and help them to reach out toward super-sensible realities." Spirituality is the very ingredient that gives meaning to life. In other words, spirituality enables a patient to constructively grapple with the realities of illness and death, and with hope and life as two opposing realities.

Abraham and Mbuy-Beya (1994:65) indicate that "these two realities (illness, death versus hope, life) stand in continual opposition and humans are only human insofar as they can conquer death. The entire structure of traditional society battles to ensure this victory of life over death., through cult, appropriate liturgy, rites, and the political, economic, and social organizations. "

The aim of all these structures is to bring freedom to humankind from everything that causes death, in pursuit of promoting everlasting qualities. These are demonstrated by special attention given to rites and rituals around birth, initiation, marriage, burial and other purifications. The hope is that these practices will bring about harmony between the individual and the community and that this union will give significance to an individual and also enables him/ her to connect with ancestors. Spirituality is a desire for life that resists death and its agents. The whole purpose is to enable an individual towards self-discovery and to develop self-worth and self-significance.

The structure of African spirituality is best depicted by a circle and not a pyramid. This confirms once again the importance of community, which is based on the ubuntu spirit of (Mtetwa 1996:24) "*umuntu ungumuntu ngabantu*". The expression states that "a person is a person through other people." In order to engage effectively with African spirituality, it is prerequisite to have some understanding of main components of African spirituality.

### 2.6.2. Main features of African spirituality

African expression of spirituality is more than a religious or pious duty. It is based on and derived from community coherence. The following are the main features that give expression to African spirituality.

- In African spirituality, God is both distant and near, transcendent and immanent. The understanding is that God is involved in daily human affairs and as a just one punishes sin (Long 2000:23). People are dependent upon God and therefore need to maintain good relations with him, as he punishes wrong doing, but rewards good with provisions of health, food, prosperity, life and children. On the other hand, there is this understanding, the dichotomy that God is viewed as supreme and too remote to enter into relationship with human beings. Transcendence is thus maintained in terms of relationships (Louw 2005:162). This outlook perceives God as immanent in his irresistible actions, but distant, unapproachable and unknowable in his being. This leads to a fatalistic approach to life, as all human beings can do is to passively accept his will (Long 2000:25, Louw 2005:162).
- Cultural images that influence African spirituality and God-images are formed along tribal, clan and social lines. God is seen as the Great Ancestor and many stories told about the divine are similar to those about the ancestors.
- African religions function both on communal and anthropocentric levels. Christian theologians have described Christ as “Brother Ancestor” (Nyamiti 1984:23) or “Proto-Ancestor”, which means that “he is the unique character who is the source of life and the highest model of ancestorship” (Nyamiti 1984:7).
- Divinity is described by African religion as a vital force that moves and rules humankind and determines their fate in the world (Setiloane 1989:34). This view holds that God penetrates everything, everywhere as a living force, and that is the very reason in Africans’ minds why things live.
- African thought is inclusive in each approach to life. The divine as the life force becomes part and parcel of the struggles of Africans to survive. Thus, the divine is incorporated into the African worldview and issues of life.
- African culture has some awareness of shame and guilt. These concepts are mainly viewed from a communal perspective as breaking certain expectations of the

community, leading to shame and guilt. The conscious of shame and guilt are mainly viewed from not meeting societal norms and values, which could result in loss of honour and status in the society. To acknowledge shame becomes very difficult and many people hide transgressions as long as they can, to avoid being shamed and possible rejection and marginalisation. In such a shame-guilt culture it is also difficult to forgive and to restore a person easily for sins committed against the community. This very point could be a big contributor to high HIV and AIDS prevalence rates in Southern Africa, as people are still afraid to disclose their HIV positive status because of the intolerant and unforgiving nature of African culture.

Reflecting upon the aforementioned features of African spirituality, the following observations are worth noting: A spirituality which doesn't express solidarity of communities, their events, hopes and concerns, cannot speak to Africans who are fundamentally communal and relational. A spirituality which doesn't reflect the struggles of people for better life, for justice and for greater unity of humankind would not attract Africans who are by heart loving and sharing. Skhakhane (1995:11) states that in African spirituality, community is a core sentiment and the concept of community embraces both the living and their ancestors. It reflects upon this intimate relationship between Africans and their ancestors. The whole concept of ancestor worship is based on the very essence of African culture, which is based on the concept of ubuntu or sense of community. This important African value is essential for meaningful human relations and interaction. The well-known African saying of "I am because you are" encapsulates this value. The individual identity and the consequent value is a direct consequence of identifying with the community. Community is the capacity to belong to one another in love, which conquers fear. The African community is a mutual society whereby the human need is the criterion of behaviour. In the community there is basically a spirit of communing. Life is characterised by exchange, inter-subjectivity and reciprocity (Ezeh 2003:67).

The great benefit of the traditional *ubuntu* spirit was the support system it rendered to everyone. The most vulnerable of the society, such as the old, disabled and poor benefited immensely through the system. There were virtually no street children, prostitutes and

beggars, even though there were poor people. The traditional African community<sup>12</sup> is understood to consist of the living, the dead and the unborn, and is of primal importance for the survival of the individual. Louw (1998:78) states that "for the African, life is a continuum of cosmic, social and personal events. When one breaks society's moral codes, the universal ties between oneself and the community are also broken."

Ancestors have a significant role to fulfil in the community as a link between the community and the spirit world. As already mentioned previously, the relationship of the living and the dead is ontologically established and maintained. Kasambala (2004:53) contributes that "moreover, it could be argued that an African cosmology forms part of an African spirituality. For an African spirituality, as well as an African cosmology, is basically based on the assumption that life is influenced by relationships between human beings, the visible and invisible." African cosmology is driven by a dynamic power that governs communities and this power is invisible yet effective (Nürnberger 2007:22). This dynamic life force is the very drive of a community, which is ordered on hierarchical structures. The whole life pattern is centred on the core dynamic power imagery from where all life emanates in Africa. A good example is how spatial expressions are used, like African huts which are round with the fire place as the central place of all activities (Nürnberger 2007:22). Family sits around the fire in a circle where a hierarchy is maintained; this circle becomes the centre of solidarity. The whole life of family, clan, tribe and community structure is organised from a dynamic power position in order of importance. This is also quite important in cases of calamity, sickness and death. The ubuntu solidarity makes it easier to deal with such crises. One person's sickness becomes the community sickness. Spirituality is our connectedness to God, to our human roots, to the rest of nature, to one another and to us. It is the experience of the Holy Spirit moving us and our communities to be life-giving and life-affirming.

Spirituality that will affect Africans must incorporate all people, their events, their richness, their hopes, aspirations and concerns, as Africans are communal people in essence (Bellagamba 1987:107). Throughout the so-called Third World, spirituality is celebrated in

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<sup>12</sup> It is a community of the living and the dead. This is how the ancestor worship becomes part of the traditional African culture, as both present and the past members form a community. The same understanding is maintained also on the physical side. The traditions, taboos and norms of the past are still maintained as a source of wisdom, guidance and inspiration by the living ones. Death only widens the communal relationship and therefore communion of the dead is maintained through ceremonies, sacrifices and rites.

songs, rituals, and symbols that show the energizing Spirit animating the community to move together in response to God (Lutheran World Federation 2004). Many churches have indigenised their worship patterns, where drums and instruments are used with Western hymns to give recognition to the way Africans express spirituality. The challenge, however, is to go beyond the Africanisation of Western hymns to a place where African Christian hymns and songs are created from African experiences of sufferings and joys and included as ways of expressing African spirituality.

The fact that many churches have attempted to embrace more African expressions and styles in worship also has a strong significance for the healing ministry. Chances for a person suffering with illness to be healed are improved greatly when the environment is conducive. The indigenisation of worship and understanding cultural dynamics all play a part in the process of holistic healing. The faith healing practice has not in any way dealt with the issues of indigenisation of the gospel, but has been fruitful because of the realities of illness it attempts to solve through healing. Faith healing is also rigid, as healing is perceived to be manifested only through prayers of faith. In that sense, the rigidity of faith healing practice that mostly emphasise prayer only as a method for treating ill people, can construe what Kretzschmar (1995:69-70) warns against as narrow, privatised spirituality. In her view narrow, privatised spirituality:

- Is inherently individual and dualistic, as it separates reality into different spheres; physical versus spiritual, secular versus sacred, public versus private, soul saving versus social involvement.
- Spiritualises the gospel. Biblical terms such as healing, salvation and poverty are understood to address spiritual needs and not the physical or material.
- Is individualistic and not emphasising both individual and the community or group aspects. Over-emphasis of one against the other leads to dysfunctionality and ineffective Christian impact.
- Is contextual. The tendency is to neglect the real issues people face and to spiritualise in a way that the reason and faith issues are not seriously engaged with.

The faith healing practice is much individualised and exposed to the same dangers of privatised spirituality, as warned against by Kretzschmar, in the way it ignores the whole

dynamics of the African communal concept and concentrates on the individual alone. Healing is understood to manifest through the faith healer as an individual vessel, which compromises the teaching of the Bible that talks about the congregational setting of healing, and says that elders must be called in to minister healing prayers (James 5:14-15)<sup>13</sup>. This text has been thoroughly commented on in the previous chapter, and thus its meaning established. The important link here is that as a model text for the Christian healing ministry, it gives us some indications of how to engage in healing ministry. Importantly, the corporate involvement of leadership in ministry is emphasised and its benefits shown as going beyond physical to spiritual and emotional healing.

The ultimate spirituality of a person or a community must enhance both the vertical relationship (God-Man) and horizontal relationship (Man-Man) for significant service. In other words, spirituality creates awareness of transcendence in the midst of existential and social conflicts (Louw 2005:51). This awareness results in prayer and charitable deeds of love within society. The fact that spirituality forms the basis of human dignity and purposeful living, as outlined in this section, has some implications when considering illness and health. Illness attacks the very core of human dignity and human wholeness, and on reflection the same spirituality is paramount in fighting against illness and promoting of health. Therefore, a discussion on the relationship between illness and spirituality follows.

### 2.6.3. The role of African spirituality in Illness and health

Spirituality plays an important role in the way illness and health are perceived and treated by Africans. In an African understanding, health is to be in good standing with one's environment, whilst illness disturbs and destabilises the societal order, equilibrium and harmony (Louw 2005:169). Illness has a broad sociological impact as different social relations are affected, such as family, clan and community. It is also a religious reality, as traditional Africans perceive that protection networks were broken, thus causing ancestors or spiritual forces to be unhappy and remonstrating with vengeance to an individual or a community. Mpolo (1994:24) remarks that:

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<sup>13</sup> James speaks of three instances in which prayer must be offered in this chapter; namely, when suffering- v. 13 "*kakopatheia*", when cheerful- v.13 "*euthymeo*" and when ill (v.14). In the case of illness, however, a believer is encouraged to call in elders to pray over him. The Greek words used here are "*proseuchomai epi*." *Epi*- over

In African traditional spirituality, possession as well as bewitchment and any other forces clearly indicate that illness is an invasion of the body by powers which negate human life. Seen and unseen, evil and good powers cohabit with human beings, the good spiritual forces protecting members of the family. The departed ancestors are part of this constellation of living spirits. By virtue of the moral integrity which made them to become ancestors, they live in close proximity to God and are believed to possess special powers.

The aforementioned quotation highlights the African belief in spiritual forces that either work for good or do harm to people. The ultimate desire is to live healthy and productive lives, which are viewed as a blessing from ancestors to those whom they are well pleased with. According to Dwane (2002:19f), African spirituality is underpinned by three basic elements namely:

- a) The value attached to life
- b) The interconnectedness of illness, misfortune and sin
- c) The place of spirits and ancestors in the community.

Fundamentally, an African spirituality upholds the sanctity of life. The fact that an individual life finds meaning and significance in a shared community experience is emphasised. The ubuntu notion (Lartey *et al* 1994:19) “I am because you are” is at the order of the day. In African societies, a person is not a closed unit, but a magnet which interacts with other persons. In other words, being is belonging, so a person finds meaning and fulfilment in the common life (Dwane 2002:28).

Disease was reckoned to be more than just a biological phenomenon. Disease in the African context is not simply failure of mechanisms of the body; it is connected to breakdown in human relationships and neglect of certain important human values (Dwane 2002:26). Illness occurs when the unity is lost and a person becomes separated from the genealogical basis. This is a condition where a person becomes a refugee within his/ her own soul. The outbreak of illness is the way the self is seeking to attract attention to factors that are preventing a realisation of unity (Aldridge 2000:35). Illness is somehow viewed as an inseparable reality of living. People viewed illness in some instances as caused by being bewitched by someone because of jealousy or a relationship that became sour. At other times, misfortune is viewed

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may mean both the physical position and the laying on of hands and is accompanied by anointing with oil. This could be for practical reasons, as oil was widely used as medicine in the ancient world (Moo 1990:174-177).

as happening when ancestors are not appeased and are therefore angry and turn their backs on their descendants (Dwane 2002:26).

Health is basically a temporary balance between the forces of life and other opposing forces wanting to destroy it. At times, when we even believe to be in good health, illness is still potentially there within us, and as soon as the defensive systems of the body weaken, it comes to the fore in one way or the other. So much so, that at certain times it causes great damage even before we become aware (Larchet 2002:9). Any form of illness causes a great deal of suffering and pain, whether physical or psychological, creates ultimately spiritual suffering and reveals the underlying fragility of our condition. Larchet (2002:10) observes that:

Illness normally plunges us into unfamiliar territory, where the conditions of our life are significantly modified and where our relationships with those around us are disturbed and often weakened by imposed isolation. In such cases, we are obliged to deal not only with physical pain, but with anxiety and discouragement, even anguish and despair. This simply increases our sense of solitude, since we feel so very much alone in our efforts to confront the situation.

In view of the pain, trauma, debilitating effects and strain on relationships illness causes, health should not be taken for granted, but appreciated with gratitude as a gift from God. Healing is an integral part of the community and religion involves the whole society in the African context. Louw (2005:169) indicates that “the fact that the illness and illness concept in Africa is both individual and cosmic, and that illness is closely linked to behaviour, which has damaged spiritual powers within the community (e.g. the anger of the ancestors), has important consequence for pastoral model.”

For healing to be effective, it must have ways to integrate society, including family, friends, neighbours etc. The fact that illness and misfortune are viewed either from personal or group transgressions, and that illness is linked to behaviour, strongly advocates that healing and pastoral care should be integrated (Louw 2008:169).

Culture plays a central role in the way spirituality is perceived and practiced in Africa. Thus, a concise description of cultures, customs and traditional practices and how they relate to spirituality follows.

#### 2.6.3.1. The place of culture, customs and traditions in African spirituality

African thought, customs and social traditions must first be understood in order to value the role of African spirituality. Many native and spiritual healers are consulted by people for various illnesses and psychiatric conditions such as schizophrenia to neurotic syndromes etc. Some people with illnesses are treated through the power of the Holy Spirit, prayers, visions, as well as using African native healing medicine (Onyemaechi 2006).

The aforementioned characteristics are complementary to what Kretzschmar (1995:67) suggests as "a better approach" to the whole issue of spirituality in what she calls "holistic spirituality": This spirituality seeks to integrate, rather than separate the various dimensions of human existence. We were created to be in relationship with the rest of the created order, each other, and God. The loss or denial of any of these dimensions of life, results in alienation and poverty of spirit. Thus, a holistic spirituality combines both aspects of psychological maturity and theological maturity in linking spirituality to human life and living. Louw (2005:54) states that such spirituality should improve the quality of human dignity. The presence of God in a person's life should contribute to life's meaning and humanity. It should link the inner and the private dimensions to the external dimensions of public life and our social context. African spirituality is the very benchmark of the vibrancy of the Church in Africa. The challenge is to go beyond liturgies, hymns and dancing to a place where this spirituality impacts the daily life of people at home, work and community with positive and productive change. In other words, African spirituality which has already many facets of holism through its integrated nature must be developed to enhance holistic spirituality. This will benefit even a person grappling with illness, as he/ she would not be looked at as an independent entity, but as an interdependent, spiritual-social being that needs to be treated with a broad healing intervention. Nketia (2010) states that:

The creative expressions of African Christian Spirituality need not to be confined to occasions of public worship whose regular liturgy may be crowded out of announcements, cacophony of praying voices and spirited dancing etc. If its provenance is expanded and

not constricted to contexts of formal worship, Christian churches can make significant contributions to culture in contemporary contexts, as creative artists inspired by the spirituality of their Christian faith create 'great works' of art and or models of excellence in the various domains of art.

The holistic approach to spirituality is valuable, as it guards against making spirituality an abstract reality of the heart only, and expands it to whole sectors of human experience and living. African spirituality is a broad experience that is open to Christian engagement and interpretation. There is caution to guard against an “imperial mentality”, however, whereby what is African is seen as primitive and what is Western as superior and something that should absorb African expressions of spirituality. As already remarked by Escobar (section 2.3.), faith healing and subsequent healing practices are very Western in modes, approaches and practice and don't have the sensitivity to be culturally relevant.

In dealing with illness and diseases, it is important to have some understanding and appreciation of certain belief and practice systems that may still be held by many African people, despite of them having embraced Christianity. An African understanding of health means to be in correct relationship to one's environment (Louw 2008: 169). On coming to Africa, missionaries built hospitals to concentrate on physical healing and left out the spiritual causes of sickness as understood by African and biblical healing (Lutheran World Federation 2004). Most Western missionaries rejected African healing practices, as they associated it with ancestors and spirits.

An African Spirituality is clearly based on the cultural and traditional realities that are in many ways syncretistic, as it accommodates both the role and influence of ancestors as well as embraces Christ and his works in its experience. The syncretistic tendencies have also been reflected in the way African spirituality becomes the melting pot of various practices, as many people seek healing from both traditional healers and Christian healers. Syncretism occurs when Christian practices are mixed with traditional worldview practices that are not necessarily biblical. This happens, especially when certain Christian rituals are perceived to have magical powers, or where the Bible is used to cast spells on people (Kraft 2009:405). There seems to be no problem or experience of dualism in this regard, as many Africans easily consult traditional doctors on Saturday and come to the church on Sunday to pray. The significance of African spirituality has everything to do with the way African people perceive

Christ in their cultural framework. In that sense, the African traditional religions that work strongly with symbols and imagery have certain metaphors that depict their relationship to Christ. Native traditions make use of various symbols, riddles and stories to convey certain truths; thus depicting Christ in Biblical metaphors is the very African way of communion.

Thus, the need is to discuss African people's perception of Jesus Christ and how biblical metaphors relate to issues of healing and wholeness in African reality. The focus is on a typical African understanding of Jesus Christ as a healer. This is done through the use of biblical metaphors of the three-fold ministry of Jesus as priest, prophet and king; and by showing his mediatory role as the first ancestor in African Christology.

#### 2.7. Biblical metaphors used in African Christianity.

African symbols were discarded as barbaric by Western missionaries who came to Africa and were replaced by Christian symbols (Kyeyane in Bediako *et al* 2001:166). This was done without any attempt to understand the significance of African religious symbols, which serve to evoke the presence of God and the ancestors among the people (Kyeyane in Bediako *et al* 2001:166). The symbols have great significance for Africans when it comes to issues of illness and health. The healing practice is an integral part of African Christianity, as demonstrated by discussions on the growth of AIC's and Pentecostal churches in Africa. The importance of this section for the research question is that it shows how the embodiment of cultural and religious concepts creates space within the African setting for a person suffering illness to consult healing mediums that use the name of God, with the hope of physical recovery. This is done within already established cultural and religious milieu and is in no sense seen as embracing a foreign concept of healing practice.

This lack of understanding of healing from cultural perspectives highlights shortcomings in the faith healing practice, which often doesn't take cultural realities seriously. African people associate with Jesus Christ within their own philosophical setting and embrace healing efforts that make sense to their reality. Hence, a reflection on African Christology as it grapples to give meaning to the Risen Christ through its various cultural symbols and representations. The humanity of Christ is really the only visual basis from which Christology becomes more meaningful. That is why the cultural expressions and parallels used in African Christology

could be helpful in engaging in a meaningful way with Christ the Lord for African reality. This manner of identification with Christ becomes a means of victory, even in the midst of tormenting pain and suffering caused by illness. A person's face reveals the person; calling his/ her name helps with identifying with such a person or a face. Sanon (in Schreiter 1997:85) states in the following words "to see the face of Christ, to recognise his face, is to find an African name for him."

To give true expression to Christ's true humanity, or to symbolise the face of Christ, is quite difficult in any culture, as there is a great mystery and hiddenness to Christ in his incarnated humanity. Nevertheless, it is an important point of reference, as Christ becomes an integral part of joys, struggles and fears of people by these metaphors. He becomes the true Immanuel and a vital link between the divine and human. The different metaphors used about Jesus give Africans hope and assurance that their plight is brought before God and their cries are heard by him. The quest of African theologians is to conceptualise an "African Jesus", who is a unique ancestor and healer, who brings together African traditional religions as life-force, in harmony with community but under the auspices of Jesus' crucifixion and resurrection in a liberating manner (Brinkman 2007:208).

The African Scholars have designated certain titles or faces to Christ; thus, relevant metaphors related to Jesus are discussed. These metaphors are relevant to the research question, as they show the cultural and religious understanding of traditional African people and how these create a symbiotic relationship with what Jesus Christ means to Africans. Hence, the following three metaphors will be discussed:

- Firstly, the threefold function of Jesus as prophet, priest and king.
- Secondly, Jesus as a healer.
- Thirdly, Jesus as an ancestor.

The two images that most stand out among different images of Jesus in African Christology are indeed Jesus as ancestor and Jesus as healer. These two images play quite a central role in the operation of African religions. The main thrust of all the images is the way they portray Jesus as the bestower and protector of life. In the image of Jesus as ancestor, the continuity of life beyond death is central, while Jesus as healer primarily deals with the restoration of life on this side of death (Brinkman 2007:224-225). Discussing these main metaphors and the

way they are appropriated and applied to African cultural-religious setting has great significance for the healing practice within the African context.

#### 2.7.1. The threefold function of Jesus as prophet, priest and king

The threefold function of Jesus Christ of Nazareth as prophet, priest and king expresses Jesus' relation to his people and his rule over both the present and the future world. These three functions of Christ are quite relevant for Africans in identifying with Christ. The metaphor of prophet, priest, and king is the very centre of the religious life of the African people and no ritual observance would be significant without them. African Christians should view Jesus Christ from their own religious consciousness. Africa is by far a Black continent, whose people mostly were oppressed, humiliated and exploited, and all these factors have some bearing on how Christianity is appreciated within the continent.

The fact that Africans view Jesus as prophet, priest and king is significant; especially if considered the practice in AIC's where people follow their leaders and is inspired by their representation of Christ (Waruta in Mugambi & Magesa 1998:50). In African religions, the roles of prophet and priest are inseparable, as they are fulfilled by the same person; nevertheless, at times the two roles are used distinct from each other. The main distinctive mark is that a priest performs rituals, which signify authority. In other words, the priest officiates over rituals and leads worship and all the rites of passage (Waruta in Mugambi & Magesa 1998:48). They are the experts in traditional wisdom, rituals and ceremonial practices. Therefore, they could be seen as the living symbols of African religious life. Community members go to them for counselling, advice and to appease the ancestors. The priests are seen as the transmitters of "life force" through which community life is transformed to a better end. Against this background, embracing Jesus Christ as prophet and priest brings about the same sentiments and appreciation to him. It further demonstrates the expectations African faith community attach to their relationship to Christ.

Jesus is also portrayed in Africa by the image of a great chief. In a typical African setting, kingship is a hereditary position based on ancestral lineage. It is customary that a chief or a king is honoured and loyalty given to him or her. An African chief is a figure of authority as the defender, protector and commander of his/ her community. The title of king is understood in African Christianity to fit well with Jesus Christ. The fact that the king fulfils both the

political and spiritual functions is significant in the way Jesus is viewed. The king supports his/ her people. Kabasélé (in Schreiter 1997:105) states that “power belongs superlatively to Jesus Christ because he is a mighty hero, because he is the chief’s son and chief’s emissary, because he is strong, because he is generous, wise and a reconciler of human beings.”

The title “chief” in the African context could be paralleled to the New Testament equivalent “Lord” (*Kyrios*), to show the place and the position Africans attribute to Jesus. The fact that Jesus Christ inherited the chieftaincy is core and complies with the African understanding of power. Kabasélé mentions five points in relation to Jesus’ chieftainship in the book of Volker Küster (2001:59-61):

- Jesus Christ is chief on account of being a hero. He is the one who has powers over the evil forces of the devil and brought a halt to these evil powers. He has demonstrated the ability to defend and protect the community.
- Jesus Christ is chief for being the son and an emissary of a chief. He is the son of God, who is the chief over all creation, whether visible or invisible, whether in heaven, on earth or under the earth, whether terrestrial or celestial. In line with the ancestral regulations, the son becomes the chief and inheritor of all rights.
- He becomes the chief because of his strength. He is the mediator and intercessor between ancestors and God and by virtue of this is to be initiated. He becomes the catalyst for life to flow to the community and hence, to protect them.
- He is the chief because of his generosity and wisdom. As chief he is concerned about the interests of the community and gives counsel and advice in line with the will of the ancestors. Jesus Christ said he only does what he sees his father doing (John 5:19).
- He is the chief because he is a reconciler. The chief must ensure unity of his subjects at all times. The chief must step in and bring order and unity in order to ensure flow of life.

Thus, ascribing to Jesus chieftainship carries the similar understanding of Jesus as Lord over all creation. In the African context, the chief ensures protection, order and rule over his subjects, so Jesus also gives sense of security to Africans in their socio-economic challenges.

The reflection on the threefold function of Jesus Christ as it relates to African Christianity has great significance. This is even true when considering the philosophical paradigms in traditional African societies concerning Jesus Christ as shown in this chapter. Jesus is culturally accepted and viewed both as judge, punishing wrong doings and rewarding good, but also as an advocate, who stands in the gap for people's needs of justice and righteousness.

People want a Jesus who is concerned about their needs in this world. The following statement shows the deep seated perception of Africans about Jesus Christ: Africans want a leader who shows them the way to liberation now; liberation from disease, oppression, hunger, fear, and death. This type of Jesus is the one that is presented by the gospels. Africans identify very much with Him. He is the prophet who exhorts them to better and more hopeful living. He is the priest who mediates between them and the external powers of the living God. He is the king who leads His people to victory over the overwhelming threats of life. In one Jesus, the three-fold office is seen in its unity. Jesus is Prophet, Priest, and Potentate, all rolled into one. This is the way the New Testament sees him. Africans would like to see Him in this manner (Waruta in Mugambi & Magesa 1998:51). The understanding of Jesus' threefold function as prophet, priest and chief, amplifies his roles as messenger of God, mediator of people before God, and as figure of authority to defend them. In fact, this becomes a solid basis and theoretical framework from which Jesus is appreciated as healer, and as first ancestor. Therefore, the imagery of Jesus as a healer and as a first ancestor gives some justification for why healing ministries are so vibrant and welcomed within African communities. It is at the very heart of an African worldview.

### 2.7.2. Jesus Christ as Healer

There is a general consensus among African theologians that the concept of "Jesus as Life-giver" is very central to all themes for African Christology as a result of the important emphasis on life in African communities. Benézét Bujo (1990:103) acknowledges that Africa has many values, but he states the main one as follows: "Among those values we have to underline life, which was the cardinal point for all the rest. Life is, of course, that to which all humanity aspires, but the way in which the African systematically centres community and ethos around life deserves particular attention. The Christian message cannot ignore this fact without exposing itself to failure."

Africans are not comfortable with either preaching that advocates purely spiritual salvation, or with a purely medical approach to diseases. Both, an approach that is too spiritual and too medical an approach ignore the many questions that physical suffering invokes. True salvation in Africa will always be viewed holistically, relating to both spirit and body (Brand 2002:103-106). The imagery of Jesus as healer or restorer is central to African Christology and need serious consideration. Africans understand God to be the source and possessor of life in the face of Africa's impediment realities of sickness, death, floods, drought, hunger, suppression, political instability, corruption and wars, and Africa's quest for healing, salvation and liberation.

The three major challenges that offer constant threats to human existence in Africa are poverty, ignorance and disease (Ezeh 2003:280-281). The issue of illness or disease is acutely serious in Africa as it impeaches on an African cosmology and the wellness of a community. Human life is viewed as good and worthy to be protected at all costs from every evil intention and attack, such as barrenness, sickness and all sorts of misfortune. We should however note that African culture does not view health only from the physical perspective, but strongly relates it to the spiritual reality. Even though most Africans recognise the natural causes of certain illnesses, these do not preclude the simultaneous role of the supernatural causes. Every misfortune, like good fortune, involves two questions: The first is how did it happen? And the second is why did it happen? (Appiah-Kubi 1987:75). Although the cause of an illness could be known on a natural level, like being bitten by a snake, the more important concern is on the spiritual level, as the question "why?" or "why me?" is asked. Therefore, spirituality is of the essence to practice of healing, as indicated earlier. It is the driving force and means of strength through challenging times of sickness and discomfort. The physical cause of a sickness is only one side of the coin. The other side, which is viewed as the real cause of a disease, is in the realm of the spirits and ancestors. Disease is primarily understood as a state that reflects upon the disturbed relationship between a person and spiritual forces. Once the generally held assumptions for causes of sickness have been investigated without the change of situation, usually suspicion of deeper causes and even evil intent such as witchcraft is assumed. Therefore, a logical solution is to seek some help from a diviner, to disclose the causes of (problems) misfortune and death (Berinyuu 1988:37). An African

Christian may start by seeking help at this point from some spiritual healer, and if he/ she is not grounded in the faith and not getting well, may be tempted to look beyond this help to traditional mediums. The involvement of diviners, herbalists and spiritual healers becomes a constant phenomenon. The diviners and spirit mediums advise on the “real cause” of misfortune, with solutions ranging as wide as not appeasing ancestors to malicious attacks from the evil spirits. The spirit mediums such as healers, miracle workers and soothsayers, are given recognition as messengers of God by Africans. The fact that bad fortune and diseases are viewed from this mystical viewpoint makes religion play a pivotal role in the healing process.

In contrast to any traditional alternative to healing, the faith healers emphasise faith in Jesus as the only means of manifestation. The faith healers have identified their ministry as the outflow of Jesus’ call to them as his servants, which he commissioned in Mathew 28:18f with the mandate to go, preach and teach and performed accompanying miracles. On the continuing ministry of the Church, Keener (2009:718) remarks that “because Jesus has all authority, because he is king in the kingdom of God, his disciples must carry on the mission of teaching the kingdom.” The faith healers believe that they are the perpetuation of the saving and healing work started by Jesus and continuing throughout Church life until the present time. "If Jesus can be called the Son of God in the New Testament, it is clear that the therapeutic gifts that the other healers already possess on behalf of the Most High will be expressed most powerfully in Jesus. In addition to the New Testament, the traditional relation of the healer to the Supreme God forms a rich soil for the image of Jesus as healer” (Brinkman 2007:235).

Jesus as healer by implication gives the African Church the mandate to continue with his ministry of healing and therefore become an important option to be employed, instead of people seeking advice from traditional healers. Stinton states that Mark 16:18 is widely used by African churches to lay hands on the sick for healing practice. Edwards (2002:506-507) states that these verses in Mark demonstrate that the consequences of salvation are not only assurance and peace, but also performing works of power, such as expulsion of demons, speaking in tongues, healing the ill by laying on of hands, and preservation from harm in handling snakes and drinking poison. Many of these mentioned charismatic gifts have operated throughout the New Testament as signs of faith. The meaning of handling snakes and drinking poison, however, is quite difficult to understand. Most scholars have noted that

Mark ends at chapter 16 verse 8, but as a result of the abrupt ending, attempts were made at later stage to supply a longer ending in the manuscripts (Donahue & Harrington 2002: 462). Hence, the use of Mark 16: 9-20 is disputed in many circles and therefore not strongly grounded to construct an argument from.

Faith healing practitioners view Jesus as the healer that brings life and life in abundance (John 10:10). The teachings about the life in Jesus from the gospels and how all these translate into physical healing is highlighted. The fourth gospel has some relevant metaphors related to life, which Africans could relate to and apply in their search for life in Christ. The Apostle John made use of metaphors such as "bread of life", "water of life" and "light of life" in referring to Jesus' statements about himself (Berinyuu 1988: iv). The water and bread are quite significant, as they demonstrate the basic needs all humanity has to sustain life. Healing is a process covering various dimensions of a person's life from physical, spiritual, psychological, social, environmental, and even political. Thus, understanding and maintaining this process, which involves the relationship between the diviner and the patient, is more important than treatment (Berinyuu 1988: iv).

It is important to note that Jesus' healing ministry brought about a social integration for people of different walks of life. He cured prostitutes, lepers, servant of a centurion, the demon-possessed and so forth. Thus, his social perspective was both embracing of the poor of the poorest or the outcast of the society, as well as the rich and the mighty ones. Christ's healing ministry pointed to the ultimate victory over all suffering and death. The healing ministry of Jesus is a demonstration of the love of God as revealed to humankind. Bujo (1981:27) states that the healings performed by Jesus do not merely reveal his divinity, but show also that Christ as Messiah came to give complete life in every sense of the word.

There are four areas to consider when dealing with Jesus as a healer in African Christianity (Diane Stinton 2004:71-75):

- Firstly, the image of Jesus corresponds to that of Jesus as life-giver, in the sense that Jesus is the restorer and repairer of life, wherever it was destroyed or broken.
- Secondly, that all African people, including theologians, church leaders and lay people, highlight Jesus' healing as re-creation of wholeness in all aspects of life. Many

Africans understand Jesus to be an all-round healer, who doesn't only heal physical ailments; but also transforms financial, marital and whatever difficult situations. He blesses people with jobs, various opportunities, marriage partners and so on.

- Thirdly, African people are burdened by all kinds of challenges and diseases and constantly consult traditional healers. The fact is that the African universe of sickness cannot be detached from the world of the spirits, and healing needs to be addressed from a symbolic universe. In this context, there is a need to embrace the belief in the supremacy of Christ over the whole universe, as Colossians 1:15-20 asserts. Christ is depicted not only as the image of God “*eikon tou theou*”, as Adam was, but he is also king over creation in a way vastly different from the first man (Thompson 2005:29). The supremacy of God is vividly portrayed in the phrase that “all things were created through him, in him and for him”. In other words, all creation has a Christocentric focus. As Thompson (2002:290) states, this shows the totality of God’s creating and redemptive work through Christ. The image of Jesus' supremacy over every form of evil that operates in the universe, whether such manifestation is at physical, mental, emotional, spiritual, or social level is confirmed by other related images that portray Jesus as victor, warrior, and conqueror (Stinton 2004:74).
- Fourthly, is related to images of liberator, saviour, and redeemer. Mbiti (1998:17) argues that Jesus Christ as Victor (miracle worker and risen Lord) is quite appealing in the African context. He is the one that conquers the evil powers such as spirits, magic, disease, death. He became the guarantor of immortality by overcoming these forces feared by Africans forces (Mbiti cited by Nyamiti in Mugambi & Magesa 1998:17-18). The fact that many vernacular terms employed for Jesus in different cultures use interrelated concepts for saving, healing conquering, and protecting shows the unison of the biblical understanding of Jesus to many cultural expectations. This is quite important, as people already have some spiritual insights from their cultures that need to be blended with the biblical understanding. Many Africans indeed have a personal experience through many healing activities to the healing power of God and its relation to prayer. The image of Jesus as healer is therefore connected to Africans, not only on cultural and biblical levels, but also by virtue of personal experiences. Ezeh (2003:283) remarks that “the image of Jesus in Africa as a healer is a Christological construct meant to show how the African drawing from

their socio-religious context of illness, misfortune experience Jesus using the analogous cultural category the community in relation to their assistance to the sick, it becomes less difficult to make an African presentation of Christ, as one who assists them in the condition of ill-health".

Any Christian healing practice to be of any significance should understand the African perspectives on healing, especially the role and the function given to Jesus Christ in African thought world. The failure of many Christian efforts are not so much because of the message, but rather how that message is brought within a certain culture. The faith healing practice may have rediscovered a very important aspect of the Church's mission to the world, which is the healing practice, but as was demonstrated many times in this chapter; faith healers fail to really go beyond the glamour and showmanship that usually goes with modern faith healing practice (Morris & Lioy 2012:76). It fails to address the question of healing from within the cultural dynamics of the African worldview.

The last metaphor discussed is about Jesus' role as an ancestor to African people. The place and roles attested to ancestors in traditional African perspectives form one of the core values of African culture. There is no way to discuss anything African without looking at the concept of ancestors in some detail. It is true to say that with the advent of Christianity, Africa has been Christianised a great deal, and that some cultures may have completely abandoned ancestor veneration. This doesn't mean that Christianity is anti-culture and in conflict with culture, however. Christianity should engage and transform culture with the aim to better serve the African people. Ancestors have always played a big role for many Africans when it comes to different rituals and practices that are geared towards worship and better service to Africans. The true colour of any culture is displayed during times of distress, pain and hurt. Illness is one such time, where people become desperate and seek any means of remedy from possibly life-threatening diseases. For many people, ancestors are not the last resort, but the place where they start before seeking any means of healing. The African view of Christ as the big brother, who intercedes in all challenges, including illness warrants some elaboration.

### 2.7.3. Ancestorship or Intermediary role of Jesus

Any study conducted on the meaning of Jesus within the African context would fall short unless it takes the prominent place and role that is fulfilled by Jesus as ancestor seriously (Brinkman 2007:225). In most African societies, ancestors influence the life and vitality of the living. The deceased is not completely in his/ her grave, as their presence is felt among the living. The dead is therefore part of the living, and a grave primarily a place where the invisible ones are gathered. In other words, they are present, although not in physical sense. In many African cultures, many Christians view their relationship to Jesus Christ as presupposed by their relationship with their ancestors, or on the flipside, by Jesus' relationship with such ancestors (Brinkman 2007:226). Ancestors are seen as "departed" parents, members of a family or a clan who maintain relationships and care for the living. They have special capabilities because of the fact that they are no longer bound by human limitations. This enables them to mediate between God and the Living. Kahakwa (2004:2) writes that "the spiritual status they have reached is differently interpreted. Some African people believe that ancestors are still parents and neither divinities nor God. Thus they are not to be worshipped but only venerated. Other Africans believe that ancestors have reached divine status; therefore they could be worshipped. Others deify only the most meritorious ones and consult the rest. Still others see the priests as higher than all the ancestors, therefore they only consult them."

The question is whether the mediating role of ancestors clarifies the place of Jesus or obstructs the view about Jesus' unique role. Bujo and Bediako (1995:127-136, 1990:41-42) confirm that "Jesus is the 'new' ancestor who breaks through the ethnic boundaries that are observed so strictly in the traditional beliefs in ancestors. He is the ancestor of all mankind." The qualifications for becoming an ancestor are confirmed by Kabasélé (in Küster 2001:62-64) as similar to those of Nyamiti, and he further states that the role of an ancestor is played only by those who have fulfilled all the criteria. He then showed four reasons why the title of ancestor could be transferred to Jesus, namely:

- Jesus Christ is an ancestor as he mediates life.
- Jesus Christ is present among the living. Many Africans hold to the view of communion with the departed who are "living- dead".

- Jesus Christ is at the same time an ancestor and the elder. As the chief and God's only Son, he is the eldest of all ancestors.
- He is an ancestor, as he mediates between God, human beings and the community.

The question and tension within the process of inculturation, especially around the ancestorship of Jesus Christ, is not an easy one to deal with. The ancestorship of Jesus should be maintained on the premise that he completely and utterly outsmarts any human ancestor and is the apex of all ancestor worship for a Christian. Jesus Christ becomes the alpha and the omega of ancestor worship for an African Christian committed to follow Christ as a disciple. By implication, no earthly ancestor is worshipped anymore; they may be venerated or honoured for the place they maintain in the memories of the living. In the book of John Pobee (1992:122-123), the ancestorship of Jesus Christ is closely linked to his saving work. As ancestor, he combines both the works of God, the great ancestor, with functions of all human ancestors. As the elder ancestor, he is qualified to represent us before God, as well as to carry out functions of God. This dual function of Jesus Christ makes him the mediator *par excellence*. Jesus is an ancestor of a higher order as stated previously, but this also carries further implications about his significance as an ancestor. Jesus is set apart from early ancestors also because of the transformative nature, and this point will be discussed in some detail.

#### 2.7.3.1. Transformative nature of Jesus as an ancestor

The ancestorship of Jesus Christ transforms all views and concepts about ancestors. The yardstick for becoming an ancestor is measured from the position of Jesus Christ. Pobee (1992:126) indicates that "the active presence of the ancestors reminds us of the truth of resurrection of Jesus Christ. Hence death is no longer a threat but rather a process of transformation that leads us ultimately closer to God." The concept of African ancestry could be embraced in a transformative manner in Jesus' role as an ancestor. Nyamiti does not have any problem with an African being both authentically Christian and also being authentically African. Brinkman (2007:226) justifies this from the roles ancestors fulfil, which are similar to the role of Jesus, and suggested a "creative synthesis," which advocates Jesus as ancestor *par excellence*. Nyamiti (1984:74-76) argues that the vivid manifestation of ancestral practice is observed in the celebration of the Lord's Supper, as this becomes the ideal symbolism of such transformation:

- The Lord's Supper is experienced as a communal meal that connects people to Jesus, ancestors and with each other.
- People experience the holy and good virtues of the Spirit during the meal, which connects people beyond their tribes to humanity.
- The benefits of partaking in the meal are not only experienced in a spiritual sense, but also manifested on physical and material levels.
- Ancestors are involved in the whole of community, so the Holy Communion is also meant for the transformation of the whole community.
- An internal growth process starts that allows sharing in Jesus' statutes as child of God, just as ancestors also allow us to share in the communal child.
- The nearness of the dead in their "being with God" is experienced more profoundly.

Ancestors interact<sup>14</sup> with the living by virtue of dreams, appearances, visions, sounds, and incarnations through animals. There is a danger in depicting Jesus as an ancestor without proper explanation. Brinkman warned against this, as he said that there are serious reservations or differences between Jesus and ancestors (Brinkman 2007:226,233); therefore comparing his role to that of the ancestors should be employed with caution.

The research benefits from this concept of Jesus' transformative role as ancestor, by virtue of him being the ancestor *par excellence* and by apprehending the spiritual and physical benefits in Jesus, which many Africans otherwise would seek in traditional healers and their ancestors. Cécé Kolié makes some important remarks concerning expectations of an African in view of healing, from those called to administer the grace of healing. Kolié (in Küster 2001:66) states that "Islam and Christianity would only have credit to Africans only as much as they share, side by side with African person in the struggle of life." Thus, solidarity with an ill or suffering person becomes an important point of contact for meaningful healing encounter. Kolié (in Küster 2001:66) further mentions that "death is not what brings fear, given that community exists beyond death, but fear comes by suffering of ill-health and

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<sup>14</sup> Messages come also through diviners, mediums, medicine- persons or priests. Ancestors perform roles such as (Lutheran World Federation 2004. [www.lutheranworld.org](http://www.lutheranworld.org) 17 Oct 2009):

1. Unifying, caring empowering, blessing, rewarding, inspiring families and peoples.
2. Mediating between people and the Divine.
3. Enforcing discipline when broken and facilitate holistic healing.

subsequently dying ill-death." The implication of this statement is that healing intervention should not merely aim at getting rid of physical illness but also respond to psychological and spiritual effects that result from illness.

Truly, African Christology could only call Jesus the ancestor *par excellence* if it accentuates the true significance and meaning of Jesus' cross. This would portray him as being more than just an ancestor, (Bujo 1992:79) but "as ancestor *par excellence*", who became a liberator and redeemer that has brought humanity in access to his Supreme Father. Depicting Jesus as the ancestor *par excellence* is in line with the teachings of the book of Hebrews, which saw his ministry as the finality of all revelation (Hebrews 1:1-2). The notion of the relationship between the prophets of the old and the revelation in Jesus Christ is that the new revelation in Christ is superior to the old but is built upon the old. Hebrews here also anticipates that Jesus is the forerunner or pioneer, who has reached first the goal toward which his brothers struggles (Johnson 2006:65, 67). The significance of appreciating Jesus as the ancestor *par excellence* points also to the present ministry of Jesus as portrayed by the Apostle John. He is seated at the right hand of the Father, where he intercedes or advocates for his people before God (1 John 2:1-2). Commenting on 1 John 2:1-2, Painter (2002:160) depicts Jesus as a "Paraclete, which is rightly translated here as the Advocate. The sense is as though he is pleading our case before the Father, as the righteous one who ensures expiation (hilasmos) of our sins." There is no better basis to build the healing ministry from than this. The faith healing movement does not utilise this concept of Jesus as the first ancestor, as the whole approach of the faith healing movement is American influenced and based on America's fascination with personal health and wealth (Morris & Lioy 2012:79).

## 2.8. Conclusion

This chapter was built around the first task according to Richard Osmer's practical theological methodology, which deals with the question - what is going on? Various aspects related to illness and health issues were discussed from the underpinning perspective of African epistemology. African cosmology and African cultures form the conceptual framework by which illness and misfortune are dealt with by African people. Hence, the same cosmology underscores intervention strategies that are being employed in pursuit of

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healing from any illness and misfortune. Thus, the chapter was structured and developed along the set out goals, and has addressed the growth and inroads of Pentecostal and Charismatic churches; importance of the African worldview, and related factors that underscore illness and health realities. As African cosmology formed the underpinning discourse of the chapter, different aspects such as African spirituality, the centrality of the role of Jesus Christ to African people and the impact of the faith healing practice on healing seeking people were critically engaged.

The faith healing practice is a popular reality in Africa, although there are many justifiable reasons for questioning the approach and hermeneutical framework applied by faith healers. It is hard to reconcile the many claims of healings with the health situation in Africa. Igwe (n.d.) reports that “Africa has the highest infant mortality rate in the world and many people are still dying of preventable diseases such as Malaria and Tuberculosis. If there are people with supernatural powers to heal the sick, raise the dead and cure all ailments, why are Africans suffering and dying; why are human beings suffering and dying?” Nevertheless, for any ministry to be significant in Africa, it needs to be culturally relevant by employing inculturation and incarnational approaches as the *modus operandi* of such a ministry.

The big issue of Christianity is to bring light and hope to nations by making the proportional truths of the gospel plain and alive to people in their own known setting. The religion Africans want is the one that seriously engages with the many spiritual, social and economic challenges the continent faces.

The fact is that no interpretation of scripture is purely objective, as background, theological persuasion and upbringing have a great impact on the way scripture is read and interpreted. The sooner this is realised, the greater the need becomes to minister healing in the social cultural framework of the recipients. A Christology that makes sense should give an African face to Jesus, and introduce the Jesus who speaks the language of Africans and is able to associate with the cultures and traditions of Africa. Healing is a fundamental activity within Africa culture. People are hurting from various "diseases and dis-eases" and are looking for a saviour that is an all- round saviour.

Africans don't live in a dualistic world. Their worldview allows people to hold to a philosophy of a closed universe and a system of interdependence. The fact is that things are not divided into material and spiritual. What happens in the visible is affected and controlled by the invisible. Therefore, healing should manifest in a holistic and broad manner, covering broad spectrum healing dimensions from the spiritual, social, psychological, political, and economical realms.

An illness affecting an individual affects also the community. Illness has many layers and is much deeper than the spiritual causes approach of Africans or than the bio-medical model of Western science. On the other hand, the different metaphors used to visualize the roles and the ministry of Jesus are very poignant. The titles he carries such as priest, prophet and king are not mere recognitions of his work, but reveal in themselves the authority and excellence of Jesus' ministry as the final and complete work of God for mankind. Jesus' mediatory role as big-brother or elder-ancestor gives freedom to Africans to approach God. Africans would better relate to Jesus through these human faces, and with boldness and faith expect that Jesus will plead their cases (of poverty, sickness, diseases, suffering, infertility, exploitation, drought etc.) before the Divine Father.

African culture calls for a deeper engagement that goes beyond the obvious diagnoses and that seeks ways to involve the whole family and the immediate community in the healing quest of an individual. Taking a broad approach to healing is tiresome and calls for increased responsibility, as faith healing prayers with "expected instant results" may be found wanting and insufficient. A broader involvement with the person around issues affecting his or her health, from environment, proper health and sanitation, micro and macro issues affecting the individual should be looked at and a solution sought in a strategized manner. It is a genuine desire of any sick person to get rid of physical pain and its inhibitions; the real essence of healing is not so much a "disease free" or "pain free" person, however, but rather the way of coping, both in illness and health with one's being. It is about being able to live meaningfully within a state of ill-health or sound-health. The importance of learning how Jesus approaches and relates to people in need of healing should be the underlying motif for healing ministry in Africa. "Jesus Christ is an example for all Christians. Jesus' ministry was holistic. It included physical and spiritual healing. Christianity moves across cultures. Wherever it goes it should be understood in the context of their culture. Therefore, if spiritual healing is central to

Africa, it does not make sense that the church in Africa has mainly limited itself to Western healing systems at the expense of African ones” (Lutheran World Federation 2004).

Chapter 3 is a further reflection on the question of task one - what is going on? The experiences of ill persons in dealing with their illnesses and efforts to obtain healing are therefore investigated in the following chapter. Hence, the discussion and analysis of field research that was conducted with individuals affected by various degrees of illness; who underwent faith healing practice but evidently remain unhealed and continue to grapple the aftermath of such healing practice. Their experiences and contributions will contribute towards better application of theories and assumptions that will be gathered throughout the study.

## Chapter 3 Empirical research and data collection

### 3.1. Introduction

The previous chapter dealt with African epistemology and its views on healing. It formed a theoretical basis in relation to African epistemology on issues related to illness and health that informed field research framework and type of issues dealt with during field research. The chapter is modelled around the first task of Practical Theology, namely the descriptive-empirical as Richard Osmer refers to it. This particular task investigates the question, “What is going on?” The reason to employ the question related to the first task with the chapter dealing with empirical research is the recognition that field research explores the core functions of addressing this question. The reality of illness that people grapple with and the many ways and methods they employ in pursuit of healing are part and parcel of this question. In fact, Chapter Two, which covered African cosmology and views on illness and health, is the undergirding framework by which people perceive illnesses and misfortune. Chapter Two also focused on the first task of practical theology. African culture has a holistic outlook that views life in a cyclical way and does not necessarily differentiate between material and spiritual aspects of life (Dwane 2002:25). On the one hand, the African worldview is anthropocentric, as it focuses on the value of humanity, based on the strong bond of the communal spirit, but on the other hand, it emphasises a strong sense of spirituality and belief in the involvement of spirit beings in the affairs of human beings. This is clearly demonstrated by the place and role ancestors are given in many African cultures and practices (Hagan 1999:58). Healing practices are an integral component of African experiences and cultures, and people have strong beliefs in healing mediums such as priests, prophets, sangomas and traditional doctors (Mwaura 2004:109).

This chapter is based on two sections: The first section will deal with the process of sampling, data collection, data coding and analysis; and the second section will focus on the field research that was conducted in Windhoek on the spiritual and emotional impact of healing practice. The empirical research aims at collecting data on the question of the impact of faith healing on people grappling with ongoing illness.

The focus was on ascertaining the spiritual and emotional impact of faith prayers on healing seeking believers, especially when anticipated healing didn't materialise. This is in realisation

of the fact that people facing illness are mostly desperate and earnestly seeking ways and means to get well. In other words, the descriptive-empirical task needs to be interpreted against the impact of the various faith healing practices that people experience as they seek healing. In order to draw on people's experiences with illness and healing practices, the chapter is set out in the following manner:

Firstly, the relevant methodology for the research is explained, as this is crucial for successful completion of the study. A brief introduction to grounded theory is stated, as this is empirical approach used in this study.

Secondly, the data collection procedures are discussed. Different processes involved in data gathering and the deciphering of material are explained, namely data collection, sampling and selection.

Thirdly, the face to face interviews with a targeted group of people on faith healing impact are reflected on. The process that led to face-to-face interviews and its integration into data collection is outlined.

Fourthly, the transcription, data analysis and data interpretation of field research interviews are undertaken.

Fifthly, the introduction of the computer software programme ATLAS.ti, which has been instrumental for data coding and data analysis.

Finally, the introduction of themes designed with ATLAS.ti are explored and summarised.

The type of research determines the methodology used for gathering, analysis and interpretation of data. There are two broad methodologies for data collection; the qualitative and quantitative approaches. Qualitative methods involve open ended explorations of people's words, thoughts, actions, and intentions as means of obtaining information. An interview that results in written transcripts, field notes reflecting direct observation of participants, and video recordings are examples of qualitative approaches. On the contrary, the quantitative approach focuses on 'how much', 'how often' or 'how many', and thus makes use of numerical data, such as questionnaires that uses response scale numbered 1-5 (Colton & Covert 2007:35-36). This research deals with qualitative approach, as empirical research inquiry is employed to investigate the impact of faith healing on the illness-health paradigm.

This chapter is structured in a way that develops from theory of research design to practical implementation, by employing different stages from sampling and collection, through to data analysis and interpretation.

Hence, the discussion of methodology employed for the empirical research and the mode of collecting information are henceforth discussed.

### 3.2. Research methodology

There are various theories for collecting data, such as meta-theory, grand theory, top-down-theory, variation theory and bottom up theory (Gibson & Brown 2009:15-16). The choice of a theory depends upon the type of an anticipated research. Gibson and Brown (2009:19) indicate that “theory is a practical activity and a way of thinking through problems or of looking at things in different ways. In all of these approaches, though, theory is a resource for doing things with data. It is important to choose a method that enables a researcher to deal with research questions with ingenuity and incisiveness.” Similar sentiments are stated by Charmaz (2006:15), that “how you collect data affects which phenomena you will see, how, where, and when you will view them, and what sense you will make of them.” The top-down theory refers to any theory that has been formulated prior to empirical work, either by other theorists or by the researcher him/herself. On the other hand, the bottom-up theory is built around the grounded theory. Gibson and Brown (2009:26) remark that “grounded theory refers to the process of developing theory through analysis, rather than using analysis to test reformulated theories.” Grounded theory enables the researcher to shape and reshape the collected data. This theory gives flexible guidelines rather than rigid prescriptions, such flexible guidelines gives direction to study but also leave room for imagination. Grounded theory guides the way data is gathered, as well as theoretical development of it. The research makes use of qualitative research methodologies with a basis of grounded theory, which better serves the research question under investigation. The choice to gather information from the participants through interviewing is in line with the bottom-up approach of grounded theory, which develops theories from collected data from the participants.

#### 3.2.1. Interviewing methodology

Intensive interviewing method has long been a useful data gathering tool for various types of qualitative research. Interviewing is in essence a directed conversation (Charmaz 2006:25),

thus intensive interviewing makes in-depth exploration of a particular topic of experience possible. Broad open-ended, non-judgmental questions are devised, with the hope that unanticipated statements and stories will emerge. The structure of the interview is loosely guided with semi-structured focus questions in order to bring some uniformity to the structure (Charmaz 2006:26). Gibson and Brown (2009:84) indicate that “semi-structured interview works with a list of questions that are used in flexible and contextually appropriate manner. The aim was to ask all on the list sensitively in developing conversational structure, although not in a particular manner. On the other hand, unstructured interview has no predetermined questions as the interview is treated as an opportunity to engage in a conversation on particular topic or set of topics.”

The level of moderation best suited for the research was determined and what is called low-level moderation was utilised. By this process, the facilitator introduced the broad topic and then guided the interview without any pressure, so that the interviewee paved her/ his own way. Contrary to this approach, in high-level moderation the facilitator has more control over the direction and the nature of the discussion. High-level moderation asks questions in a specific order and strict control is kept so that participants did not deviate from the topic (Gilbert 2008: 229). High-level moderation is good for instances where very specific information is needed, but is not desirable for testing attitudes, behaviours and experiences. In fact, this method can easily inhibit creative discussion.

The role of the facilitator is to guide discussions and keep the conversation going. Good observation and listening skills are also vital as a facilitator (Adam *et al* 2007:150). Thus, the researcher mainly listens, observes with sensitivity, and encourages the participant to respond. Hence, in this conversation the participant does most of the talking (Charmaz 2006:25-26). As a researcher, how you make comments, pose questions and probe for information will help the participant to articulate his or her intentions and meanings. Grounded theory enables the researcher to take direct control over the construction of data more than most methods such as ethnography and textual analysis (Charmaz 2006:28). The dynamic nature of interviewing is underscored by Charmaz (2006:29) as follows “interviewing is flexible, emergent technique, ideas and issues emerge during the interview and interviewers can immediately pursue these leads.” Conversational space was created for the interviewee to address issues he/ she saw relevant and desire to share. It is a joy to see

people sharing from the depths of their hearts about their concerns. The role of the researcher is to be tactful and astute in this process.

### 3.3. Sampling and selection

It is quite important during the planning phase to decide on the way the information would be collected from the population sample. On the onset of the research planning, consider whether the process will be self-contained or form part of a process of triangulation with other research methods, for example, individual interviews or surveys (Gilbert 2008:234). As interviewing is the method used to collect data, there are important considerations to make in selecting interviewees. Seidman (1998:44) indicates that “the purpose of an in- depth interview study is to understand the experiences of those who are interviewed, not to predict or to control that experience.” Through a sampling process, the various Pentecostal ministers in Windhoek have indicated people who have volunteered for interviews. Sampling involves making decisions about who will be selected and what will be measured (Colton & Covert 2007:317). Interviews are a powerful tool, as it connects the researcher and interviewer with a personal touch, which creates opportunities for honest sharing of life experiences. Seidman (1998:44) informs that “instead the researcher’s task is to present the experience of the people who he or she interviews in compelling enough detail and in sufficient depth that those who read the study can connect to that experience, learn how it is constituted, and deepen their understanding of the issues it reflects.” In that sense, selecting participants are done differently from those in an experimental study. If the researcher obtains information-rich participants, snowball or chain sampling will be done to provide further pertinent information and to suggest other important links (Struwig & Stead 2001:123). The following steps were followed to ensure credible selection and sampling:

#### Step 1

The research population was invited on a voluntarily basis through church ministers to avail themselves for interviews. The list of churches and ministers who volunteered members for interviewing are indicated in appendix C. Introductory letters were written to various ministers and the request was made by the researcher to invite members who were willing to share their experiences of how they cope or grapple with ongoing illness.

## Step 2

Out of the names forwarded by the ministers of churches, a pilot study group of six participants were drawn. The pilot interviews were conducted in September 2009 and ongoing contact was maintained until such time interviews were conducted. This small sample was carried out over a period of week. A pilot study was conducted to pre-test measuring instruments on a small number of persons with similar characteristics as those of the targeted group of respondents (Singleton *et al* 1988:290). Pilot study informed on necessary readjustments to the interviews to make it more relevant and understandable. The interviewees were contacted, the purpose of the study explained, and their participation and co-operation requested. Each interviewee was ensured of confidentiality and that the information was only for research related purposes for this project. Discussions were recorded, so that the researcher can later reflect upon them and to assist with the data analysis and decoding. The pilot study worked around the research question of faith healing and what happens to those people who are not healed through faith healing exercise. The pilot study has enabled the researcher to simplify questions, as it was found that questions were not clear enough for the interviewees. The researcher needed to explain through more for clarification, thus a need to first thoroughly explain the purpose of the research study and then to pose concise and simple questions were identified. The new insights gained from the pilot study were incorporated into the main face to face interview sessions planned for 2010.

## Step 3

The formal interviews were conducted over December 2010 and January 2011 in Windhoek. The researcher followed up on samples forwarded by various ministers of people who were willing to be interviewed. This excluded the six participants in the pilot study. Telephone contact was made by the researcher and appointments set up for suitable day, time and place for interviews. Most of the interviews happened at the church of the interviewee, although some were conducted at interviewee's homes. The principles of ethical conduct and confidentiality were upheld at all times.

The interviews were guided by the research goal that assesses the spiritual and emotional impact of faith healing on healing seeking people, especially when the anticipated healing don't materialise. The research consisted of interviewees from various Pentecostal and Charismatic churches in the city of Windhoek. The researcher and each participant entered a contract where the governing ethical code, frequency and time of contact sessions were

determined before commencing with the interview. The researcher has made use of face to face interviews with thirty selected participants. The researcher led the sessions, which lasted one hour to one and a half hour. Face-to-face sessions were conducted with selected interviewees around the question of illness and health to ascertain how their spirituality and emotions were affected. The interviews were audio-recorded, while notes were also taken by a secretary during interviews.

The way the interviewee describes and reflects upon his/ her experiences is of immense value to the researcher, as this will contribute greatly benefiting the whole study. The researcher views these findings as of immense value in introducing a pastoral care approach of hope and compassion that will benefit both people suffering with illness and the broader Christian community.

The interviewees came from diverse social, racial and denominational backgrounds. In the composition of the group of participants, attention was given to their social standing. The social standing of an individual is perceived from things such as age, gender, race, education, occupation, income and wealth (Fern 2001:30). Race, ethnicity and gender are other social dividers that need cautious handling during the selection and interviewing process. Confidentiality was maintained throughout, as data collected from interviews would be coded and pseudonyms used to protect individuals. Once the data was collected, the process of transcription started, as discussed in what follows.

#### 3.4. Data collection strategy

The researcher had contacted various pastors through email and telephone and requested to invite members who have undergone faith healing practice for enduring illnesses to volunteer for interviews with the researcher. The research was not aiming to approve or disprove faith healing as such, but rather recognises the need to assist those people who are somehow disappointed, frustrated and confused and not understanding why they are not be healed after many prayers and their faith. The aim was to give space for them to express their feelings and pain and to reflect upon their situation. In all cases, the research was governed by research ethics.

Data collection is a vital step of any research, as a thorough data collection strategy is paramount to success of the research study. The quality and credibility of any study starts with collection of good data. Charmaz (2006:18) indicates that “a study based upon rich, substantial, and relevant data stands out. Thus, in addition to their usefulness for developing core categories, two other criteria for data are their sustainability and sufficiency for depicting empirical events.” Grounded theory was employed, as this theory best captures the context and relates it to empirical reality. Charmaz (2006:10) points out that it enables us “to learn about the worlds we study and a method for developing theories to understand them.”

The way qualitative data is organised depends in part on what the data looks like, for example, textual notes like field notes can be made into textual form, by transcribing them from tape-recorded interviews (Berg 2009:53). The level of interaction with the interviewee, which is pertinent for data collection, largely depends upon the way the facilitator handles the process. Seidman (1998:5-6) observes that “interviewing process takes a great deal of time and money. The researcher has to conceptualize the project, interview them, transcribe the data, and then work with the material and share what he or she has learned.” The researcher served as a facilitator and did not impose his/her views on the interviewee, as he respected all views even if not in agreement.

There are two criteria that determine whether data collected are sufficient for the intended purpose. These are sufficiency, that shows that sufficient representative population was taken and saturation of information. This is when no new information comes in, but participants rather repeat what was already said by others, which shows that the data is exhausted (Seidman 1998:47-48).

Booth *et al* (2003:76) identify three sources for information gathering, namely primary, secondary and tertiary. The major part of the research dealt with the primary sources (the affected participants) and the secondary sources (books and articles) in the collecting, analysing and coding of results. The process of collection and analysis of data can be mutually informative. Gibson and Brown (2009:84) indicate that “action research, for example, with its clinical approach to data gathering and analysis, and grounded theory’s interactive drive to the construction of theory both involve working through the relationship between analysis and data collection in non-linear ways.”

The research dealt with unstructured interviewing, which aims to perform three functions (Seidman 1998:11-12):

- Firstly, to bring out the experiences of interviewees regarding illness and faith healing prayers.
- Secondly, to enable interviewees to elaborate more on their experiences.
- Thirdly, to encourage interviewees to reflect on their experiences in a meaningful manner.

### 3.5. Transcription and data representation

Transcription is a translation, and all translations are partial; the partiality in the case of research derives from the theoretical perspectives of the research. Transcriptions are never value free; they are theory laden (Kress *et al* 2005:10).

Transcription is a form of representation, it is not simply writing down what someone or people said or did. Gibson and Brown (2009:109) observe that “it involves making analytic judgements about what do represent and how to represent it, and choosing to display or focus on certain features of a piece of talk, action or interaction rather than others.” To transcript refers to a mode of representing a piece of data that has been gathered, while data refers to material gathered or generated during the research process. Thus, through the process of transcription this data is put into a representational form (Gibson & Brown 2009:109). The researcher draws out particularly relevant data for the analytic purposes by means of transcription. In that sense, transcriptions fulfil two different goals: It highlights which features of the data are relevant and to find a best way to represent these features. There are two interrelated aims for production of transcriptions, namely to provide a guide to a set of data, and to produce an analytic focus on the data. Transcription helps the researcher to dissect and work with the data. It is a kind of shorthand version of the data that is more practical to work with than the data itself. It also saves time, as the researcher doesn’t need to replay audio recordings of interviews or videos all over again to assess the information. The researcher is cautioned however, to guard against relying too heavily on the transcriptions and not returning to data itself, as this could lead to problems. Transcriptions are only representations, and do not carry the detailed information represented in the data. Transcription doesn’t only serve as a guide, but also as a way to analytically work through problems

encountered in relation to data. It is an approach whereby analytic focus is generated, as it points out the important features of data and filters out less important ones.

There are many ways researchers can represent their data, although three general ways to transcribe audio data are noted herewith. However, these are merely general intended ways of thinking about data representation. The first approach is indexical transcription, which works with the indexing of data. The second approach is unfocussed transcription, also known as 'broad' approach. It is quite similar to indexical transcription in the way it seeks to provide overview of the data. Gibson and Brown (2009:114) state that "an index may provide an overview of a given data set in much the same way as unfocussed transcription, and an unfocussed transcript may well include an 'index' that indicates where the data is to be found." Unfocussed transcript does slightly more than the former however, in the way the data is written down or the manner that the video observations occurred. The third approach is focussed transcription, also known as the 'narrow' approach. The focussed approach deals with the concerns of how things were said or done within the data. As this approach is based on a strong analytical judgement, only particular sections of the data are examined in great detail and not the entire body of detail.

The researcher has worked with unfocussed transcription, as it best suited the type of interview mode employed during field studies. This was further boosted by the fact that some interviews were conducted in Namibian native languages, which the researcher is not conversant with, and translation was thus used in such cases. Transcription of data from face to face interviews is not an easy task, however, efforts were made to transcribe all recorded speech, transcript speeches as they happened, with all the stops, 'um' and 'er' people make and to identify the speaker as far as possible. Transcript should be a replica of what happened during the interviews, so that whoever reads the transcript may see how it actually went (see examples of transcripts in appendix E). The researcher does the transcription of the material. Transcription of collected material is important, as analysing without it causes the loss of rich data and results in selective analysis. Rigorous analysis follows thorough transcription of tape recorded data (Bloor *et al* 2001:59).

Gibson and Brown (2009:116) define unfocussed transcription as "unfocussed transcription involves outlining the basic 'intended meaning' of a recording of speech or action without

attempting to represent its detailed contextual and interactional characteristics. This mode of representation does not involve a concern with illustrating nuances of speech or action such as the intonation of voices, overlaps in talk or non-verbal forms of communication like gestures or gazes, but simply attempts to characterize what was meant within a given piece of data.”

The basic focus areas are the identification of people speaking, and the basic sense of what was said. The unfocussed approach does not strictly follow ‘accuracy’ as a certain degree of flexibility and freedom is required in order to bring representation and data closer. There might be a need to change some words or to correct mistakes or confusions that may mislead the reader. Gibson and Brown (2009:118) state that “the aim is not to show what was said, but what was meant by what was said, or perhaps what the researcher interpreted in what was said and, as such, some level of alteration is to be both expected and creatively embraced.” Transcription is a crucial step towards data analysis and interpretation and therefore needs careful consideration.

### 3.6. Data analysis and interpretation

After transcription there are many pages of data to be analysed. Proper analysis of data is important for successful research project. Gibson and Brown (2009:1) define this process as “being able to say something through engagement with the data and using it to reflect not just on the particular setting being explored, but ideally, to create some generalizable or at least ‘generally interesting’ finding or idea that can be taken forward in the contexts.” This is an ongoing process and the researcher makes use of it throughout the research process as it occurs. This helps with the direction of the research, as the early analysis will inform the focus of further data collection. The researcher searches for ways to explain and understand the findings and by doing so, to create new theories (Blaxter *et al* 2001:193 & 200). The validity of measurements are reliable and valid by double-checking the measuring instruments, hence the need for pilot studies. To further enhance honesty and openness, the environment and circumstances under which data is collected and people interviewed must be favourable. The interviewee should be comfortable with enough space and a sense of freedom to speak without intimidation or any fear. At some places, where people live in small crowded homes, sitting under a tree for example could make a big difference between the

failure and the success of an interview. The fact that the researcher makes use of a recorder will greatly minimise the incorrect writing down of interviews. Care must be taken to minimise methods that are inadequate, such as a sample that is too small, or badly chosen, answers incorrectly recorded, or careless analysis employed (Peil *et al* 1982:10; De Vos 1998:82-86).

The ATLAS.ti computer software was utilised for data coding and analysis. The first step is to index the data: This is to bring it into a manageable format that enables interpretation. The process here seeks to bring together all the extracts of data that is pertinent to a particular theme, topic or hypothesis (Coffey & Atkinson 1996). The data involves analyst reading, rereading and creating index codes in line with the content of the data. At the beginning index code could quite be broad, but it narrows down as work progress, similar to chapters and subheadings (Bloor *et al* 2001:64). Qualitative analysis consists of segmenting the data and reassembling them with the aim of transforming the data into findings. Findings can consist of descriptions that are more or less theoretical, as well as interpretive explanations of the research subject. Findings of qualitative research always include interpretation of the empirical data. It is a mistake to consider raw data as findings. In the analysis phase of the research, project data are sorted, named, categorised and connected, and all these activities entail interpretation. The real test of quality of the research comes in at the stage of data analysis, as this process requires analytical skills and understanding to grasp data in writing form. Holliday (2001:99) notes that by “showing the workings of the data” the researcher also demonstrates how much he or she understands logical design. In qualitative research, there are various ways to translate ‘raw material’ into meaningful final patterns, however, the researcher makes use of qualitative content analysis for research design. In qualitative content analysis, the researcher starts with a set of data, such as a transcribed interview. Transcription is verbatim and advisably typed in double line spacing, so that the working of data by hand may proceed with enough space for notes, arrows and other requirements. A wide margin is left at the right hand side of the page for notes and the writing of codes. This method is known as open coding, and entire context is read through to get a global impression of the content. Open coding is a process of (Strauss & Corbin 2007:61) “breaking down, examining, comparing, conceptualizing and categorizing data.” All data must be collected, carefully read and put into fragments. Fragments are compared among each other, grouped into categories according the same subject, and labelled with a code. Henning *et al* (2004:104) suggest that

“because open coding is an inductive process, whereby the codes are selected according to what the data mean (to the researcher), you need to have an overview of as much contextual data as possible. It does make good sense to read all the relevant transcriptions before any formal meaning is attributed to a single unit.”

A code will be linked to a word, phrase, sentence, paragraph or larger sections of data and need to be interpreted within a certain context and in relationship to other codes, as they are never isolated units of meanings (Struwig & Stead 2001:169). Open coding helps with the clear organization of the data, as it results in an indexing system that fits the researcher’s analytical needs. Codes contribute toward an easy retrieval of fragments that have been assigned to a specific code. The different fragments are then compared, because it is likely that multiple fragments in a text address the same topic and should receive the same code. In other words, everything boils down to coding, as any data is to be read and then classified into segments. Charmaz (2006:43) remarks that “coding means categorizing segments of data with a short name that simultaneously summarizes and accounts for each piece of data. Your codes show how you select, separate, and sort data to begin an analytic accounting of them.” Coding enables the researcher to distinguish themes or categories in the research data and name them by attributing a code. A code is a label that depicts the core topic of a segment (Boeije 2010:95). While coding, the researcher must look for descriptions and sometimes theoretical statements that go beyond the concrete observations in the specific sample. After coding is done, start to identify the categories as they are surfacing.

Henning *et al* (2004:107-108) observe that:

In this recontextualisation of the data text (when the final data are integrated as evidence in an argument), the original data text and the context (the “text” with the “text”) are merged. This merging is also evidence of the intellectual labour of the researcher. To merge the text of the data with other text(s) in the literature and to forge your own argument and take your position cannot happen without a broad and thorough of both the texts- the empirical and theoretical.

The coding will give format and structure to the work, as different segments will be grouped together, and comparisons, contrasting and conclusions made under separate headings. In fact, the researcher makes use of constant comparative method of coding to do inductive analysis of the data (Struwig & Stead 2001:170-171). The researcher uses ATLAS.ti to do

qualitative analysis of research data, hence what follows is the description of this programme and its various features.

### 3.6.1. Background to ATLAS.ti programme

ATLAS.ti computer software makes the process of data coding, transcription and identification of main concepts and themes manageable for the purposes of dissecting the gathered data for analysis. In the user manual, the programme is described as “a powerful workbench for the qualitative analysis of large bodies of textual, graphical, audio, and video data. The content or subject matter of these materials is in no way limited to any one particular field of scientific or scholarly investigation. Its emphasis is on qualitative, rather than quantitative, analysis, i.e., determining the elements that comprise the primary data material and interpreting their meaning” (ATLAS.ti 6 user manual:21).

This programme offers different tools to achieve tasks associated with any systematic approach to unstructured data. This is basically data that cannot be meaningfully analysed by formal, statistical approaches. The programme is designed to enable the researcher to explore the complex aspects contained in collected data. A comprehensive term to use would be “knowledge management” (ATLAS.ti 6 user manual:23), as this implies the transformation of data into meaningful knowledge. The programme enables the researcher to cope with the inherent complexity of the tasks and the data by creating a powerful and intuitive environment to analyse materials. The programme has useful tools to manage, extract, compare, explore, and reassemble meaningful pieces from a large body of data in innovative, versatile, and systematic ways.

### 3.6.2. Main Concepts and Features

The concepts of primary documents, quotations, codes, and memos are the overall foundation needed to work with ATLAS.ti. These are complemented by a variety of special aspects such as families, network views, and analytical/data querying tools. All of these come together in the overall “project container,” The Hermeneutic Unit, HU for short (ATLAS.ti 6 user manual:25). The HU provides the data structure for each project in ATLAS.ti. Everything that is relevant to a particular project is part of the HU and resides in the digital domain. For instance, the primary documents representing the data sources, quotations, codes, conceptual

linkages (families, networks), and memos and so forth, are all part of one HU. The creation of the HU is a cumbersome process, as each component is loaded with substantial material. The outputs do not detail every component, seeing that it will cause information overload by creating unnecessary files. Thus, some components are only indicated by titles, without giving the information contained therein. This is even true of all the primary documents that deal with the transcript of each interview. The quotations created for these primary documents or transcripts are also not indicated for the very same reason of minimizing information for effectiveness. The most basic level of an HU contains the primary documents, followed closely by the "quotations" as selections of the primary documents. On the next level, codes refer to quotations, and memos are broadly used. In short, an HU is an entity with high connectivity, a dense web of primary data, associated memos and codes, and the interrelations between the codes and the data. Describing the features of the programme in written terms is confusing, as prior knowledge of the software is needed to appreciate its functions.

Appendix F reflects raw data, including the transcribed interviews and different outputs or results created with ATLAS.ti computer software. The ATLAS.ti outputs in appendix F covers the detailed information that was interpreted and used through the study. The researcher has worked through the HU and subsequently drawn some findings that resulted from field research outcomes. The focus areas are structured as follows in relation to the task one question of practical methodology; "what is going on?"

- Firstly, to give a short introduction and background to the field research process.
- Secondly, to indicate themes as identified by the ATLAS.ti programme.
- Thirdly, to draw conclusions based on the field research.

### 3.6.3. Themes as indicated with ATLAS.ti programme

#### 3.6.3.1. Introduction

The interviews were conducted over a period of two months from December 2010 to January 2011. Face-to-face interviews were conducted on an individual basis with thirty one (31) respondents selected from various churches, social standings, races and localities in the city of Windhoek, Namibia. Twenty five samples were relevant as they were responses of people

who were struggling with ongoing illnesses; while the remaining six did not satisfy the research focus. There are three observations to make at the onset about the socio-economic background of the interviewees:

- The interviewees consist of nineteen (19) female and six (6) male respondents. The majority of respondents (76%) were female, which reflects the composition of most Christian denominations in Africa. This is also true of African demographics in general, which is composed of more woman and children.
- The respondents had different range of illnesses. Five participants were HIV positive, which is 20% of respondents. This underscores the high prevalent rate of HIV/ AIDS in Southern Africa. The interviewees suffered from conditions ranging from the chronic, acute, physical, mental, demonic, physical and natural. The HIV related responses were in conformity with literature study that illustrated the high number of HIV infection in Southern Africa. The correlation of poverty to illness was also confirmed, as majority of respondents come from low income group, and some were also not employed.
- The unemployed group had the largest representation, with six (6) respondents (24%), followed by teachers (3) with 12% and other professions represented by either one or two respondent(s), this is in the range of 4% to 8% per respondent(s). The higher unemployed respondents reflect the research hypothesis that poverty contributes to high illness risk. Poverty and health are intrinsically linked, given that poverty impacts on people's total view of living and worldview. Coetzee (2002:5) indicates that poverty causes vulnerability that has a ripple effect on all aspects of meaningful human existence. Myers (2008:84) underscores this by stating that poverty impinges human dignity of self-worth and breeds anger and disillusionment.

The twenty five (25) primary documents employed as basis for the information used in coding and analysis are indicated by *P1 to P25*. Acronym *P* represented primary document, thus representing twenty five respondents or interviewees in alphabetical order. Although interviews were unstructured, the following questions were used to guide the process and to ensure some uniformity:

- Share with us your experience of healing prayers made for your ongoing illness?
- How did grappling with the illness affect you emotionally?
- How did it affect you spiritually?

- How did it affect your faith or view of God?
- Are prayers sufficient for ill people or do they need other kinds of assistance?

The coding, analysis and data output of the interviews were produced by means of ATLAS.ti software. The Hermeneutic Unit or the coding and analysis process that were conducted on the research topic is included as an attachment under appendix F.

The presentation and discussing of data is derived from using nodes (see examples in appendix F) that were designed through the transcribing of the interviews of respondents with ATLAS.ti software. The generated nodes are sorted according to themes that emanate from the interviews on the spiritual and emotional impact of faith healing practice. The ATLAS.ti is able to create various relationships between codes, nodes and themes; such collating of data thus makes it plausible to determine main themes and possible sub themes. This process enables the researcher to work with the coded data on different levels, which ensures that the main themes are captured.

The researcher uses the generated themes, both key themes and possible sub-themes, to categorise data that will be developed into arguments. Categorisation is an important activity; categories help in creating the themes that will be constructed from the data used when dealing with the inquiry. This is quite an important development, perhaps even more so than coding (Henning 2004:106). After coding and categorising is completed, the researcher must now visualise separate entities as one whole unit. As analysis continues, the writing of the research report will have progressed. It is important to be explicit in showing what was done and how in the writing of the report. The final thematic pattern is born out of the process and the researcher should be able to (Henning *et al* 2004:107) “move backwards through the process from thematic pattern to categories, to codes and then to raw data.” The process of analysis should become more of a writing process, which explains all steps that were taken while analysing. This saves time and enhances the reasoning process. When the researcher is satisfied that the themes represent a reasonably researched data, then each theme could be used as a basis of an argument in discussing around them. Processed data only obtains the status of findings when emanating themes are discussed and put into points, and that a point to be made comes from the research questions. The sorting of the process have enabled the researcher to identify four main themes and auxiliary themes. The researcher reflects on four themes and their sub-themes, which were identified and collated by ATLAS.ti programme.

The four themes are the spirituality of people grappling with illness, the view of God for people grappling with illness, the emotional condition of people grappling with illness and the supporting resources for people grappling with illness.

ATLAS.ti programme has indicated responses from the interviewees according to themes and grouped them as nodes. Node is a cluster of quotations or references made on a certain topic by various respondents. The following keys are provided to interpret nodes:

- The cluster node at the beginning is followed by a number in brackets, for example (15), this indicates the number or total codes under that cluster.
- CO- denotes the code or reference made by a respondent, such as “I have learnt to help others” for example.
- The bracket after the code {1-1}: The first number shows the frequency (how often the code has been applied). It gives some information on the roundedness of a code, i.e. how relevant this code is in the data. The second number indicates the density (how many other codes this code is linked to). For example, this code is linked once to another code.

The nodes are used to interpret the four themes as designed through the ATLAS.ti programme.

### 3.6.3.2. Theme 1: The spirituality of people grappling with illness

The expressions made during interviews in relation to how ongoing illness affects spirituality are represented by the following fifteen nodes as drawn from ATLAS.ti. The following nodes<sup>15</sup> represented the expressions made by interviewees on the spirituality of people grappling with illness.

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<sup>15</sup> **Nodes (15):** CO: learning to help others {1-1}, CO: illness serves a greater purpose {4-0}, CO: patience is needed for healing {4-0}, CO: being encouraged by preaching {1-0}, CO: becoming stronger through spiritual growth {1-0}, CO: encounter with God {1-1}, CO: pledge to serve God {1-0}, CO: encouragement to persevere {1-0}, CO: soul searching and cleansing {1-0}, CO: crying out to God {1-1}, CO: learning more {1-0}, CO: learning to sympathise with others {1-1}, CO: resolved to wait in faith {1-0}, CO: spiritual support and friends {1-0}, CF: spiritual impact (14)~

Spiritual impact had 15 nodes in total, of which 8 codes (references) confirmed a positive spiritual attitude in illness and suffering. These two nodes are that *“illness needs patience for healing,”* which was applied four times or mentioned by four respondents and *“illness serves a greater purpose”* that was also equally referenced four times. Being patient in illness is further augmented by the codes such as *resolved to wait in faith* and *encouraged to persevere*, while the code *illness serves a greater purpose* was complimented by codes such as *becoming stronger through spiritual growth, pledge to serve God, soul searching and cleansing, learning more, and learning to sympathise with others*. These references highlight the spiritual attitude illness commands, especially to those who have learnt to see beyond the immediate discomfort pain and illness causes. The lesson is to humbly ask for what is needed, whether physical, material or spiritual, with the belief that the powerful and merciful Lord will hear and respond. One does not always know what is good for one self however. Ultimately, a Christian should strive against all odds to seek and honour the Father’s will as this glorifies Him. Angelica (1999) also remarks that “the sick who are not cured after they ask the Father for healing, are loved by God in a special way. He trusts that their faith will not be shaken as they share the splinter of His Son’s Cross. They witness to the power of His Spirit as he gives weak men the gifts of Fortitude to endure the cross. They radiate hope by their acceptance and their souls grow in the image of Jesus as he lovingly directs their feet in His footsteps.” Carrying the cross may for some people mean to glorify Christ through the way they carry their ailments and diseases positively and so exalt Christ, both in their living and dying (Parachin 2011:28).

Through the interviews it became clear that some people realised that although instant healing is desired, it has not happened for them. Hence, the mental shift to patiently wait in faith for healing. Those who have stressed this point did not lose faith in God’s healing power; they still believe that God will heal them; however, they now perceive healing as a process.

### 3.6.3.3. Theme 2: The view of God for people grappling with illness

There were 14 nodes that covered various responses of interviewees on how illness affected their view of God. The nodes here revealed something of a struggle persons grappling with

illness deal with when healing tarries to manifest. The following statements<sup>16</sup> were made by respondents on how God is perceived during illness.

The majority of interviewees had at some point grappled with the question of why they suffer or why God doesn't heal their illnesses. In fact, 20 codes (references) were recorded in this regard. Louw (2006:25) observes *“die lyding in lyding is juis om te vra: Hoekom? Waarom? Hoe raak dit my en my lewensgehalte? ..... In die waarom vraag het jy 'n keuse: Vlieg of vloek, maak of breek, leef of sterf.”*

Although “why” questions were dominant, it was obvious that most respondents had positive view about God. They did not blame God for their situation or harbour bitterness towards him. The fact that they did not blame God or shown signs of bitterness were expressed by the majority of respondents with codes (references) such as *healing is a process in God's timing, belief in God's love, not questioning God, maintaining faith and trust in God, having faith in God's provision, God's intervention, God's love as source of hope, God's faithfulness, and it may be God's will to be ill*. However, there were still a few expressions such as *thoughts of God not caring, confused as to why there is suffering, and initially questioning God*.

Another contributing factor for the dominance of “why” questions, except what Louw stated previously, may be as a result of people's theological understanding, which generally perceive God to be good, loving and powerful and not responsible for evil. Thus, this creates tension when after many prayers and exercise of faith, illness still prevails, that may result in “why” questions.

The tension is also caused by the way faith healers emphasise the concept of faith to people coming for healing. Anderson (2002:529) states that “even more questionable feature is the possibility that human faith is placed above the sovereignty and grace of God. Faith becomes a condition for God's action and the strength of faith is measured by results.” What we see as the unwanted outcome may be the best outcome in God's divine purposes. Rae (2006:155) indicates that “we can affirm that God is at work, using illness and tragedy for our good

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<sup>16</sup> **Nodes (14):** CO: thoughts of God not caring {1-0}, CO: healing is a process in God's time {12-0}~, CO: belief in a God of love {1-1}, CO: confused as to why there is suffering {1-0}, CO: not questioning God {1-0}, CO: maintaining faith and trust in God {1-1}, CO: having faith in God's provision {1-1}, CO: God's intervention {1-0}, CO: asking “why” questions? {20-0}, CO: God's love as source of hope {1-1}, CO: God's faithfulness {1-1}, CO: it may be God's will for the individual to be ill {1-0}, CO: initially questioning why God? {1-0}, CF: view of God (13)~

(Romans 8:28), but we cannot pinpoint the reasons why illness comes into our lives, or what its purpose is. To attempt such an explanation, when we cannot grasp what God is doing, is simplistic at best and presumptuous at worst.”

The further tension is that faith healing practitioners do not entertain any alternative than faith healing (Anderson 2002:525). This causes tension, as a person grappling with illness is caught up in a situation where he/she doesn't know whether to consult a medical practitioner at all. The person faces a real challenge, because seeing a doctor may be interpreted as lacking in faith (Anderson 2002:529). The following observation made by Anderson (2002:529) is worth mentioning: “Some faith teachers reject the use of medicine as evidence of a weak faith, and overlook the role of suffering, persecution and poverty in the purposes of God.”

#### 3.6.3.4. Theme 3: The emotions of people grappling with illness

There were 40 nodes recorded on emotional responses, of which 11 codes represented viewpoints made by respondents affirming their positive responses and 29 codes reflected negative responses in the midst of adverse illness conditions. The following negative<sup>17</sup> emotional responses were expressed during interviews.

The general attestation was that the respondents become stronger emotionally as time passed by; this has also contributed to them increasing in confidence. On the other hand, a large number of codes (29) represented negative emotional expressions from respondents, even more than those with positive emotional responses. The codes representing negative emotional responses are 18 codes more than the positive emotional responses. The nodes with the highest scores are: *stress and emotionally drained* (10 codes), *grappling with fear* (9 codes), *disappointed and sad* (6 codes), *blaming and guilt to unhealed person* (6 codes), and *doubt and uncertainties* (6 codes). These emotional responses were further augmented by

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<sup>17</sup> **Nodes (29):** CO: feeling dizzy at times {1-0}, CO: spiritually drained {1-0}, CO: doubt {1-1}, CO: feeling hopeless, stress and emotionally drained {10-1}~, CO: discouraged and losing hope {1-1}, CO: grappling with fear {9-1}, CO: stigma a problem {1-0}, CO: disappointed and sad {6-3}, CO: felt her efforts wasted {1-0}, CO: relationship with wife tense {1-0}, CO: blaming and guilt of unhealed person {6-0}, CO: low self-esteem and low confidence {1-1}, CO: disillusionment and hopeless {1-1}, CO: causing emotional wounds {1-0}, CO: want to quit {1-0}, CO: becoming suicidal {1-1}, CO: tension and shame to have ulcers {1-0}, CO: stigma and isolation to guard against {1-0}, CO: frustrating and limiting {1-1}, CO: annoyed when faith is blamed {1-1}, CO: the “how” questions lead to resentment {1-0}, CO: doubt and uncertainties {5-1}, CO: demotivated, not wanting to pray {1-1}, CO: hard to forgive {1-0}, CO: to quit if God doesn't help {1-0}, CO: emotionally stress and drained {1-1}, CO: hard to accept {1-0}, CO: affecting marriage {1-0}, CF: negative emotions (28)~

responses such as: *Feeling dizzy at times, spiritually drained, feeling hopeless, discouraged and loosing hope, grappled with fear, stigma a problem, disappointed and sad, felt efforts wasted, relationship with wife tense, low self esteem, disillusioned and hopeless, causing emotional wounds, wanting to quit, becoming suicidal, tension and shame of having ulcers, frustrating and limiting, annoyed when my faith was blamed, resentment, uncertainties, demotivated, not wanted to pray, hard to forgive, quit if God doesn't help, hard to accept, and affecting marriage.*

The following positive<sup>18</sup> emotional responses were expressed on how people experience ongoing illness.

In contrast, the interviewees experiencing positive emotional responses were quite low compared to the high number of respondents who have experienced negative emotions. This is somehow understandable, as people who are promised healing come with high expectations and when instant healing is not experienced, they struggle to cope emotionally and to balance the faith expectations to the reality of prevailing illness.

The number of codes in this section suggests that there is a serious need to address the psychological issues illness causes. This is even true when noting that all these people have been through faith healing practice, but still struggle with their feelings. The emotions revealed here deal with the basic human needs that are core to survival and purposeful living.

The basic needs of love, security and self actualisation are the very ones respondents grappled with during their illnesses. Illness is a life threatening reality that causes anxiety, especially in cases where healing doesn't manifest; and most often results in uncertainty, fear and doubt. Anything that hinders the normal functioning of the body threatens health and can lead to stress. Van der Merwe (2004:13) indicates that "stress is the physiological, emotional and behavioural response of a person seeking to adapt and adjust to internal and external pressures or demands. It is basically a physical survival response, leading to a fight or flight reaction".

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<sup>18</sup> **Nodes (11):** CO: dealing with the vicious cycle {1-0}, CO: being strong emotionally {1-2}, CO: gradual increase in self confidence {1-1}, CO: became strong {1-0}, CO: feeling better after prayers {1-1}, CO: became strong emotionally {1-0}, CO: dealing with shyness {0-0}, CO: dealing with fear {1-0}, CO: feeling better now {1-2}, CO: managing emotions {1-1}, CF: positive emotions (10)~

### 3.6.3.5. Theme 4: The supporting resources for people grappling with illness

The following nodes<sup>19</sup> highlight issues that were mentioned by respondents as necessary supporting resources to sustain them through their period of illness.

The three main areas that were emphasised by many interviewees were:

- The need to have *groups to care and encourage* people suffering with illness (14 codes).
- The need for *teaching and equipping* people struggling with illness (5 codes).
- The *supporting structures* were mentioned as lacking in faith healing practices (9 codes).

Faith healing churches are strong on praying for people but do not have any follow up mechanisms and supporting structures to carry people along the road to recovery or healing. The emotional and faith issues that people grapple with are not catered for in structured and responsive ways. All respondents mentioned that there is a lack of such supporting structures for people grappling with illness within the Pentecostal churches. This was perceived as a weakness, as people suffering ongoing illness are left on their own after prayers and not supported with a systematic and thorough programmes. Respondents have mentioned that many people testify of being healed during faith healing practice, but on returning home they experience reoccurrence of their conditions. This led to confusion and doubt as such people are not sustained through any means other than prayers and may subsequently result in disillusionment.

These results demonstrated that the greatest need persons grappling with illness have is in the realm of encouragement and caring. These are functions of pastoral care and counselling. Preaching and praying are good and necessary, but must be merged with pastoral care to form vital and indispensable ministries for suffering and hurting people. On the other hand, the emphasis on teaching and equipping skills are also significant, as people grappling with illness want to be informed and empowered to take some control of their lives. In fact, this

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<sup>19</sup> **Nodes (10):** CO: groups for teaching and equipping {5-1}, CO: moral support more than medicine {1-1}, CO: support structures lacking {1-0}, CO: need for counselling {1-2}, CO: groups to care and encourage {14-1}, CO: church to be a safe place {1-3}, CO: groups for some, but not all {1-0}, CO: need constant assistance {1-1}, CO: more support needed {1-1}, CF: support structures (9)~

desire speaks against the tendency in African churches that grows at alarming rates through evangelism, but remains shallow in discipleship and doctrinal authenticity source.

The issues that were brought out by respondents are in line with the research hypothesis, which envisaged a holistic pastoral approach of care and compassion for people grappling with illness. In view of the themes indicated previously, there are many important issues to consider in the pursuit of a pastoral approach of hope and compassion that will be responsive to the needs of people suffering ill health. The following observations conclude this chapter, which addressed the first task focus on what is going on in view of empirical reality.

### 3.7. Preliminary comments on themes

In line with the themes as indicated with ATLAS.ti outputs, the following observations are worth noting concerning people suffering with ongoing illness despite undergoing faith healing practice. Illness may cause a predicament that triggers various responses and behavioural patterns. If not managed well, it could result in anxiety, insecurity, loneliness and despondency. These facts are important, as they inform the way people suffering from ongoing illness perceive their situation and what they do in pursuit of healing. This is core to understanding the focus of the first task of practical theological methodology, namely “what is going on?”

The empirical research has demonstrated that people grappling with illness have many issues affecting them on various levels. Thus, the response of people facing the reality of ongoing illness is that:

- Some may experience varying spiritual and emotional levels. There were two major areas of concern where respondents were adversely affected. These were on an emotional level and on the way God is perceived in illness. Prolonged illness in some instances causes negative emotional responses that made many people despondent and disillusioned. In the process of seeking healing, many people experience all kinds of emotions. The response on this question has shown that emotional stability is an important issue that needs to be addressed, even where physical healing is concerned. The interviews have illustrated that some people grappling with illness have found the equilibrium to channel their emotions positively, while for others it is quite turbulent

as they grapple the emotional instability because of ongoing illness. The literature study has demonstrated that people handled trauma caused by illness differently. Some people handle it well and with some degree of control, while others become bitter, resentful and disillusioned with “why me God?” questions that lead to self pity and self condemnation (Roan 2009). The interviewees experienced personal and inner struggles that in many cases impinge on their confidence and Christian effectiveness. The concern illness carried along is stated by Dunn (1997:19) as causing “insecurity about where God fits in the picture.” Illness results in people asking many faith questions dealing with why they are not healed or why they suffer while faithfully serving the Lord. These questions affect their faith and tend to cause some doubt and uncertainty. Interviewees did not really question the character of God as loving and caring, but many were confused as to why they were not becoming well. They upheld the faithfulness of God and believe that God has his own time and ways to heal them. They resolved to wait patiently, believing that healing will ultimately come. Louw (1994:175) indicates that the solution to questions of “why” and “for what purpose” is not a clear cut answer, but requires a process that challenges one’s basic attitude, value system, belief and philosophy of life.

- That there were a few people who understood that their illnesses may not be cured in this world. These people were open to the possibility that their suffering might be the way to glorify God in this world. McCullough (1995:16) indicates that some benefits of prayer may take time and things may first become worse before any improvement is perceived. The view or perception that a person grappling with illness develops about God can either be destructive or constructive in pursuit of health and wholeness. This is confirmed by Stoeber (2005:5), who alludes that there are two kinds of suffering; destructive and transformative. He viewed destructive suffering as negative and to be resisted, while transformative suffering is positive and leads to personal and social growth, which is redemptive in nature. The fact that some people remain ill after faith healing practice is an uncontested reality (McCullough 1995:15-29). This calls for humility, as the outcome of any prayer cannot be guaranteed. In that sense, spirituality is about the sharing of experiences of an individual and community together, which inspires person grappling with illness to draw from and to live beyond pain and discomfort to a reality that transcends these challenges. It is worth to note that many people have a higher understanding of their illnesses and try to understand

the deeper meaning of it. To overcome the inhibiting realities of illness, there seems to be a need for mental, spiritual, social and psychological transition from self-centeredness to God and other person centeredness. This confirms the views of African spirituality that is expressed through various relationships; with the self, God, ancestors, fellow human beings and nature (Kalimbo 1999:219; Lartey 1997:113-123). These relationships transcend the sensory experiences and seek deeper significance in illness.

- Many interviewees grapple with the “why” question during illness. This question covered various areas, such as why God has allowed illness and why he doesn’t heal? It has also addressed the area of faith and why healing doesn’t come as promised by faith healers despite believing. The Pentecostal teaching of “name and claim” contribute to this tension, as people cannot reconcile why they are still unhealed despite having faith and claiming their healing. MacArthur (1992:322) states that by this doctrine, followers of the faith movement<sup>20</sup> are instructed to speak physical healing and material prosperity into existence via faith-filled words. The faith movement has been dubbed by its critics as a “health-wealth gospel” that tells people to “name it and claim it” (MacArthur 1992:322-325). This doctrine encourages people to have faith in the healing prayers and confess healing, even when physical manifestation is not yet evident (MacGregor 2007:113). The phrase ‘positive confession’ could be legitimately interpreted in various ways, but most significantly, the phrase refer literally to bringing into existence that which is stated by the mouth, given that faith is understood to be a confession (Burgess & Van der Maas 2002:992-994). The faith movement has an anthropocentric worldview, by which Christians are entitled to health, wealth and prosperity, all of which are obtainable using only one’s faith (Morris & Liroy March 2012:73). The strong views of the faith movement or positive confession as explained in the literature study were held by most respondents. Many interviewees were positive or anticipating to eventually receive their healing as they prevail in faith. The tension of claiming healing by faith but not being healed

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<sup>20</sup> The Faith Movement is best known for its teachings that physical healing and financial prosperity are readily available for anyone with sufficient faith. It is believed that God wills all believers to be healthy and wealthy. The examples of popular American preachers associated with this movement are Kenneth Copleland, Benny Hinn, Frederick K.C. Price, Creflo Dollar and Joel Osteen (Thumma 1996:482-485). Word- Faith preachers have strong following all over the world and some have established satalite churches in many parts of Africa.

show the inner struggle of doubt and uncertainty that the respondents grappled with in their quest for healing.

### 3.8. Conclusion

In concluding this chapter, it is valuable to note that human stories and lessons learnt through people's experiences contribute to both the theoretical and practical frameworks of the study. The literature study has dealt with various viewpoints within evangelical Christianity on the issue of faith healing. Notwithstanding this, the interviews focussed on Christians from Pentecostal and Charismatic backgrounds that experience illness and are being prayed for by faith healers. This may have biased the research towards a certain theological position, but the fact of the matter is that faith healing is a ministry that is very popular within Pentecostal Christianity and therefore justifies the narrow focus.

The individualised approach of faith healing practices that focuses on the person as an individual over against the corporate approach to healing practice in dealing with illness was also confirmed through the interviews. The congregational method of healing, which is based on texts such as James 5:14-16, was not emphasised by the interviewees. The interviewees seemed to hold strong individualised views that understand healing to be through personal prayers or by another person's prayer. There was little appreciation or expression for the power of corporate prayers through church leadership.

Faith healing practice is a viable option many people follow and still hold on to even when not healed. Although some people may experience spiritual and emotional instability, faith in Christ and belief that healing may still happen sustain them. The interviewees generally had a high regard for faith healers and their gift of healing, although they argued that healing can happen through the prayers of any believer, and by the exercise of their own faith. Ervin (2002:75-76) states that faith cannot be quantified or exponentially increased by human effort, as faith is manifested by the Holy Spirit.

It has become evident from the input of empirical studies that people who experience ongoing illness have different coping systems. The empirical research has indicated the need to respond in holistic ways to the plight of people grappling with ongoing illness. In fact, faith

healing practice alone is not sufficient to respond to the plight of people suffering ill health. The strategic and vital role of pastoral care and counselling come to play at this moment. This chapter has made valuable inputs that will be integrated throughout the entire study in order to form a basis for the envisaged pastoral approach of hope and compassion.

In light of the experiences of people grappling with illness in respect to their faith and emotions, the next chapter addresses psychosomatic diseases and possible implications for the healing practice. On many occasions, after healing a sick person Jesus said to him/her to “go and sin no more.” These words of Jesus indicate that there is somehow a connection between physical healing and the psyche of a human being. The area of psychosomatic diseases and their relation to African experiences of illness is explored in consultation with disciplines of psychology and sociology.

## Chapter 4: Understanding psychosomatic diseases in relation to faith healing practice

### 4.1. Introduction

The preceding chapter on empirical field research has gathered material around the key research questions of the study. The main focus of the interviews was for people grappling with illness to share their experiences of the emotional and spiritual impact of faith healing practice, especially when the expected healing does not materialise. The results of field research have contributed some important outcomes that will be considered in establishing the pastoral approach of hope and compassion.

The structure of this research follows the four task approach of practical theology methodology as proposed by Richard Osmer (2008:4f). This chapter deals with task two of Richard Osmer's approach according to his practical theological methodology. This is an interpretive task that explores the question of "why is this going on?" with the view to better understand why certain patterns and dynamics are occurring. The understanding is that various psychosomatic diseases are one of the key reasons why people suffer ongoing illnesses and subsequently, seek healing from faith healing practitioners.

This question is about listening to other disciplines, such as psychology, medical science and sociology, to interpret the research topic. In that sense, psychosomatic diseases are discussed with their various manifestations and are reviewed against an African understanding of illnesses and how all these relate to the faith healing practice in the African context from other disciplines.

Faith healing is also a typical response to conditions of illness, especially for the poor and the disadvantaged who do not always have the luxury of resources to visit health facilities. This notion is confirmed by Kalu (2008:263): "It is surmised that the popularity of divine healing in Africa arises from the poverty in the communities that are plagued by collapse of health care delivery system. And the use of olive oil and local symbols heightens the possibility of manipulation and emotional control in the healing process." The impact of poverty as socio-economic factor and how this contributes to illness has been sufficiently dealt with in chapter 2 and therefore, will not be discussed any further under psychosomatic disease.

Africa, as a very religious and spiritual continent, embraces faith healing as a display of God's super power. Many people are drawn to healing meetings and some testify about miraculous healings, although these are in many cases not proven medically (Mohr 2011:77). Contrary to these positive testimonies, there are also people who feel that their hopes have been dashed by faith healing encounters (Findlayson n.d). They blame themselves for the failure to recover from illnesses, which they believe is as a result of either their "little" faith; or that they have some deep, unknown un-confessed sin committed by them or their ancestors. Pattison (1989:71) indicates that "such people suffer despair and a sense of abandonment by God from their encounters with religious healing. If there are more of them than there are people who feel that they have been helped, there is a strong case for changing beliefs and practices in Christian healing as well as for ceasing to practice religious healing altogether." This is a serious statement that calls for responsible approaches to healing, which consciously safeguard against causing harm or pain to those coming to receive healing. Such measures should ensure that supporting measures are in place for people who may be hurt or harmed by the indiscreet use of the healing practice, so that they may be assured of God's love, presence and care.

There is a need to interact with the hypothesis of the research question in this chapter. The research hypothesis, 1.9., has suggested:

- One, that faith healing promises made during faith healing practice to healing seekers often cause spiritual and emotional pain when instant healing doesn't materialise as promised by faith healers.
- Two, that many faith healers operate within the area of psychosomatic diseases, which are very closely linked to demonic possessions and somatic (spirit-body relational diseases) that are common among African illnesses.

In view of the hypothesis, the concepts of psychosomatic diseases in relation to healing practice warrants some investigation in reflecting on task two of practical theological methodology, dealing with why is this going on? It builds on the reality of healing practices in Africa and in particular, looks at how the psychological factors relate to psychosomatic diseases in faith healing practices in Africa. The chapter develops around psychosomatic diseases and reflects on various factors that deal with issues related to illness and health.

According to Anderson (2002:525), the emphasis of faith healing practice as means for healing may result in persons seeking healing being left without any alternative treatment strategies. This puts undue pressure on people who also consult medical services. Anderson (2002:525) highlights this attitude of prayer alone in the following passage: “For some Pentecostals, faith in God’s power to heal directly through prayer resulted in a rejection of other methods of healing.” Subsequently, in most cases no referrals for alternative support interventions are advised. The lack of such support structures deny the patients the opportunity for holistic treatment interventions. Illness and healing are central realities of human existence; any theological reflection that doesn’t address the issues of illness and healing falls short dismally (Pattison 1989:7). Therefore, the envisaged goals of this chapter are:

- To investigate the impact of the faith healing practice in relation to psychosomatic diseases, with special reference to its effect on the spiritual and emotional wellbeing of healing seeking believers. This is done in consultation with the disciplines of psychology and sociology.
- To highlight the psychosomatic diseases and their relation to faith healing practices in the pursuit of establishing a responsive holistic illness-health approach. In this way, the research question on faith healing and its emotional and spiritual impact on people suffering ill health will be addressed.

The chapter explores psychosomatic diseases in African perspectives as follows:

Firstly, psychosomatic diseases will be discussed in relation to faith healing practice.

Secondly, by dealing with various factors that contributes to psychosomatic diseases and investigating ways to best deal with them.

Thirdly, drawing on lessons from various empirical studies from disciplines of psychotherapy that were conducted on illness and health as it relates to body-mind integration.

#### 4.2. Psychosomatic diseases and their relation to faith healing

The impact of psychosomatic diseases in health sciences has not been taken seriously, as a result of the dominant nature of the biomedical model, which is based on scientifically

verifiable evidence in diagnosing and treating illness. Reflecting upon psychosomatic diseases has direct implications for the research question, as it deals with one of the main assumptions of the hypothesis in 1.9.2. It interacts with the notion that faith healing practitioners operate mainly within the field of psychosomatic diseases, which by and large manifest in Africa through all kinds of demonic possessions, witchcraft, sorcery and body-mind related conditions (Maboea 2002:66-68). In that sense, it is justifiable to reflect upon how psychosomatic factors manifest in the African context. The complexities around the nature and causes of illnesses have changed over times; even Western medical science realise this fact, as stated by Ross and Deverell (2004:4) that “the pattern of diseases has changed dramatically from the nineteenth century acute, infectious diseases such as pneumonia, typhoid fever and diphtheria, to that of chronic diseases today. Many people suffer today from ill conditions related to bad nutrition, lack of exercise and stress due to work and social pressures.” This is quite an important observation, which confirms the research hypothesis on the question of the emotional impact of healing. Emotional instability, as stated previously by Ross and Deverell, becomes a health risk issue. As such, in dealing with modern illnesses it is important to deal also with people’s attitudes and behaviour patterns in treating illnesses. The notion that emotions, beliefs and attitudes affect physical health has been held for a very long time (Albery & Munafò 2008:2). Thus, it is necessary to investigate the interrelatedness of body-mind (psychosomatic) illnesses. Crossley (2000:3) indicates that:

If psychological factors play a potentially mediating role in the onset and progression of illness, then factors such as beliefs, coping strategies and healthy or unhealthy behaviours could be identified and encouraged or discouraged in the pursuit of health. This conception of the relationship between mind and illness is a departure from the dualism of the traditional biomedical model, indicating an increasing recognition of the interactional processes taking place between mind and body.

The general challenge with psychosomatic diseases is the lack of enough evidence that demonstrate how emotions contribute to health or illness (Orr & Patient 2004:19). Thus, psychosomatic diseases are not considered seriously in the medical field. Scepticism was justified, as psychosomatic diseases in general cannot prove the connection between emotions and the body in relation to their affects on ill-health or the health of the body. They can only show how certain diseases are linked to certain behaviours, characteristics and coping ways. In fact, this research does not aim to prove the connection between emotional factors and

illness, but rather to make use of these assumptions and to establish the relationship of psychosomatic diseases to faith healing.

Diseases and disorders have multiple causes and occur for various reasons. There is no simple explanation for illness or a disease because of myriads of reasons that may be the cause. The discomfort and distress caused by physical illness is hard to imagine - illness incapacitates people as it attacks human vitality. It destroys life-long values and commitments, destroys social relationships, causes loss of dignity and forces people to live with debilitating uncertainties, and at its core threatens life itself (Lazarus *et al* 1984: 125). Seeing as many people suffer degenerative, chronic conditions, such as cardio-vascular diseases, cancer, diabetes and HIV and AIDS at present, there is a need for long term engagement strategies with various health care professionals. In most cases, the conditions patients suffer from are irreversible, thus the health professionals are called upon to enable the persons to manage and live meaningfully with his/ her condition. The focus here is not on curing the disease, but on taking care of the patient (Ross & Deverell 2004: 4).

The scientific advances have contributed to the fact that most modern people view illness in organic terms and therefore primarily seek cures from modern medicine. This statement is confirmed by Larchet (2002:11), by stating that:

By regarding sickness and suffering as autonomous realities of a purely physiological character- and consequently as susceptible to treatment that is purely technical, applied to the body alone- modern medicine does practically nothing to help patients assume them. Rather, it encourages patients to consider that both their state and their fate lie entirely in the hands of physicians, that the only solution to their troubles is purely medical, and that the only way they can endure their suffering is to look passively to medicine for any hope of relief and healing.

This has also affected Africans, who are not immune to modern scientific advances and the impact of globalisation. Subsequently issues of faith and prayer become increasingly obsolete for many people. Pattison (1989:49) reflects on modern persons's value to religion in illness by stating that "perhaps they will see theological significance in their disease. Possibly they may give thanks to God for the gift of modern medicine. Resort to sacraments, prayer, or any other distinctively 'religious' healing method will, however, usually be very much an

accompaniment, a second thought, or indeed, a last hope.” In other words, disconnect of modern secular persons from religion and spirituality make it difficult for them to view illness holistically, as consisting of spiritual, social, psychological and physical dimensions (Musgrave & Bickle 2003:101).

The intricate nature of various influences on psychosomatic diseases makes it difficult to clearly distinguish variables such as somatization from psychosomatic diseases. The interrelatedness is such, however, that they feed off each other.

#### 4.2.1. The link between somatization and psychosomatic diseases

Somatization is a disorder in which a patient complains of physical symptoms for which there are no demonstrable organic findings or known physiological mechanisms (Kihlstrom & Kihlstrom 2001:240). This disorder is sometimes viewed as the product of mind-body interaction that manifests emotional distress through somatic symptoms (Kihlstrom & Kihlstrom 2001:240-41). In medical science, psychosomatic diseases were classified in general as mental disorders and not given the necessary research attention as a result of the fact that they are difficult to verify. Initially, medical scholars rejected psychosomatic factors, and psychosomatic illnesses were perceived to be based on the outdated Cartesian dualism between mind and body (McWhinney *et al* 2001:235-239). The mind and body were viewed as one and the same thing; therefore, there was no need to investigate how the mind affects the body. Somatization doesn't involve somatic symptoms that can be examined and explained by physical or laboratory examinations (Kihlstrom & Kihlstrom 2001:241). Although a patient may complain of a certain illness, the physical testing reveals no symptoms. This situation is compounded by the fact that (Nikendei *et al* 2009:199) “somatoform disorders are characterized by patterns of persistent bodily complaints for which no sufficient explanatory structural or other specified pathology can be identified.” By contrast, psychosomatic and psycho-physiological illnesses can be tested and confirmed by a physician, although causes may not be easy to identify. Psychosomatic sickness may be classified as physical illness, while somatization could be best described as a behaviour that displays a certain type of illness. The somatizing patient complains more about feelings, relationships and how sickness affects the wellbeing, and not necessarily about the actual cause of the problem. This type of condition seems to cause some personality crisis for an individual as he/she grapples to make sense of sudden, unstable personality traits (Landa *et al*

2012:414). The struggle becomes a quest for renewed understanding of the self and understanding of one's own personhood. This reality of self quest and making sense of changing temperaments suggests that the best way to treat somatization is within the social and cultural context. This enables the affected person to receive appraisal, warmth and support from the positive supporting structures of friends, relatives and the faith community. Kihlstrom & Kihlstrom (2001:241) state that "in fact much of the basis for somatization probably lies outside the individual patients, in the social context in which their behavior takes place. Just as cultural factors affect the individual's experience and presentation of physical symptoms, so some cultures may prefer somatization over psychologization as the means of individual's behavioral expression of distress."

Psychosomatic factors are perceived by some people to be a Western-invented concept, while somatization is viewed to be the reality of the rest of the world (McWhinney 2001:235). In African epistemological reality, it is hard to distinguish between these disorders. In the African mind, they are spiritual manifestations that have an evil origin and need to be treated through rituals, sacrifices and rites. Kihlstrom, Kihlstrom & Mechanic (2001: 241) demonstrate the distinction between psychosomatic diseases and somatisation disorders in the following way:

While psychosomatic syndromes may be properly construed as physical illness with psychosomatic causes, it seems likely that somatization is better construed as illness behaviour -- behaviour that, like all other behaviour, must be understood in terms of the patient's personal experiences and life circumstances. The somatizing patient may be anxious or sad, angry or resentful, unhappy in marriage, or frustrated at school or work, or have any host of problems in living. This is what the complaints are really about, not the heart or the gut, and these are the problems that have to be addressed. Nothing is embodied in somatisation at all.

Somatization is an outflow of Western medicine's dualistic ontology (McWhinney 2001:235). The notion is that emotions, instead of being articulated in words, are manifested in bodily ways, and that emotions are not embodied. The idea of disembodiment of emotions is a modern viewpoint; such notions were never entertained in the past. The relationship between emotions, such as anger, fear and love and the physical state was always maintained. African and Western cultures have different ways to express emotions and views about mind-

body relationships. The Western perception is that bodily emotions come from the mind and are not “real”; therefore, bodily emotions are ascribed to mental causes. In contrast, African experiences such as bodily emotions are viewed as common and legitimate in Africa. This is supported by the fact that spiritual and physical realities influence each other in a reciprocal way (Ezeh 2003:38-39). The way language is used in somatization seems to suggest that expression of emotions in bodily form is abnormal and the way to a cure is to acknowledge the mental causes, verbalise them, and seek ways to resolve them (Landa *et al* 2012:413-414). Counsellors must be careful not to be too quick in telling a person that his/her illness is merely mental, as this could cause unnecessary tension and fear. As mentioned earlier, culture and assumptions determine whether somato-form disorders are construed as embodied emotions or otherwise. The fact that these disorders function within mind-body conditions and mental conditions for which there are no bodily symptoms (in the case of somatization), warranted further research to enable the research process to discern the emotional and spiritual impact faith healing may have on individuals healing seeking.

Therefore, in dealing with psychosomatic diseases, dualistic tendencies to separate treatment as purely medical or purely non-scientific must be avoided. In African holistic cosmology, physical and spiritual realities have a close networking relationship (Ezeh 2003:39). In light of this, Kalu (2008:265) observes that “lack of physical health is often understood to be symptomatic of lack of spiritual, emotional or moral health. It is physically harmful to the society and the individual concerned.” In fact, helping people towards health is a community issue and should therefore not be focussed only on an unwell individual. The hospital, church, community and all other social and cultural structures should embrace and facilitate the healing process from illnesses. It is important to reflect upon the body and spirit interrelatedness of psychosomatic diseases with a view to better understand how to deal with complexities involved in treating people with such illnesses.

Factors such as emotional instabilities, social and economic inequalities and cultural and religious expectations, could all affect a person’s health and lead to illness, if not tackled with collective and complementary tools. In other words, illness is more than only biological and should therefore be understood in a broader framework of human existence and dynamics and treated likewise. Thus, in addressing task two question of practical theological methodology “why is this going on?” the researcher argues that difficulties in dealing with psychosomatic

illnesses, especially in proper diagnoses and lack of effective treating methods, both by faith healers and Western medicine, is at the centre of this question. There is a need to further explore the dynamics and the relationship between psychosomatic diseases and how they relate to illness and health experiences. Thus, highlighting the body-spirit relationship is crucial to understand the intricacies of psychosomatic factors. In so doing, a clearer picture of body-spirit relationship of psychosomatic diseases will enable a better assessment of the healing impact on people suffering from psychosomatic illnesses.

#### 4.3. The body and spirit interrelatedness and psychosomatic illnesses

Task two, according to Richard Osmer's approach, deals with "why is this going on?" The hypothesis in 1.5.2 has stated that faith healers claim healing for what may be classified as psychosomatic illnesses. Therefore, a better understanding of the body-spirit relationship is integral in responding on why this is going on? There seems to be a symbiotic relationship and connectedness between body and spirit, which also has an affect on illness and health realities. For example, the negative impact psychosocial stressors has on the immune system is well documented (Evans *et al* 2000), and the explanation for this can be found at least partly in the activation of various neuroendocrine pathways, rather than simply through alterations in our behavioural patterns. To substantiate the body-spirit relatedness to illness, Roberts *et al* (2002:433) states that "it has been empirically demonstrated that beliefs, psychological mind-set, and attitudes have a direct connection to physiological responses. How we think and feel, relate to others, face our fears, and perceive our self- image all have an effect not only on well-being and the ability to live life fully but also on the progression of the disease and its effects on our lives." Treatment in cases of psychosomatic conditions is not obvious or that simple, as a result of the intricacies of each case and varying underlying reasons that affect each ill person. It involves both medical and nonconventional ways for effective response.

The task two focus of this practical theological methodology further employs various sciences in an interdisciplinary manner to enrich the topic of enquiry. In that sense, the first interdisciplinary contribution discusses psychologist Ken Welber's four quadrants of knowledge to elaborate on the mind-body relationship.

To better explore the different functions of mind-body dynamics, Ken Wilber's psychosocial determinants of health and illness, commonly known as the "four corners of the universe" are employed (Astin & Forsys 2004:15). The four quadrants create a theoretical framework from which to engage with the illness-health paradigm, in order to understand and better serve people on their journey of health. As every quadrant represents an important reality that any ill person grapples with, knowing the dynamics of each quadrant and taking people through various stages of health is desirable. Astin and Forsys (2004:14f) draw on Ken Wilber's quadrants, which essentially divide the universe and desire for knowledge into four faces of the kosmos, namely:

- i) The interior dimensions of individuals, including feelings, meanings, concepts, and beliefs.
- ii) The interior dimensions of collective understandings, including shared meanings, cultural beliefs, worldviews, and value subcultures.
- iii) The exteriors of individuals, covering organs, tissues, cells and behaviour.
- iv) The exteriors of the collective, covering social structures, families/tribes, ecosystems and modes of production.

These different domains are better known as the four quadrants and are explained by the following figure. The upper two domains are responsible for individual dimensions: Upper left and upper right quadrants deal with interior and exterior realities, while the lower left and lower right quadrants refer to the collective level.

<p>Upper Left</p> <p>Interior-Individual</p> <ul style="list-style-type: none"> <li>• Feelings</li> <li>• Meaning</li> <li>• Concepts</li> <li>• Beliefs</li> </ul>	<p>Upper Right</p> <p>Exterior-Individual</p> <ul style="list-style-type: none"> <li>• Organs</li> <li>• Tissues</li> <li>• Cells</li> <li>• Behaviour</li> </ul>
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Lower Left	Lower Right
Interior-Collective	Exterior-Collective
<ul style="list-style-type: none"> <li>• Shared meetings</li> <li>• Cultural Beliefs</li> <li>• Worldviews</li> <li>• Value Subcultures</li> </ul>	<ul style="list-style-type: none"> <li>3 Social Structures</li> <li>4 Families/Tribes</li> <li>5 Ecosystems</li> <li>Modes of Production</li> </ul>

Figure 3: Wilber's four quadrants of knowledge or four faces of kosmos

In the above figure, the medical and biological sciences mainly make use of the spheres of the body (upper-right quadrant) and mind (upper-left quadrant) in treatment of illnesses (Astin & Forsys 2004:15). The emphasis on biomedical treatment has limitations, especially by not approaching treatment in a holistic manner. This is confirmed by Astin and Forsys (2004:15), who state "the disaster of modernity is that this positive differentiation has, unfortunately, led to a kind of dissociation or fracturing of mind from body, resulting in medicine that is not really 'integral' precisely because it too often fails to consider factors other than those in the upper-right quadrant".

The cultural experiences and religious perspectives to illness and treatment strategies are not easy to locate in one quadrant and also invariable by scientific methods and therefore, ignored or seen as primitive by Western sciences. African culture is based on a communal framework, where relationships are taken seriously; therefore treatment that goes beyond the two upper quadrants and embraces the two lower ones will be most valuable in African context. Thus, the challenge is to mingle the strong aspects of all four quadrants for treatment of all kinds of illnesses people grapple with daily. The spirit-body dualism in relation to illness must be avoided, as this compartmentalises diseases as either medical or psychiatric (Rubin & Wesley 2001:257). The spirit-body dualism is insufficient to treat African people who hold to the view that what happens in the physical, such as illnesses, is connected to the spiritual (Ezeh 2003:39). Africans believe that the visible (material) and invisible (spirit) worlds are inseparably linked to each other. Ezeh (2003:39) indicates that these two worlds overlap and share into each other and are in constant communication with each other. There is a close connection between physical and mental disorders in African understanding. In

fact, doctors deal mainly with the physiological aspects of treatment and do not necessarily consider psychological or mental treatment (Musgrave & Bickle 2003:108).

The four quadrants seem to be an effective tool for working towards an integrated approach in dealing with issues of health and illness. In fact, Wilber's four faces of kosmos/quadrants are advocating for the uniqueness of the various quadrants and each function, and also to seek the unity within the quadrants for better appreciation and maximisation of human potentiality. This type of paradigm shift in treatment is needed in the social dynamics<sup>21</sup> of the world and society we live in.

Growth and transformation should also take cognisance of the societal values and best employ them for meaningful and supportive treatment of illnesses. Wilber's four corners of the universe/ quadrants have shown the importance of interacting with all four quadrants in dealing with health issues. The quadrants have brought some important aspects that will enhance the research to the fore:

- Firstly, the relationship between psychological control and health is not a simple, linear one; more control does not suggest better health and poor control poor health.
- Secondly, although material/ physical components (upper-right quadrant) are dominant in Western treatment, there is a need to understand and apply socially and culturally constructed phenomena. The fact is that actions of individuals when they are sick are strongly influenced by culture. Culture determines the type of action or behaviour that is a socially appropriate or an acceptable way of response to illness.
- Thirdly, the social factors (Wilber's lower-right quadrant) are important in treating and dealing with issues of illness and health. There is a linear correlation<sup>22</sup> between

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<sup>21</sup> "Changes in the social world. Changes in emotional and mental states. At first glance, it may seem that these changes have little to do with disease. But 'real,' organic diseases are linked to changed beliefs about oneself, to the nature of one's relationships to others, and one's position in the social world. Such links only appear impossible, or at least irrelevant or unimportant, from the early and simplistic medical view, which regards the body as a mindless automaton. Our hearts, lungs, stomach, immune systems, and all other organs are hardly independent, autonomous organs. Certainly they have autonomous functions, but they are regulated by and in communication with the brain" (Ornstein 1987:35).

<sup>22</sup> "The cumulative evidence presented in this paper strongly supports the notion that an array of psychosocial factors can contribute to physical health and illness in significant ways. It points to profound importance of not

lower economic status, especially education and poor health (Astin & Forys 2004:20).

The interrelatedness of human composition, and therefore the complexity of psychosomatic illnesses, has been highlighted; subsequently, a better knowledge of these kinds of conditions would ensure better treatment interventions for affected persons. The four quadrants explore the effect of traumatic experiences and introduce ways to facilitate a hurting person through different emotional stages. By implication, this gives justification to the research, as spiritual and emotional dimensions of healing seekers demand a multiplicity approach for treatment. In other words, people who are facing ongoing illness may experience various stages of trauma or crisis, hence a need to understand the dynamics of these stages.

#### 4.4. The processes of dealing with pain when not healed from illness

Illness is not only a threat to one's productivity and meaningful living; it affects a person in totality. Healing is the ultimate quest for a person suffering ill-health, and the road to healing starts by dealing with various emotional challenges ongoing illness causes. Louw (1994:34) states that illness primarily affects body functioning and everything associated with basic bodily needs of existence. The fact is that as human beings, we do not only possess bodies; we are bodies. When the body becomes ill, it is not only a part that is attacked by illness, but the whole person in fact becomes sick. Louw (1994:34) remarks that "a disorder of bodily functions affects the entire person, as well as his/ her feeling of identity. Because the body is the instrument through which we orientate ourselves in the world, a sick body signifies a sick person. Thus, illness is a problem of the total person and affects the human self or ego most profoundly." It is important to note that pain is not merely a physical phenomenon, but involves the whole person; body, mind and spirit (Musgrave & Bickle 2003:3). People who are ill go through different feelings and these feelings are not all experienced at the same

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only Wilber's upper-right quadrant (i.e. biology, physiology, and genetics), which has been the primary focus of medical research in the 19<sup>th</sup> and 20<sup>th</sup> centuries, but of the other three quadrants in the Wilber model: psychological, cultural and social. Given this body of epidemiological and laboratory findings, it would, therefore, be logical to hypothesize that if we intervened clinically at the level of the other three quadrants (e.g., through teaching individuals to manage stress more effectively, to increase sense of control, and so on), we would be able to significantly influence outcomes" (Astin & Forys 2004:20).

stage or time during the process of illness. Nevertheless, Musgrave and Bickle (2003:22) indicate that all the feelings must be experienced if the ill person is to come to a state of acceptance and peace. The stages<sup>23</sup> include denial, bargaining, guilt and acceptance (Astin & Forsys 2004:16-18; Louw 2008:552-559; Bowman 1998:84-96). The following stages commonly manifest during illness:

#### 4.4.1. Shock and Anxiety

Shock is usually the first emotion a person deals with on hearing or experiencing an unexpected event. It usually goes along with a feeling of numbness and disbelief. Louw states that a state of shock causes total obstruction of emotions (2008:552). Although this stage is hard to handle and can lead to devastating consequences if prolonged, it eventually moves over to the stage of anxiety. Louw (2012:152) records that in terms of past experiences and possible indications, an anticipation of loss is experienced. He calls this feeling an anticipatory threat of anxiety.

Roukema (2003:72) observes that “anxiety is a generalized, very unpleasant feeling of apprehension. It is often hard for the patient to describe. It is usually accompanied by physical discomfort such as palpitations, shortness of breath, excessive perspiration, and motor restlessness.”

Anxiety comes from the same Latin root, *angere*, which carries the idea of anger or anguish. Special characteristics of anxiety are the feelings of uncertainty and helplessness in the face of danger to one’s wellbeing (Cole 2008:1, 9). Anxiety can manifest itself because of great uncertainty caused by a diagnosis of chronic disease (Devins & Binik 1996:640-696). Anxiety is an emotion that comes about because of worry, tension, or conflict. It is not necessarily harmful, but could be seen as the way the body reacts when faced by a situation perceived as harmful or dangerous. Collins and Culbertson (2003:39) indicate that “all people experience anxiety to a greater or lesser degree, and the causes of anxiety are variable among people. Since anxiety is a normal emotion, reactive to normal and abnormal life stresses, we all must develop coping skills of adaptive psychological and behavioural mechanisms for

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<sup>23</sup> Collectively, these stages attempt to understand the emotional and spiritual state of a person that grapple with ill-health. These emotional reactions are applicable to a broad spectrum of disabilities and chronic conditions. Emotions are only symptoms that alerts that all is not well, the real diagnosis is deeper than emotions. In that sense, treatment should deal with emotions as means to an end, but ultimately seek ways to restore the person to

managing anxiety in a healthy way.” The moment an individual cannot manage his/ her coping and adapting mechanisms, ineffective ways to deal with the situation come to the fore, which results in loss of emotional balance, functional capacity and social adaptation skills.

Anxiety is heightened when people feel overwhelmed about the thought of controlling the disease and the long term consequences and problems of living with a chronic illness. The other worrying factor is to not know the gravity of the disease and how life will further be crippled or advanced. A chronically ill person is troubled by questions such as whether he/she will be able to work and provide for the family, and how to relate to friends and cope at work. Cole (2008:105) observes that “since anxiety is the response to a problem (fear of perceived danger), as opposed to the cause of it, we should not focus our efforts on anxiety itself, rather, we should focus on identifying, understanding, and striving to diminish or alleviate the fear that prompts the anxiety response, and also on working on the manner in which the anxious person appraises the fear that eventuates in anxiety.” The next emotional response is generally denial.

#### 4.4.2. Denial

Louw (2012:148) indicates that “when a person is in a condition of shock, denial is a short-term escape mechanism. It functions as a pause before the storm; as an opportunity to debrief.” This is also true in cases where some ill persons may deny illness and heroically put up a healthy front, despite the obvious symptoms of illness (Louw 2000:194). In this case, patients may try to negate their condition by heroic acts that reflect that they are in control of their lives. This is another affective state frequently experienced in the grieving process and may manifest in many ways. This could be by rejection of the diagnosis, or its seriousness. Those who reject the diagnosis may argue and disagree with the therapist or the medical person about the accuracy of the diagnosis. Others may not show their denial towards the medical personnel, but may not follow the recommendations or procedures of health officials. Weaver *et al* (2003:43) state that “some numbing and denial could be understood as adaptive and welcomed respite from being psychologically overwhelmed. However, if extreme or prolonged, this state can result in emotional paralysis, withdrawal from life, and occupational

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his/ her original state of mind, soul and body. Where such stage is not possible to regain the person should be able to accept his/ her condition and to live meaningfully despite the debilitating health situations.

dysfunction. Among the most devastating results of chronic numbing are loneliness and withdrawal from connection or intimacy with others.”

Understanding this is very crucial, so that the healing strategies employed do not further ostracise the ill person. Extreme care must be taken to minister healing love to such a person. Ross and Deverell (2004:37) indicate that "the process of denial is probably the most frustrating one for professionals because so much evidence point to the efficacy of early intervention. However, denial is a valuable defence mechanism that protects the psyche from trauma that people are not ready to deal with. Individuals who are experiencing denial often feel distressed and agitated to the extent that they may even experience sleep difficulties." Denial is not a passive process, but is active, whereby a traumatised person redeems time to regroup and re-energise in order to face the reality. During this time, the traumatised person tends to "shop around", consulting different health professionals or healers with the hope of being healed or given an alternative diagnosis. Denial is only overcome when the affected person obtains inner strength, external support and better knowledge about how to cope with the threatening situation. Although different emotional phases are not always chronologically experienced, denial is usually followed by anger.

#### 4.4.3. Anger/ Hostility

Many epidemiological and clinical studies that have been undertaken show the strong connection between anger/hostility and negative health outcomes. Williams and others (2000:2034-2039) suggest that people, both male and female, who are prone towards anger, are at high risk for developing coronary heart diseases. Hostility may contribute to negative pathophysiological effects and leads to a poor health situation. Williams and others (2000:2034-2039) have argued that stressors caused by anxiety and hostility can result in cardiovascular diseases such as blood pressure irregularities. There is also link between anxiety and negative health outcomes, especially in the area of cardiovascular diseases, as shown by studies on the relationship between anxiety disorders and cardiac death (Rozanski *et al* 1999:2192-2217).

Anger is an integral part of grieving and mourning and often goes along with questions such as "why me?" and "what did I do to deserve this?" Anger could be directed towards oneself, others, God or therapists. Weaver and others (2003:44) indicate that “if not expressed,

honored, and understood, anger can poison; it can result in bitterness, erupt into violence or chronic irritability, and cause serious health problems - most notably high blood pressure.”

One way to deal with anger is by the grace of forgiveness, but as noted by psychiatrist Scot Peck (cited by Weaver *et al* 2003:44), many people engage in cheap forgiveness, which is shallow and does little to extinguish root feelings. There is a need to first acknowledge one’s deep seated anger in order to experience meaningful forgiveness. Anger cannot be washed away, be left for time to heal or be removed by saying things such as “just trust God and all will be well”. There is a need to create a supportive and non-judgemental environment, so that an affected person can express his/her anger and feelings openly, as a way to get rid of them. Weaver *et al* (2003:44) indicate that “patience, care, love, and continued availability are the responses that afford the greatest chance of reducing the suffering of survivors facing existential crises.” Anger and hostility can easily lead to feelings of guilt.

#### 4.4.4. Guilt

Guilt is a frequent and significant problem, causing psychological and interpersonal problems in the lives of distraught persons. Aden and Benner (1989:99) suggest that: “It is what we are and not just what we have done, so it becomes a decisive determinant of who we are and of who we become. It enslaves with its subtlety, paralyzes with its pain, and drives us towards despair and endlessness. Consequently, we often try to push it into our dark and hidden recesses of our lives - or, in a more positive vein, we face up to our powerlessness and seek help from someone beyond ourselves.”

Guilt is caused by the fact that an ill person feels that he/she is the cause of the condition, and the belief that he/ she is getting just punishment because of his/ her actions. The person becomes miserable, guilt driven and self-pitying as he/ she believes that good things happen to good people and bad things to bad people. This process goes along with the period of grief, which may have a negative impact on a person’s immune system, as shown by some researchers (Irwin & Pike 1993:160-171; Kim & Jacobs 1993:143-159). Guilt is a normal process of grieving that happens once the affected person takes stock of his/her life and re-examines his/her life. If not controlled and channelled well, guilt may lead to depression or another destructive stage.

#### 4.4.5. Depression

Some people are at a stage during their crisis where they resign to their condition and let suffering overpower them, without any positive effort to integrate suffering positively. Human existence is viewed as miserable and thus finding any meaning in suffering is not sought. Louw (2000:195) states that “when sufferers regard themselves as victims of fate and realize their personal guilt, they surrender to self- castigation and self- pity.” Many people with chronic illnesses experience depression, which is caused, at least in part, by the major loss of control that comes by having a chronic disease (Epping-Jordan *et al* 1999:18, 315-326; Spiegel 1996:168, 109-116).

There are various forms of depression, as well as reasons for it. The related constructs of hopelessness of an individual, including negative expectations about the future and one’s goals, and helplessness play significant roles in both cardiovascular diseases and cancer. Everson *et al* (2000) have found that, for example, Finish men with high levels of baseline hopelessness were three times more likely to become hypertensive in the intervening years. Some depression cases are caused by some sort of chemical imbalance in the body; the ones discussed here however, are depression caused by grief or sense of loss of something significant, in this case health. Depression may be another form of inward anger a person has for believing that he/she has failed him/herself. Ross and Deverell (2004:39) observe that "people who are depressed often perceive themselves as impotent, incompetent, incapable and of little value, since they have been powerless to influence something so close to them that they want so desperately to alter." Depression is a necessary part of grieving, as long as it does not continue too long and become uncontrolled. It separates the reality from fantasy. Depression and stress are closely connected and feed off each other.

#### 4.4.6. Stress

Stress is often a result of an individual that views his/her situation as overwhelming and draining and above his/her resources to make amends or cope with. Constant exposure to chronic stressful situations can elicit profound physiological changes (e.g., cardiovascular, immune, and neuroendocrine systems) that can, in turn, lead to negative health consequences (Kiecolt-Glaser *et al* 2002:83-107; 2002:15-28). Anything that hinders normal functioning of the body, which threatens our health in other words, can cause stress, although it may be in small measures and easy to handle.

There are two kinds of stresses identifiable, namely *external stress*, which is caused by factors outside one's body, like a hostile job environment, home pressures, noise, trauma, injury etc., and *internal stress* that comes from within one's own body. Van der Merwe (2004:13) indicates that "stress is the physiological, emotional and behavioural response of a person seeking to adapt and adjust to internal and external pressures or demands. It is basically a physical survival response, leading to a fight or flight reaction." Generally, human beings have ways of coping with daily stress, whether from home, work or society. Stress may accumulate over time however, and suddenly erupt into a devastating volcano that creates 'dis-ease' after many months and sometimes years of unresolved tension.

Stress that is unresolved develops into all kinds of ailments and illness. Emotions like resentment, bitterness, fear and worry constantly trigger stress responses and are harboured inside thick, deep cell memories. These layers are used as physical imprints for dreams, body, psyche, soul and psychological issues. Stress causes or increases the risk for all kinds of conditions (Astin & Forsys 2004:18), such as diabetes, high blood pressure, asthma, migraines, allergies etc. The emotional and behavioural consequences of hostility/anger, anxiety, depression/helplessness are in many instances a result of stress - the cognitive/affective result when one perceives that one does not have the internal/external resources to meet a given demand or challenge in life (Astin & Forsys 2004:18). When an ill person realises that the illness remains with him/ her despite many medical interventions and even healing prayers, then the patient goes into a stage of bargaining.

#### 4.4.7. Bargaining

This is a process whereby acceptance of an illness is delayed with the hope of manoeuvring for a better outcome. A depressed person is in no mood to bargain. Roukema (2003:147) argues that "there is a silent anger, feelings of hopelessness, and thoughts of no way out. At some point, it occurs to the person that if a bargain can be made with God or fate or life itself, perhaps he or she can emerge victorious." Bargaining is a desperate effort where an ill person makes a plea bargain to God with the hope that the desired result will be granted. The ill person or others affected may try to bargain with God or the therapist to change the situation, saying they would be more obedient and follow henceforth an exemplarity life (Bowman 1998:58). The bargaining can take different forms, but usually proposes a win-win proposal,

for example: “God if you save me from this disease I will devote my life to a good cause” (Roukema 2003:147). Even in cases where a person is not religious, the basis of bargaining is still a strong quest to live and to contribute to life. The counsellor must guard against giving people false hope and promises, like “if you follow the prescription fully you will be healed”. Such suggestions could also be seen as a way of bargaining that may end up in frustration and disappointment.

#### 4.4.8. Acceptance and growth

Acceptance happens when realisation comes that the crisis is unavoidable and must be dealt with in a proper manner. It designates a position of realism and identification (Louw 2012:153). This can also be a way to link suffering to a higher purpose or meaning. Louw (2000:195) indicates that “it is important that pastoral care to people in suffering should enable them to look upon suffering as an opportunity to embrace their trauma as a calling and a challenge to grow.” As time passes, the grieving person comes to terms with realities and starts to adapt to the loss or the reality of the illness. People process and ultimately cope with their grief in different ways and at different rates. Some people may retreat to the denial phase and never progress from there and never reach the point of acceptance (Roukema 2003:147), while others may work through their grief and reach acceptance in a relatively shorter time. Those who are unable to move forward remain stuck in anger or depression. It doesn't mean however, that arriving at a mature conclusion means that there are no more moments of anger and regression. Roukema (2003:147) states that “no one can be so emotionally secure as to never revert to former levels of despair. But many individuals can, for the most part, attain the stage of resolution on a day to day basis.” It is therefore important to handle each individual case separately and on its own merit. The human spirit is resilient and all individuals possess strength and virtue (Seligman and Csikszentmihalyi 2000:5-14).

All the stages mentioned previously may not necessarily be experienced by every person who faces illness. The fact is that each person responds and copes with trauma differently; there is not a one fits all reality. One person could become bitter, resentful and become completely disillusioned because of his/ her debilitating physical situation. This could lead to doubt and disillusionment and to “why me God?” types of questions, that easily lead to self-pity and self-condemnation.

#### 4.4.8.1. Recognising and dealing with negative emotions

Bitterness is a common and deeply destructive manifestation, which could possibly be identified as a mental illness under the name post-traumatic embitterment disorder (Roan 2009). Embitterment is caused by a sudden, unexpected negative happening, whether the loss of a job, the realisation of a dreaded disease or the loss of a loved one. Many anger and stress-provoking instances occur in social contexts, especially in stable but troubled interpersonal relationships (Smith & Christenen 1992:33-44; Spielberger, Reheiser & Sydeman 1995:49-67). This is what makes psychological and psychosomatic illnesses complex, as what happens in one aspect of human life undoubtedly affects the totality of a person. The fact is that, for example, poor couple relationships can induce stress, which can affect health (Berry & Worthington Jr. 2001:447). The healing practice must engage an ill person in his/her completeness as soul, body and spirit for meaningful intervention strategies. People often come for help to deal with symptoms related to some type of offense, hurt, or trauma. Wade *et al* (2005:634) argue that the need to help clients to make sense of and to get beyond these experiences is often a necessary and helpful therapeutic goal; certainly, processing these events in a supportive and validating environment is a large part of the healing process.

Roan (2009) discusses the effects of trauma as “instead of dealing with the loss, with the help of family and friends, they cannot let go of the feeling of being victimized. Almost immediately after the traumatic event, they become angry, pessimistic, aggressive, hopeless haters.” One person may take his/ her illness with grace and extreme patience. In such a case, the person may look for any good that may come out of it, with questions like “how can I help others through my experience?” Such a response is only possible by divine grace and extreme courage, especially in the midst of suffering and pain if facing the reality of life-threatening illness.

In many instances, the victim suffers from bitterness, resentment and anger, as they find it hard to forgive themselves, others and God. The choice, according to Rodriguez (n.d.), is that “one can hold anger until anguish builds a prison of bitterness. In this cage you will live a diminished and pain-filled life. Or you can choose a life to forgive. By choosing forgiveness you are choosing abundant life.” Often there are valid reasons to harbour revenge, but there is no retribution in a hurting heart. Although forgiveness is never easy, it is even harder to live

with an unforgiving heart. Rodriguez (n.d.) states that “unable to face their anger and confront their embittered issues, people allow an unforgiving attitude to cause much distress with their souls. It is like a poison, destroying the heart and mind.” There are three harmful results of unforgiveness; bitterness, blame and bondage. Sara Rowe (2012:18) demonstrates that unforgiveness harbours the negative emotions of hatred and anger toward someone who has caused harm. These strong emotions can impact not only the emotional state, but also the physical state. She continues to state that holding on to these emotions causes the body to be in a constant state of high anxiety, which releases stress hormones of adrenaline and cortisol. When the levels of the stress hormones are consistently high, a number of health outcomes result, including problems with heart, sleep, digestion and depression. The common modern diseases are stress and depression, which result in very young and healthy looking individuals ending up in centres of psychiatric care (Sanderson 2004:112). It is not an overstatement to suggest that psychosocial disturbances may cause diseases through psychophysiological<sup>24</sup> disturbances (Albery & Munafò 2008:79). There seems to be a link between emotional imbalances and certain types of illness conditions. Some authors (Astin & Forsys 2004:16; Ellis & Abrahams 1978:1-2) have argued that certain bodily disorders like ulcers, rheumatoid arthritis, and hypertension are caused by emotional conflicts. This has implications for illness of a psychosomatic nature, which could be more apparent as a result of the aforementioned pressures. The psychosomatic effects of pain are demonstrated by the manner in which people respond to interpersonal offences that affect their health conditions. This is underscored by the research, which linked anger, blame, hostility, and resentment with negative outcomes (Williams R & V 1993:37-38). Similarly, anger and resentment in some people result in high blood pressure, while forgiveness training may be effective clinical intervention in some hypertensive patients (Tibbits *et al* 2006:27). Where people harbour anger and resentment, possible ways and remedy strategies to cope with must be taught.

A growing body of evidence links chronic states of unforgiveness, including anger and hostility, to adverse health outcomes (Kaplan 1992:3-14; Williams 1989). Unforgiveness is destructive and devastating and also affects self identity and self esteem (Wade *et al* 2005:634). Williams and Williams (1993:37-38) indicate that “unforgiving responses (rehearsing the hurt or retaining the grudge); activate negative intense emotions which in turn

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<sup>24</sup> Pressures that cause immense changes in the nervous system, immune system and homeostasis of the body put so much strain on both emotional and physical elements of human existence (Sanderson 2004:112-128).

causes sympathetic nervous system reactivity.” On the other hand, Thoresen, Harris and Luskin (1999:254-280) state “whereas forgiving responses (empathising with the offender or granting forgiveness), can reverse these physiological reactions.” On the other hand, although forgiveness is not easy and can be emotionally taxing, it is the best way to get rid of unforgiveness and bitterness. Researchers (Thoresen *et al* 2000:254-280) have proposed that forgiveness should be associated with its benefits to physical and mental health. Forgiveness is the replacement of the negative emotions of unforgiveness by positive, love- based emotions. Such positive emotions include empathy, compassion, sympathy, and affection for the offender (Berry & Worthington 2001:447). The same sentiments are echoed by Wade *et al* (2005:634), by indicating “forgiveness as replacing the bitter, angry feelings of vengefulness often resulting from a hurt with positive feelings of good will toward the offender.” Forgiveness is a process that may benefit people who are in pain caused by anger and resentment, which if untreated may lead to other complications. Tibbits *et al* (2006:28) define forgiveness as “the process of reframing one’s anger from the past, with the goal of recovering one’s peace in the present and revitalizing one’s purpose for the future. In this way one learns how to deal with the past offences, which can lead to current emotional disturbances, and ultimately to perceived limitations on the future.”

The anxiety, fear and worry caused by illness cannot be explained away by any psychology, but rather calls for a connection to God as the higher source and the reason of all existence. Van der Merwe (2004:151-153) states:

The message of hope and healing is that the process can be made conscious, allowing you to acknowledge the fear, depression and anxiety and to access the deeper fulfilling process, even if it is accompanied by pain, suffering and capitulation, but once used as a focus for deep inner reflection, it helps you grow and mature as a truly healed and whole being - whether the physical body finally dies, or not - hence the gift of disease.

In dealing with harmful feelings, there must be some motivating factor that will encourage a suffering person to have a positive outlook and to hope for change. Orr and Patient (2004:94) indicate that “fundamentally, you need challenge and stimulation as much as you need water and food.” Difficult times could become opportunities for reflection, learning and growth. In that sense, Smith (1990:177) mentions that “a crisis could become a vehicle for growth.” Illness and its consequences could ultimately become devastating experience to one’s self, or

they could also be times of positive reflection and refocus. Stratton *et al* (2007:590) remark that “the presence of death or debilitating illness in our own lives can make navigating the day-to-day demands of life and work difficult. Yet, in the presence of such extraordinary difficulties, we can continue to learn and grow by reconciling these painful experiences.” The ultimate hope is that people facing illness will eventually attempt to re-orientate their lives towards the future, where new perspectives and a new approach is developed. This is only possible as mechanisms are effectively and skilfully used. Louw (2012:153) mentions that the indicators to growth in a crisis are hope, patience, humour, gratitude and courage.

In view of the body- mind interrelatedness of illnesses and psychosomatic diseases, a reflection on placebo effect is explored. Therefore, a closer look at the role of placebo effect as it relates to psychosomatic diseases and faith healing practice is needed.

#### 4.5. The placebo effect on psychosomatic diseases

The fact that this chapter focuses on psychosomatic diseases within the African context opens up possibilities for further research. The faith healing practice should not be seen in isolation, but as part of broader healing strategies for people grappling with illness. Likewise, psychosomatic conditions should not be considered without the cultural, social and economic context and various challenges African people face. Illness and health are human rights issues, this is demonstrated by Louw (2006:24) as he states “*lyding het te doen met die menslikheid en waardigheid van 'n mens se siel.*” and as stated in chapter one, the poor are the most vulnerable to grave conditions of illness. The investigation of the relationship between the placebo effect and psychosomatic illnesses will shed more light on the focus of Osmer’s practical theological methodology in task two - why is this going on? Hence, a discussion on the role placebo effect and how this complicates treatment of psychosomatic diseases.

African epistemology views unaccounted conditions as demonic and evil, or as curses that need to be dealt with through rituals, sacrifices and appeasement to ancestors. Mwaura (2004:109) observes that “the approach to healing is a complex affair that digs deep into social, spiritual and mystical roots of illness.” The Christians from Charismatic and Pentecostal churches in Windhoek are more conservative in their understanding and

application of the scriptures. This creates a tension between trusting God for healing through prayers and the use of alternative means of healing, such as medicine (Asser & Smith 1998:625). The dualism comes about because of teachings of some faith healers that do not encourage alternative treatment outside of faith healing encounters (Kalu 2008:263). This may contribute to this tension, as some people may understand that you cannot maintain or practice both options. The scientific world may claim that they only make use of pure methods that are scientifically verifiable; however, despite such emphasis on technology, there is an unspoken faith<sup>25</sup> exercise between the patient and his/ her doctor.

The term “placebo effect” is an important concept in the healing activity and needs a clear explanation: Placebo is derived from the Latin word meaning ‘I shall please’ (Ornstein 1987:72- 78). Placebo refers to an inert substance the doctor may give to the patient in distress in replacement of a sedative or addictive drug (Berinyuu 1989:73). Placebo power may work because of the role of a doctor in community, and the community’s expectations of a doctor, which evokes an expectant trust in a patient. The placebo effect could be tricky and complicated, as perceived healing may be caused just by the very fact of seeing a doctor without any real significant treatment on the doctor’s side. This brings about the question whether placebo effect is based on deception? Berinyuu (1989:73) argues that “the question of deception may have limited the use of placebo or at least made the doctor conscious of this role of the placebo in the doctor-patient relations. However, the placebo does play a role in effecting some types of treatment on some patients, especially in psychosomatic illness and treatment of some psychiatric cases.” The same placebo effect can manifest on the basis of a promise made by a faith healer. The real question is whether the placebo effect is a “pressurised” outcome of “healing” a patient experience, as the patient is concerned about satisfying the doctor or the person who prays.

Generally, the medical world has judged the placebo to be unsound and foolish; there is some evidence however, that the placebo contributes towards relief for some patients (Ornstein

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<sup>25</sup> “Perhaps one of the most tangible symbols of the healing power of the doctor is a pill. In addition to whatever specific pharmacological activity the medication might have, the giving and the taking of medication is a cue which triggers a positive response. The belief of the patient and doctor in the power of the medication or treatment has historically been one of the most potent therapeutic agents, often derided as just a placebo” (Ornstein 1987:78).

1987:78). The placebo effect has been known for centuries; however, it has only been taken seriously since 1977, after the researchers of the University of California at San Francisco brought out groundbreaking research on the placebo-induced pain relief effect (Ornstein 1987:96). The test was made with morphine as a painkiller. People were told that morphine has a strong effect on pain and were then treated with morphine to ease their pain. Almost certainly most people experienced relief from pain; however other people, who were treated unknowingly with an inert substance without any pharmaceutical properties, also got well, as they thought they had been treated with morphine. This is the placebo effect.

The aforementioned test demonstrates the power of expectations on experience. Approximately one third of patients experienced significant relief from pain, although some had not received treatment with morphine. This was because of the placebo effect (Ornstein 1987:96). The placebo-effect has been highlighted for the contribution it makes towards self-healing possibilities. Harrington (2008:133) states that “it was not just a trick; it produced real (physiologically discernible) effects, and therefore it need not inherently undermine patient trust in doctors or function as a source of patient disempowerment. On the contrary, rightly understood, it could be a source of patient empowerment and a means of enriching the doctor-patient relationship.” This important observation also called for caution, as certain responses or remedies could happen by “make- believe” as a result of the trust relationship between a sick person and a healer, especially in religious healing practices. The danger is that faith healers may unwittingly deal with people who may claim healing on the basis of their word, without actually being healed.

The placebo effect is based on the belief in treatment and not in the treatment action itself (Orr & Patient 2004:72). People may suffer from psychosomatic illnesses, which are caused by high demands of living and pressures of life that result in stress and all kinds of cardiovascular conditions. Faith healing operations mainly deal with psychosomatic diseases, which are hard to verify. There is a need to investigate the placebo effect generated by high expectations and high motivation and how these affect spontaneous healing. People who are seeking healing are desperate to become well and would seek healing at all costs. Many diseases once thought to be purely physical or organic are known to be caused by or related to a person’s mental condition. In such cases of mental illusion of illness, many physicians

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have given “fake medicine,” which has a placebo effect. Dunn (1997:96) alleges that placebo medicines do not affect the patient, but because patients believe that they receive treatment for their illness, they feel healed.

This reality could also manifest within the faith healing practice, where a person could be taken in by the hype of the moment and the preceding advertising campaign about what the healer can do. Subsequently, the ill person may experience a cure by the placebo effect. The danger is that such healing is not genuine and the illness not really treated; therefore, illness could recur in no time (Pattison 1989:54-55).

The role of the placebo effect triggers question such as whether faith healing practices are reliable or just a deception. In the view of this question, the study by Harvard University on prayer outcomes is important to reflect upon.

The interdisciplinary nature of practical theology warrants interaction with other social sciences and in order to engage, critique, and feed on each other for better integrated healing interventions (Goodliff 1998:176). To substantiate the interdisciplinary nature of task two, the following study, done by Harvard Medical School in the Department of Psychiatry, on the outcomes of intercessory prayer on targeted group of patients is important to discuss. Berry and Worthington (2001:447) state that more research studies have come out that demonstrates the medical significance and correlation between body and mind factors on the wellbeing of a patient. A research study conducted on the impact of prayer at Harvard University has some significant outcomes that relate to the role of prayer and of the placebo effect on patients. Hence, a closer look at this research and its conclusions is needed, as these have direct relationship to the research question and contribute invaluable information for understanding and dealing with psychosomatic and the body- mind relatedness of illnesses. The Harvard study research is important when considering the focus of Osmer’s practical theological methodology in the second task, which advocates for the integration of various disciplines. The fact that the Harvard research contributes input from outside the field of theology on the question of the impact of prayers on healing seekers broadens the scope of the researcher’s study on faith healing practice in pastoral context.

#### 4.6. Reflecting on a study done at the Harvard University on healing prayers

In determining the impact of faith healing practice on individuals seeking healing, it is important to reflect upon a Harvard University study that dealt with the question of whether prayers make any difference to the health of a patient. The research question does not seek validity for healing practice; it rather looks at the impact of healing prayers on a recipient. The Harvard study carefully monitored patients in different control groups and ultimately has come to important conclusions in relation to the placebo effect and the impact of healing prayers.

##### 4.6.1. Harvard University study on prayer

The best known prayer-and healing experiment was conducted by Harvard Medical School in the Study of the Therapeutic Effects of Intercessory Prayer (STEP), which was published in 2006 by physicians Herbert Benson *et al* (2006:934-942). The purpose of STEP was to determine the certainty and uncertainty of the possible effectiveness of intercessory prayer in patients undergoing coronary bypass surgery. The STEP experiment was carried out with 1802 patients in various USA hospitals who were undergoing coronary-artery surgery bypass. The patients were placed in three categories, namely:

- Group A - 604 patients who were told that they might or might not be prayed for, and were prayed for.
- Group B - 597 patients who were told that they might or might not be prayed for, and were not prayed for.
- Group C- 601 patients who were told that they would certainly be prayed for and were.

Two prayer groups from Catholics and one from the Protestants were mobilised to intercede for two weeks, beginning on the eve of the day of the bypass. The intercessors were given a prescribed prayer, and following this they were at liberty to intercede freely in their customary way. They had only the first name and the initial of the last name of the subjects they were praying for.

##### 4.6.2. Results

Results indicated that 54% of patients in *group A*, who was told they might or might not be prayed for and who were prayed for, experienced postoperative complications.

In *group B*, who were told the same as group A, but not prayed for, 51% had postoperative complications.

In *group C*, where patients were assured of prayer and also prayed for, 59% had postoperative complications. The research did not apply itself to the question and the probability of correct scientific methodology. If the methodology was flawed in any way, then it may have led to misguided results. Nevertheless, the result outcomes are something to take serious note of.

The results suggested that group C, who were certainly assured of prayers, had the worst clinical outcome when compared to group A and group B. The implications of the Harvard research are discussed and three possible outcomes considered in view of praying for ill persons.

#### 4.6.3. Observations to make from the Harvard study outcomes

Careful analysis suggests that the results do not deny the important role prayer fulfils as a means of healing from illness. It does not contradict Christian understanding of prayer. God is not bound by human request or desire to get well. He responds to his people in the context of his covenant relationship and does whatever he does for their good (Louw 1994:184f). God may answer our prayers with affirmation, or may deny a required desire for His own wisdom and for our ultimate good, or may delay the request.

##### 4.6.3.1. Three possible Implications of the Harvard outcomes

*The first consideration* is in the area of effectiveness or ineffectiveness of prayers:

One may say that *if prayer were effective*, then group A and C would have equal outcomes, and group C may have done better as a result of the placebo response of being assured of prayer. The fact that the outcomes were not as expected seems to suggest that this approach did not bring about the desirable result. On the other hand, *if prayer were ineffective*, there shouldn't have been any effect on any group. In fact, group C should have done better because of the placebo effect for the benefit of receiving prayer, but group C did the worst, which shows that ineffective prayer does not explain the results. *If prayer were harmful*, then both groups A and C should have come off worse than group B, which were not prayed for.

In this case, group B should have done better than others, but group B did the same as group A. In that sense, negative or harmful prayer doesn't explain the results of STEP.

*The second consideration* is on the appropriateness or inappropriateness of prayers made: There is a possibility that in randomised, controlled studies patients who are under treatment and those in control groups could pray for themselves and that their relatives and friends also prayed for them. It is difficult to know exactly in control groups what causes the desired result. "The effects of this extraneous prayer is equally distributed between the intervention and control groups and does not create statistical difference between the two" (Dossey 2008:344). The assumption is well stated by Jain, in his interview posted on the website of Harvard Medical School, as he says: "One caveat [of STEP] is that with so many individuals receiving prayer from friends and family, as well as personal prayer, it may be impossible to distinguish the effects of study prayer from the background prayer" (Jain March, 2006 interview).

*The third consideration* is on the psychological influences on the patients:

The patients in groups A and B who were told that they might be or might not be prayed for may have experienced some psychological dilemma, which may have resulted in the outcomes as recorded. There is a possibility that groups A and B, on the realisation that they might not be prayed for, solicited prayer from friends and families and also even intensified their own praying. If this option is remotely possible, then groups A and B may have paradoxically been prayed for more and not prayed for less than group C. If prayer is effective, then these unforeseen, extraneous prayers may have put A and B in a better position to experience better clinical outcomes than C. The other possibility is that patients in group C, who knew many people were praying for them, may have become anxious or stressed and felt the pressure to do well as a result of the prayers made for them. The anxiety and stress may also have intensified, as a patient may think: "Am I so badly ill that outside people are called upon to form a prayer team that pray for me?" All these factors could lead to increased vulnerability that became negative to the condition of health.

The important contribution of Harvard study is the light it shed on how to engage with people who need prayers for healing. They need to be understood and supported emotionally, morally and spiritually to heal their souls and spirits while they grapple with the decaying

reality of their bodies. Faith is surely important for anything, including trusting God for healing; however faith is not only positive attestation of an outcome, but also trusting when odds are against us. There is clearly a need to establish the connection between emotions and the physical state in order to treat the patient with the best effective possible means available. Such treatment must be inclusive and cover all dimensions: spiritual, physical, social, psychological, affective and cognitive. McWhinney *et al* (2001:238) argue that “we should also have to abandon the belief that the only way to deal with embodied emotions is to ‘re-transduce’ them to mental states. The physical therapies may also be effective in helping the patient to make the breakthrough to a new level of understanding without the requirement of verbalisation.” The results were quite controversial because of the negative conclusions and became a tool by sceptics to completely discredit healing prayers. On the flipside, the negative outcomes become the very point of victory for healing practitioners. Dossey (2008:343) observes that “it has actually contributed to healing research, because some of the most instructive experiments are those that fail.”

People are seeking for life-giving and transforming power that gives wholeness and fulfilment to their brokenness and emptiness. They are looking for power that manifests in justice, freedom and peace, which is contrary to hate, injustice and bondage that they experience in the world (Migliore 1983:16). The interplay of power and powerlessness are real human experiences. We have certain power as human beings that develop through our human developmental stages. We are limited in this power however, and rely upon the power beyond us in many issues, which is really God. No human being can develop from infancy to maturity (adulthood) without a basic trust in a power beyond his/her own.

Faith healers concentrate on the individual in healing practices, which makes illness the focus, and thus they neglect to address the social structures that may contribute to illness. Through this researcher’s personal involvement in Charismatic and Pentecostal ministries in Namibia, an observation has been made that faith healers often perceive illness as personal misfortune and do not entertain any possibility that illness could be an issue of social justice. Dreher (2001) states “certainly, treat the illness with mind-body and complementary and alternative medicine therapies, but don’t neglect the outer rings of the concentric circle that is health: the macro influences of society and environment.”

The challenge for any healing practice is to realise that healing goes much deeper than the physical symptoms people complain about. Mwaura (2004:109-10) indicates that: “Healing is a search not only for physical well being but also wholeness, interpreted as salvation. Healing therefore has spiritual, social, physical, psychological and cosmic connotations.” Healing is a process that should not be forced, as it is not easy for people to uproot the inner conflicts and pain and to share openly about their challenges. Unfortunately, many faith healers want to see instant healings happening during their services and do not create spaces for pastoral care and counselling.

The healing system that will best respond to the needs of people suffering with illness must be multifunctional, embracing all the dimensions of healing, so that healing manifests on social, spiritual, psychological and aesthetic levels. The concern for the emotional wellbeing of people grappling with illness and innovation of multidirectional ways of treatment, encompassing spiritual, medical, social and cultural dimensions have been the main issues of this section. There is a need to engage both counselling professionals and medical professionals in a dialogue to better understand each other’s roles to foster more holistic encounter for the client (Roberts *et al* 2002:423). This will help with the blending of all the important facets, both physical and psychological in the way illness is viewed and treated. Pollin (1995:11) observes that “psychosocial sequelae of long- term illness deserve equal attention with the physical ones, and that such sequelae are normal, not pathological.” The research hopes to establish a pastoral approach of hope and compassion that goes beyond the popular faith healers’ slogan of “have faith to be healed”; to what Sperry (2006:27) indicates as holistic intervention that is based on moral, spiritual, social, psychological and medical supportive mechanisms as patients seek to recover from illness. Treating illness in the African context calls for a holistic approach. Africans see life as a unit and do not compartmentalise it as soul, spirit and body; therefore treatment of the whole person should be emphasised and not only treatment of the symptoms. Treatment methodologies should take cognisance of this and not only try to heal one segment of a person. Healing must address issues of social-religious spheres and not only biological symptoms. All these socio-economic and health factors should inform any healing ministry in Africa. Although, physical healing is heartily embraced by many communities in Africa, there is a need for a more holistic approach that responds to spiritual, social, psychological, economic and cultural needs of people to bring about a radical healing paradigm.

#### 4.7. Conclusion

The second task according to Richard Osmer's methodology that reflects on the question "why is this going on?" was introduced in this chapter, with the aim to constructively engage with disciplines other than practical theology on the research topic. This chapter has reflected upon a psychological understanding of psychosomatic diseases in its application within the faith healing practice. In dealing with illness, the ultimate is to look at the affect of healing practices on the emotions and faith of the recipient. Indications are that there is some relation between mind and body, and such connections need further exploration to show the greater significance spiritual prayers and other religious rites may fulfil on the health of the body.

The focus on "why is this going on" also addresses issues of attitude: There is a need for an attitudinal change required from all role players to embrace each other in pursuit of better health for all. Science tends to regard Christian healing experiences as a result of the placebo effect, and disregard anything that is not acceptable to natural laws as a nuisance. In the quest for an interdisciplinary and multifaceted approach to healing, there must be recognition of dialectic relationship between faith practitioners and the medical practitioners. Harrington (2008:135) observes that "the study of the placebo effect, it is said, brings us back to bigger questions about the healing power of faith more generally: faith in doctors, faith in medical treatments, but especially faith in divinity. Religion, it has been suggested, is a system that, to a believer, can produce a supercharged placebo effect- and now we have the scientific evidence to proof it."

The attitudinal change on the side of faith healers will require openness to new insights from medical science, by reading and contributing to Christian medical journals as a way to promote responsible healing ministry. The important factor to note is that the healing seeking believer is the focus of healing, not the faith healer and his egotism or popularity. If patients are put first, then their feelings must be taken seriously and their human dignity respected. There must be extreme care not to make promises that can not be fulfilled, which would ultimately leave ill persons more bruised and tormented than before. The fact is that God expresses his love both through justice and in caring for the individual. Monsma (2006:93) states that "we follow our Lord's command to let our light shine by telling others about

salvation through Christ and by living out the love of Christ in acts of mercy and helpfulness.”

The next chapter discusses the theological basis for healing practices by reflecting on the scriptural understanding of the causes of illness and approaches to healing, both from the Old and the New Testament.

## Chapter 5 Theological interpretation of healing practice

### 5.1. Introduction

The previous chapter has demonstrated the intricate nature of illnesses, especially in the realm of psychosomatic diseases. There is a parallel between psychosomatic diseases and some African illnesses believed to be caused by witchcraft and by evil spirits (Maboea 2000:66-68). As demonstrated in Chapter two (2.4.2), these illnesses are not treatable by Western medicine (Conco in Msomi 2008:107). The body-spirit interrelatedness has shown that what happens in the psyche of a person affects their physiological condition. Harboursing negative and harmful feelings such as bitterness and unforgiveness were also shown to be detrimental to physical health.

This chapter is central to the entire study, as it connects and applies the biblical and theological interpretation to healing practices. The chapter deals with task three in the practical theological methodology as outlined by Richard Osmer. Task three is the normative task, which explores the question of “What ought to be going on?” by employing theological concepts that interpret specific episodes, situations and contexts. The goal of theological reflection and engagement is to establish ethical norms and values that inform and review praxis of faith healing. The chapter explores theological concepts related to healing from the Old and New Testaments, and from the ministry of Jesus and the Early Church. The following objective directs the flow and the structure of the chapter:

- To engage and explore some key biblical and theological perspectives with the view to establishing the hermeneutical context of healing practice.

The chapter is structured in a way that firstly establish the biblical and scriptural terms related to healing by dealing with the Old and New Testament references. A discussion of the Old and New Testament terms and concepts on illness, such as the causes and reasons for illness are also explored. Secondly, to reflect on how Jesus and the Early Church approached and practiced healing as recorded in the New Testament. Jesus’ approach and views on illness, and how he related to ill and vulnerable people are discussed. The impact of Jesus’ ministry to the Early Church is also explored. Thirdly, theological reflection is given, especially on the place and role of God in illness and suffering.

Thus, the chapter seeks to become aware of relevant scriptures on illness and healing and to apply them to the research topic of faith healing practice in pastoral care. These are important considerations towards the formation of a theological framework for illness and health discourse as it develops throughout the study.

Hence, a discussion on some key aspects around healing terms used in the Old and the New Testament are explored. This section is by no means a comprehensive study, but rather meant only to bring about awareness of some key aspects of healing that are relevant for the study.

## 5.2. The concepts of illness and health in the scriptures

The perspectives on illness and healing in the Old Covenant are discussed by elaborating on healing in the Old Testament and then reflecting on the effects of illness, illness as punishment and healing in the Old Testament. The Old Testament has different perspectives on the phenomenon of illness and health, which relate to the experiences of people who went through trying times of illness and suffering.

### 5.2.1. Healing in the Old Testament

The Old Testament connects healing and spiritual benefits very closely, as seen in Exodus 15:26: *“If you listen carefully to the voice of the Lord your God and do what is right in his eyes, if you pay attention to his commands and keep all his decrees, I will not bring on you any of the diseases I brought on the Egyptians, for I am the Lord, who heals you.”* This passage stresses the benefits that belong to Israelites if they remain loyal to God. The book of Exodus carries the message of obedience, especially in connection with the covenant made at Sinai. The other theme that is prominent in the book is the way God tested his people to ascertain their level of obedience, cf. 15:25, 16:4, 17:2, 7 and 20:20 (Carson *et al* 1994:105). This view is further underscored by scriptures such as Leviticus 26:14-17, which allude to the same fact. The covenant relationship Israel had with God was based on the law that stipulated the privileges and responsibilities Israel, as people chosen and liberated from slavery, needed to show obedience and loyalty in response to God’s gracious acts towards them. They were to live according to his will, as “obedience to God’s will bring blessing, but the failure to fulfil its demands would result in the divine judgement falling upon the transgressors” (Farmer *et*

al 2000:473). God is identified by this verse (Exodus 15:26) as the “healer” or “the one, who heals you,” who has the ultimate sovereignty over health and disease, life and death (Meyers 2005:129). The relationship God has with Israel was the basis for his acts of mercy, including healing from illnesses. As a righteous God he requires obedience, however, as privileges carry responsibilities and consequences if they are not adhered to.

The fact that God identified himself as “God your healing one” or “*Yahweh Ropeeka*” (Gaiser 2010:21) doesn’t suggest that he disapproves of the use of medicine. Even as the Old Testament emphasises the spiritual dimension of healing, it also recognises the use of medication. That is why, for example, the prophet Isaiah instructed King Hezekiah to apply a ‘poultice of figs’ in addition to his prayer in 2 Kings 20:7: “*Then Isaiah said, ‘prepare a poultice of figs.’ They did so and applied it to the boil, and he recovered.*”

There is no obvious reason why God changed his divine will and spared Hezekiah, but it appeared it was because of Hezekiah’s change of behaviour in verse 2. Volkmar Fritz (2003:381) observes about verse 7 that “the actual healing happens by means of a visible object. He indicates that dried figs were generally known for their healing power. In that sense, a healing object with a proven therapeutic effect was used.”

The comprehensive biblical word for health and wholeness in the Old Testament is *shalom*. There are many places in the Old Testament where *shalom* is linked to health (Atkinson *et al* 1995:88), for example in Jeremiah 8:15: “*We hope for peace (shalom), but no good has come for the time of healing, but there was only terror.*” In another example, *shalom* is linked to pain afflicted on the suffering servant of Isaiah 53:5: “*Upon him was the chastisement that made us whole (shalom).*” *Shalom* is used in Leviticus 26:3-6 to reveal God’s character as the “Saviour and Healer of Israel” who gives *shalom*; peace (Magezi & Keya 2013:6). *Shalom* means more than health; it also encompasses aspects such as security, prosperity, and a long and happy life (Thomas 1994:44). This all-inclusive nature of the word means that *shalom* and salvation share the same meaning (Isaiah 52:7), and this link between health and salvation become more obvious with the later prophets (Isaiah 53:5 and Jeremiah 8:22). Biblical scholar, John Oswalt (1998:368, 388) related the centrality of *shalom* in both Isaiah 52:7 and 53:5, by stating that the good news of God’s salvation reaches climax in peace, good and salvation - where God reigns. When things are out of order, there is no *shalom*, but when authority is restored and disobedience punished, then *shalom* is entrenched. This statement

shows the centrality of *shalom* in any turbulent situation. Struys (1968:423) teaches that God's involvement, whether in his punishing wrath or in his correcting love, remains aimed at change, rising up to conversion, retention, liberation and the reparation of *shalom* by recalling the covenant. In confirming the last mentioned statement, Louw (1994:29) indicates that recovery from illness must always be understood in the context of this *shalom* principle.

### 5.2.2. Effects of illness

Illness has both a debilitating and a liberating effect on people of all times. The Old Testament reflects these emotions and realities, especially demonstrating how pain and disorientation are some of the emotional turbulences people experience in illness. The cry of horror and desperation of Job demonstrated the intensity of illness: "*The churning inside me never stops; days of suffering confront me*" (Job 30:27). In Psalm 38:6-9, the turmoil of illness is described as follows: "*I am bowed down and brought very low; all day long I go about mourning; my back is filled with searing pain; there is no health in my body. I am feeble and utterly crushed; I groan in anguish of heart. All my longings lay open before you, O Lord; my sighing is not hidden from you.*" Balentine (2006:460) comments that illness has shattered the moral and religious coherence of Job's world like his convulsing, yet Job remained hopeful in the midst of severe adversity. He argues that Job turned to God in his pain by realising only God can help. If not to God, to whom can he turn?

In another instance the psalmist described the horror, fear and anxiety brought about by illness in the lament of Hezekiah in Isaiah 38:14: "*I cried like a swift or thrush, I moaned like a mourning dove. My eyes grew weak as I looked to the heavens. I am troubled; O lord, come to my aid.*" Wildberger (2002:460) remarks that the emphatic groan of a sick person could be compared to that of a frightened bird; such is Hezekiah's condition that he can hardly even put his suffering into words. His eyes pined away towards the heights and he cried out for help. The psalmist expressed anguish in prayer that burst out with a desperate cry for help in the midst of severe pain, yet still was not certain whether one can turn in confidence to God for help. As the strength wanes, a person slowly becomes weak and defenceless. Illness robs a person of strength and health, which leads to disintegration (Louw 2005:109-11). Thus, the effects of illness are devastating, as it touches on the physical, spiritual and psychological dimensions of an affected person. One important aspect to consider is the reason or cause for illness in the Old Testament.

### 5.2.3. Illness as punishment

The Jewish people understood that everything that happened to a human being was caused by God, so it was believed that God was responsible for both health and sickness (Musgrave & Bickle 2003:4,5). This is because of the way the Old Testament portrays God, for example in Deuteronomy 32:39: *“See now that I myself am He! There is no god besides me. I put to death and I bring to life, I have wounded and I will heal, and no-one can deliver out of my hand.”* Musgrave and Bickle (2003:4,5) attest that the context of this statement is to first show that the Jewish people in exile were experiencing depression in Babylon. It seemed that the foreign gods were very powerful and more appealing than *Yahweh*. In the midst of these realities, the Lord showed that he is the only powerful one. The Old Testament people associated illness with the judgement and wrath of God, as indicated in Psalm 38:3: *“Because of your wrath there is no health in my body; my bones have no soundness because of my sin.”* Eaton (2003:168) remarks that the psalmist acknowledged that affliction is in a sense intended by the Lord as a corrective response to some wrongdoing. Nevertheless, the psalmist lamented and appealed to God for pity on him. His afflictions were seen in his outward wounds and his inward yearning.

Another example that supports the sin-punishment notion is in the account of King Asa, in 2 Chronicles 16:10, 12: *“Asa was angry with the seer because of this, and he was so enraged that he put him in prison. At the same time Asa brutally oppressed some of the people. In the thirty-ninth year of his reign Asa was afflicted with a disease in his feet. Though his disease was severe, even in his illness he did not seek help from the Lord.”* Asa became ill because of his shameful behaviour towards the seer Hanani. There are other biblical references that indicate that some illnesses were punishment for sin, for example 2 Chron. 26:16-23, 2 Kings 15:4-5, Acts 12:23. Barton and Muddiman (2000:292) comment that the fact Asa contracted sickness as punishment is in direct contrast to the name of God, who is *“YHWH heals”*. Gaiser (2010:21) confirms that name *“YHWH heals”* reflects on God’s caring and compassionate nature. There is also an alternative theory that suggests that Asa died of some illness such as gout, dropsy, gangrene or venereal disease (Barton & Muddiman 2000:292). Any of these two possibilities are warranted, however, the researcher tends to agree with the view that God sent illness as punishment in Asa’s case, as a result of his ungodly behaviour

and conduct. This is not suggesting that every illness has its origin in God's punishment, but rather that God has control over his creation, and acts in line with his decrees and ordinances.

Musgrave and Bickle (2003:4) indicate that there are numerous references to illness, disease, pestilence, plague, and even death that result directly from our failure to adhere to the commandments of the Lord. This is the cause and effect approach, which involves the belief that obedience would lead to health and prosperity, and disobedience to illnesses, poverty and even death. In secular terms, this view could be described as "behaviour induced;" that is, as sickness that arises as a direct result of one's actions or failure to act (Musgrave & Bickle 2003:5). In other words, a person may develop cancer because of their smoking, or obesity that causes blocked arteries, or someone may contract HIV as a result of reckless living. Sin may also impact sickness when a patient is ill not because he or she has sinned, but because that person has been sinned against. The person in the intensive care unit who was hit by the drunk driver, the victim of sexual or other forms of assault, and the person who, through negligence, was exposed to dangerous chemicals, all have diseases that are the result of someone else's sin (Rae 2006:153). Thus, blaming a person that suffers for his/ her condition must be avoided, as the cause may not be as obvious as assumed. Rae (2006:152) claims that:

An adequate regard for the cross can protect us against any temptation of stipulating more specific cause and effect relationships between any particular person's sin and his sickness. In general, God does not punish sin with sickness, because the cross has dealt with the penalty of sin once and for all. To take that further, the cross has rendered death a conquered enemy (I Cor. 15). As a result, death need not always be resisted, nor every disease be fought with aggressive treatment. Saying "enough" to aggressive treatment at the end of life is consistent with an evangelical view of the world, lest we fall into the idolatry of considering earthly life the highest good. Of course, there are occasions in which the causal connection between sin and sickness is clear. Consider the smoker who contracts lung cancer, the person who is infected with HIV due to unprotected sex, the alcoholic with liver damage.

The fact is that not all illnesses are caused by sin or as punishment by God. Even in the examples cited here, the cause is not necessarily punishment from God, but rather a careless lifestyle. Illness is a mystery, as seen in Job's case and does not always have a rational explanation (Musgrave & Bickle 2003:6). For example, see the curses in Deuteronomy 28:15-68. The reference to statutes and ordinances is common to both the Priestly and

Deutoromic legal codes (Gaiser 2010:23-24). The condition that keeping *Yahweh's* statutes and ordinances produces life, while disregarding them leads to death, is prevalent especially in the so-called Leviticus Holiness Code (Lev. 17-26; Deuteronomy and Ezekiel). Gaiser (2003:24) believes that health also falls under this act-consequence relationship. He argues that the point was not to promote rigorous legalism (“do good and I will love you”) but observable truth: keeping God’s laws and doing what God calls good is generally productive of life, and *vice versa*.

Thomas (2002:31) states that while sin may well sometimes be the reason for sickness, sin is not always the reason for it. Therefore, by implication, one cannot assume that sickness is the direct result of sin. It is important however, to take personal responsibility for one’s own health as reckless living is catastrophic and destructive to physical, spiritual and social wellbeing.

God’s involvement in reward for obedience with health, and punishing sin with sickness must be understood against the monotheistic background of Israel. Israel upheld monotheism over and against their surrounding pagan neighbours, who believed that the world was controlled by all kinds of gods. The Jewish monotheism ascribed all things, whether good or ill, to *Yahweh*. For example, compare the following scriptures; Isaiah 45:7 and Amos 3:6. Oswalt (1998:204) claims that the prophet Isaiah chose the areas of history and nature in this text to support his claim that there is none like *Yahweh*. He does this by using a figure of antinomy or polar opposites. In each of the parallel pairs he begins with a verb that expresses specific, concrete action by God (form, make) and closes with one that is even more theologically expressive, the same one in both cases (create). What Isaiah asserted is that God, as creator, is ultimately responsible for everything in nature, from light to dark, and for everything in nature, from light to dark, and for everything in history, from good to misfortune. No other beings or forces are responsible for anything. Boice (1983:150) demonstrates more or less the same idea that God will send disaster to his people, if they don’t heed to his warnings. The later rabbinic tradition expressed “*there is no death without sin and no suffering without iniquity* (b. Shabbath 55a).” The doctrine of monotheism was comforting in the context where evil forces were also deemed powerful enough to cause misfortune and illness. Carson *et al* (1994:510) argue that “there were all sorts of divinities and demons that might be the source of human wellbeing or human ill. Such powers were to be feared and appeased. But if *Yahweh* alone is God, then demons and other divinities are excluded ... Whom would you

rather have in charge of the dark side of existence, Yahweh or the demons? And the Old Testament choice is clear.” As stated previously, however, not all illnesses are because of punishment by God.

The New Testament focus will mainly deal with the key terms of healing, as more healing concepts are explored in the approach and practice of Jesus and the Early church that are discussed later.

#### 5.2.4. The use of healing terms and their significance in the New Testament

In this section, the explanations of various healing terms in the New Testament are explored. One of the words the New Testament uses for illness is weakness (*astheneia*), which points to general condition of frailty all human beings are subjected to. The concept of weakness is noted by Brown (1971:994f), who says that in the New Testament *astheneia* is associated with illness as physical weakness, feebleness and general helplessness (Luke 13:11, Matt. 10:8, John 4:46, Acts 9:37). The New Testament also places special emphasis on the influence of demonic powers in illness. There are a few examples, such as the woman who was bound by a demon for eighteen years (Luke 13:11-13). Here, Jesus healed the woman from her bondage, without any indication of her faith. Jesus absolved the woman of her sins and over and against any taboo and fear for uncleanness laid his hands upon her. John Kealy (1979:313) remarks that this section plays on the words “freeing” and “binding.” Jesus is the stronger one who binds the strong man Satan. Louw (1994:52) concludes that by virtue of the New Testament, we must say that there is not only a connection between illness and the general sinfulness of humankind, but also between illness and personal sin. This association, however, has its limitations and may not be applied as an absolute and explanatory principle.

Sanford (1992:34) indicates that in biblical Greek language there are various words for healing, and they are all used in one way or another in the New Testament. The word “*therapeuo*” is found in various texts, such as Matthew 4:23, 24; 8:16 and in Luke 7:21; 8:2; 9:1 and 10:9. In Greek epistemology, this word was used for more than only to heal; it was used for serving the gods and cultivating the garden. The English words therapy and therapist are derived from the Greek language. Caring or nurturing for the soul is also implied by “*therapeuo*”. Sanford (1992:34f) also highlights the Greek word “*iaomai*”, which is also used in the New Testament for healing. This word was used in the case of the woman

suffering of haemorrhage in Mark 5:26, especially when referring to her unsuccessful efforts to be healed from this condition. Sanford (1992:36) further observes that the Greek word “*hygiaino*” was used in some places, and that it means to be in sound health. Interestingly, despite so many options, in dealing with the woman cured from haemorrhage, Jesus used the word, which is not strictly a medical word, “*sozo*”. This word is usually translated into English as “being made well”, and it carries the idea to save, rescue, preserve from being lost, deliver or set free. Sanford (1992:37-38) notices that Jesus always used a lesser word for curing whenever a person healed was not directly seeking healing, like in the case of the centurion’s servant, recorded in Matthew 8:5-13. On the centurion’s request his servant was cured, and Mathew used the word “*iaomai*” in verse 13; however, where a person actively pursues healing, the word “*sozo*” is used (cf. Ervin 2002:14). The use of the word “*sozo*” in the Gospels shows that the faith that saves (*sozo*) is the faith that heals (*sozo*), and the faith that heals “*sozo*” is the faith that saves “*sozo*” (Ervin 2002:23).

Healing is broadly defined as a satisfactorily response to a crisis, done by a group of people individually or corporately. The satisfactorily response has to do with being restored to purposeful living in the society by means of health (Wilson 1975:117ff). The New Testament also links the concepts of *shalom* and health, as in Luke 10:5-9 and Hebrews 12:13-14. Atkinson *et al* (1995:89) indicate that in the Synoptic Gospels, the exorcisms and healings of Jesus demonstrate that he is the Messiah, the Prince of Peace, anointed to preach good news to the poor, to proclaim release to the captives, recovering of sight to the blind, and to set at liberty those who are oppressed (Luke 4:18). Indeed, the New Testament word translated as salvation (*sozo*) can also mean health. Jesus has brought peace to the world in his earthly ministry (John 14:27). In fact, his name has the Greek root, “*soter*”, which means both saviour and healer.

The *shalom* (peace) Jesus spoke about in John 14 is very different from worldly peace. Thomas (1994:45) reflects that “Jesus’ peace is not an exemption from turmoil, danger, and duress (all of which he is facing as he speaks). ... As Jesus was about to demonstrate, his peace is not the absence of conditions that intimidate but rather is the composure to be faithful in the midst of adversity.” To augment the aforementioned view of peace in pursuit of a wholesome living for suffering people, Köstenberger (2005:444) argues for “cooperation with the Creator for reorganizing unbalanced aspects of life in order to live more deeply integrate personally and communally”.

The challenge for any healing practice is to go beyond mere physical restoration efforts to a holistic scope that opens up the possibilities for deeper relational engagement and better appreciation of human dignity. The healing miracles are not merely for the physical advantage of the sick person; they inaugurate a process that leads to total salvation (De Villiers 1987:17). In that sense, healing carries a strong spiritual dimension, and the act of gratitude for those to whom the Lord has shown his grace and benevolence was to worship him as Lord and Saviour. Louw (1994:33-34) proposes that the purpose of illness is not the discovery of all our sins, but rather a total renewal, so that in faith we can subject ourselves entirely to the mercy of God. Illness is, in fact, a phenomenon, a sign of God's judgement and punishment of sin. Christ relativises this punishment by dying in our place. As a result of the work of the mediator, illness becomes an indication of our own finiteness and is placed within the tension of eschatology; already, but not yet. These are important observations, as they suggest that the healing activity has a strong spiritual reality and deep and profound significance. It is not mere seeking of physical wholeness from illness, but also for the complete transformation of human character and being for productive living.

Another important aspect that the New Testament reveals in relation to illness is the connection between human weakness (illness) and the weakness (*astheneia*) of Christ (Louw 1994:340). Christ is actively involved with the sick, and he was crucified in weakness (1 Cor. 1:25-27). The significance of the resurrection of Jesus Christ, is the fact that God raises all the redeemed from the death of sin to the life of the new age with Christ (Eph. 2:1-7). The source for new life, as stated in verse 4, is of God, a "*God, who is rich in mercy*", and who is shown as the agent of new life and exaltation. The descriptions, "*rich*" (*plousias*) in verse 4, and "*riches of his grace*" (*ploutos tes xaristos*) form a vital link with what was described in previous verses, namely "*riches of his grace*" (1:7) and "*riches of his glorious inheritance*" (1:18). Thus, the opening section stresses the graciousness of God's life-giving power (Keck *et al* 2000:389). The hope of the gospel to a person suffering from illness is the fact that Christ becomes a source of inspiration, as he himself overcame weakness caused by illness through overcoming death on the cross. Louw (1994:34) states that "the crucifixion of Christ revealed God's creative life-giving power which identifies with the weakness of the sick. That was why Jesus took our infirmity (*astheneias*) on him and bore our illnesses (*nous*) according to Matthew 8:17. Under the healing power of Jesus, the sting of sickness and

anxiety is eliminated and, through the work of the High Priest, our illness reaches the heart of suffering God.” Reflecting on New Testament terminology of healing also encapsulates the idea of *shalom* as the end goal of healing. This is demonstrated by Jesus’ coming to earth to bring wholeness to broken humanity through his work of redemption and restoration.

### 5.3. Jesus’ mission and his approach to healing

The early ministry of Jesus Christ was driven by love and compassion and these virtues led to him never being indifferent to human pain and suffering. There are great lessons to learn from the way Jesus Christ fulfilled his calling as recorded in Luke 4:18-19: “*The Spirit of the Lord is on me, because he was anointed me to preach good news to the poor. He has sent me to proclaim freedom for the prisoners and recovery of sight for the blind, to release the oppressed, to proclaim the year of the Lord’s favour.*”

The third task of the practical theological methodology that deals with “what ought to be going on?” can best be approached by discussing the mission and the healing ways of Jesus. Thus, Jesus’ understanding of his mission, with special reference to his healing practice is discussed. This is done by:

- Firstly, elaborating on the gospels’ account of Jesus’ approach to illness and health
- Secondly, discussing the purposes of Jesus’ healing ministry.

Jesus’ healings, among other things, were meant to value human life and to demonstrate his kindness and goodness as confirmed by the apostle Peter in Acts 10:36-38. In his defence of Jesus’ ministry, Peter refuted the idea that Jesus’ ministry was exclusively for Jewish people by showing the geographical wideness of Jesus’ ministry in this text. Long *et al* (2002:166) illustrate the extent of Jesus’ prophetic ministry, as well as the manner of his public ministry in the following statement: “As demonstrated by acts of preaching, healing and good deeds, Jesus’ public ministry started in Galilee after the baptism of John. At this baptism, God anointed Jesus of Nazareth with the Holy Spirit and power (cf. Lk. 3:1-22).” The main components of Jesus’ ministry are also confirmed by Malina and Rohrbaugh (2003:39) as “teaching, proclaiming the kingdom, and healing.”

The anointing with the “Holy Spirit and power” was of significance to Jesus for various reasons: It confirmed his approval as Messiah and his empowerment to accomplish the task God had set out for him, cf. 4:1, 14, 18 (Arnold 2001:357). It also affirmed his messianic status and role that were ultimately seen in his death, resurrection and heavenly exaltation, which confirmed his divine kingship (Peterson 2009:337). Although Jesus was conscious of his authority and position as Son of God, he never abused it, but rather engaged with people in a tender and compassionate way (Mathew 12:18-21). France (1987:306) puts it emphatically that “it was in what Jesus did not do that the distinctiveness of his mission was most clearly seen, in contrast with the aggressive Messiah of popular expectation. The unassertive character of Jesus’ ministry accords with the description of himself in verse 11:29 as ‘*gentle and lowly*’.”

In fact, the basis for Jesus’ good deeds was the Hebrew idea of “*hesed*”, which means steadfast love, faithfulness, kindness and goodness. The deeds of “*hesed*” were not showy or dramatic; they were unnoticed and even expected, but never insignificant (Thomas 1994:13). Jesus brought salvation to people by preaching, healing and casting out of evil spirits from the oppressed (Mathew 4:23-25). His public ministry ushered in the dispensation of God’s kingdom and introduced the end of the prophetic, linear time (Ervin 2002:1). Jesus started his public ministry in Galilee with this: “The time has come,” he said. “The kingdom of God is near; repent, and believe the good news” (Mark 1:14- 15). Arnold (2001:212) indicates that the work of John the Baptist, the forerunner to Jesus, has been completed when he was put into prison. Jesus’ work then began as he returned victoriously from the battle with Satan. He announces God’s timely utterances into the present. The time of waiting is over, and the decisive moment has arrived when God’s rule will be established. Jesus’ message introduces the coming of the messianic kingdom, where people are called to discipleship in the kingdom through redemption. This philosophy became his *modus operandi* in everything he said and did during his earthly ministry.

Jesus did not divide the message of the kingdom and healing, as healing was seen as the sign that the kingdom has come (Arnold 2001:32). The message and the sign were complementing each other. The fact that the sign confirms the message and the message authenticates the sign, gives validity to Jesus’ miracles. The centrality of the message of God’s kingdom in Jesus’ ministry demonstrated that he was not about building his own kingdom, but rather his

purpose was to honour his father and his father's cause on the earth. Keller (1969:227) states that: "Jesus demonstrated in His ministry an unreserved submission to the divine order which issued forth in His healing power." This is quite an important statement with implications for the healing ministry in Africa, as anything less than building God's kingdom falls short. Ervin (2002:4) makes this groundbreaking statement "what must be understood here is that the miracles of Jesus did not occur outside the preaching and teaching of the gospel of the kingdom, Jesus was not a miracle monger. He refused to perform miracles to gratify the curious."

This is one aspect which is seldom compromised in the faith healing practices today. In comparing Jesus modus operandi to faith healers, Edward Gross (1990:65), in comparing of Jesus' miracles to modern miracles, claims that "miracles directly from God never support error ... Jesus often healed with word or by touch. It is evident that he did not use theatrics or parade his gift before an audience. Instead, he often told people not to advertise their healings. He performed his miracles everywhere, not in some special setting." Therefore, Jesus' healing ministry was God-glorifying and motivated by the desire to please his Father, who sent him to fulfil his will on the earth (John 4:34). On dealing with the question of ailment and diseases, Jesus had a different understanding to the popularly held assumptions, which sees sin as the cause of illness. It is therefore significant to understand how Jesus understands and approaches illness.

### 5.3.1. The account of the gospels on Jesus' approach to illness and health

The story of the man born blind in John 9:1-7 contributes some insight into Jesus' revolutionary understanding of sickness that stands in contrast to the popularly held view of the Jewish religion, which equates sickness to sinfulness. Jesus rejects the popular view that a person who suffers sickness or misfortune must have sinned. Only twice did Jesus refer the sick to their sins. The first incident involves the paralytic whom Jesus forgave before healing (Mark 2:5, Luke 5:20). There seems to be some connection between disease and forgiveness of sin, as suggested by Psalm 103:3, where it reads "*the Lord forgives all your sins and heals all your diseases.*"

The Jewish people believed that all diseases were as a result of personal sin. In this regard, Pilch (2000:132) states "stereotypical thinking of the time explains how Israelites concluded that given the justice of God, suffering could only be the result of some sin, whether

conscious or unconscious”. The prevailing theological position during Jesus’ time is reflected by the question his disciples posed: *‘Rabbi, who sinned, this man or his parents, that he is born blind?’* The question did not only reveal the Jewish belief in the relation of sickness to sin, but also evoked other theological problems, especially how a newborn baby could sin. There are two alternative answers to the question: Either they were alluding that a child could sin in his/ her mother’s womb, even before birth, or that the parents’ sins were inherited by the child. In the Old Testament, the prophet Jeremiah hinted to the latter view in Jeremiah 31:29: *“In those days people will no longer say, The Fathers have eaten sour grapes, and the children’s teeth are set on edge”*, but balanced this with the qualifying statement in the following verse: *“Instead, everyone will die for his own sin; whoever eats sour grapes- his own teeth will be set on edge.”* Feinberg (1992:217) indicates the bitterness of the exiles who blamed their current predicament on the sins of their parents and ancestors. They felt God was judging them unfairly for circumstances they were not responsible for. This is also confirmed by the lament of the people who went into self-pity and fatalistic despair that they were being punished unjustly for the sins of the previous generation: Lam. 5:7 *“Our fathers sinned and are no more, and we bear their punishment”* (Huey 1993:279).

In contrast, Jesus refuted such perspectives in John 9:2-3. Arnold (2001:371) argues that: “It is not clear in the present case, however, whether Jesus is suggesting that this paralysis is a result of specific sins, or whether his words merely stress the priority of the man’s spiritual needs over the physical needs. The latter is more likely.” Jesus did not make cause-and-effect statements between the sin of the man and his healing. He clearly rejected such a direct correlation, however, he warned him not to sin, unless something worst would happen to him; Jesus was addressing the eschatological correlation between sin and judgement. A Johannine scholar, Andreas Köstenberger (2005:281), comments that “Jewish Rabbis generally believed in a direct cause-and-effect relationship between suffering and sin” (cf. the book of Job, e.g. 4:7; b. Šabb. 55a). Jesus, however, while acknowledging the possibility that suffering may be the direct result of sin (cf. John 5:14), denied that such was invariably the case (cf. Luke 13:2-3a; see also Ridderbos 1997:333).

In another incident (John 5:1-14), that has similar application to the consequence of sin, Harris (1994:177) comments that “to those held in the bondage of death and sin the Son offers life, and the only danger is that an individual will ignore that offer. To do so would be

not to trust in the Son. And something worse, condemnation at the Last Judgement (John 5:29) would surely befall such person.” Furthermore, the nature of the 'worse fate' is not clarified. Given the extent of the man's suffering for the previous thirty-eight years, it is probable that Jesus had the eternal consequences of a sinful life in mind. Thus, he advised him to aim for a life that sought after God; otherwise, the trauma and frustration of thirty-eight years as an invalid would be less than the worse fate that would befall him in the next life. Jesus provided him with a fresh start. To fail to take advantage of this would inevitably lead to dire results (Warrington 2007:189). Therefore, it is clear that illness and suffering must be viewed from the context of eternity, over which God has supreme authority. Warrington (2007:189) brought another dimension and emphasis to John 5:1-14 by stating that:

Here, Jesus heals a man who had been disabled for thirty-eight years, warning him not to sin any more or a worse fate would befall him. It is possible that this is a reference to the possibility that the disability had been given by God as a punishment for a particular sin and that if he returned to this sinful practice, he would receive a more grievous punishment than thirty eight-years of paralysis. It is unlikely, however, that Jesus is here identifying a relationship between a specific sin and its consequent sickness.

Jesus was quite aware of the relation between sin and sickness and of humanity's need for encouragement towards wholeness. In spite of this, he never made sin the sole cause of sickness, as illustrated in the story of the child born blind and those killed by the tower of Siloam in Luke 13:4-5. Bruce Milne (1993:99) indicates that “*stop sinning or something worse may happen to you*” in John 5:24 refers to the judgment this man will face at the end of times. He has personally received the healing grace, and if he doesn't change his ways, then he will account to Jesus at the judgment day. Carroll (1995:130f) states that “both in Luke (13:1-5) and in John (9:1-3), Jesus explicitly rejects the assumption that misfortune results from sin.” Sickness in individual cases is not linked to sin, although it may be a cause of it (Thomas 1998:31-32). The important point to note here is the fact that Jesus suggested that a person may be healed and still be judged if he/ she doesn't stand in the right standing with God. Clearly, sickness and sin can be closely related, as can healing and the experience of forgiveness, for a person's health involves physical, psychological, spiritual, and relational dimensions. The Gospel stories of healing, however, rule out any approach that explains all sickness as the product of sin. Therefore, it is important not to link every suffering and illness

to sin. As stated before, poverty and poor living conditions have subjected majority of African people to all kinds of illnesses and diseases.

Matthew noted Jesus' healing ministry in 8:16-17 as "*when evening came, many who were demon- possessed were brought to him, and he drove out the spirits with a word and healed all the sick. This was to fulfil what was spoken through the prophet Isaiah: 'He took our infirmities and carried our diseases.'*"

Exorcism and healing are two complementary terms of deliverance used in the gospels (Hacking 2006:181). Jesus' approach was quite different from the then prevailing approaches used by exorcists, that included various techniques and elaborate incantations; he simply used a word of command (Carroll 1995:30f). This was also the same wording Jesus used to the centurion in verse 8, thus signifying his unquestionable authority (Peterson 2009:321). The healing force (*dunameis*) Jesus used was not subject to human faith, as could be seen in the story of the woman with the issue of the blood (Mark 2:24-26). Hedrick (2007:300) comments that Jesus did not apparently notice nor see her, until he felt power going out from him. By implication, this seems to suggest that the healer is only a vessel being used by God and therefore does not rely upon his/ her own abilities.

A further observation from Mark's Gospel is that Jesus' healing power seemed to be limited, as in his attempt to heal a blind person, who was not instantly healed but only recovered full sight at Jesus' second attempt in Mark 8:22-26. Edwards (2002:174-175) comments that the limitations of Jesus' healing power became more apparent as Mark recorded the fact that he could not perform mighty deeds in his home town because of the unbelief of people (Mark 6:1-6). Gundry (1993:293) also attests to few miracles of Jesus in his home town, although he does not see it as invalidating his authority. The unwillingness of people to believe that culminates in Jesus not performing any miracle in his hometown is not so much the failure of God to act, but rather the unwillingness of the human heart to accept the God who condescends to us in only a carpenter, the son of Mary. The seeming inability of Jesus to perform miracles in his home town, and cases where his power seemed to be limited as previously illustrated, suggest the complex nature of illness that needs a broader understanding and application of healing function. There are inhibiting human limitations that call for humble dependence upon God and recognition of one's own strengths and

weaknesses when dealing with people's plight. The Gospels seem to suggest that the faith that matters is the one that is simply open and responsive to acts of God (Mann 1986:142).

Jesus' miracles and healings were not merely acts of good deeds; there were deeper significance to them. It is therefore necessary to explore why Jesus was performing miracles and healings.

### 5.3.2. The purpose of Jesus' healing ministry

The Gospel healings should not only be viewed in their historicity, or what actually happened. There is a need for creative space to explore the inner meaning of the stories. In other words, the approach should go beyond 'what is written' to 'what is written about' (Woodward 1995:93). The New Testament healings were validating Jesus' role in God's kingdom, and were deemed to introduce God's kingdom and his reign of wholeness and spiritual progression, such as demonstrated by Luke 4:18-19. Bock (1994: 394, 404) explains that the passage portrays God's plan and Jesus' role in it. It outlines in scriptural terms Jesus' mission and proclaims its fulfilment (4:21).

Healings were a way that Jesus demonstrated God's love and sympathy to the suffering people. He was never indifferent to suffering, but was always moved by compassionate love (Matthew 20:34). Ultimately, healings validated the status of Jesus as the Messiah, as pointed out in the following statement (Kim 2008:422): "Although Jesus' divine sonship is the primary focus of His miracle in John 5 and its attendant discourse, there are also significant messianic implications. For instance the miracle of Jesus healing the lame man provides yet another aspect of the Messiah's work in His coming kingdom, namely the healing of the blind, the dumb, the mute, and the lame in Isaiah. 35:5-6, 61:1." This point is further substantiated by the fact that (Angelica 1999) "Jesus wanted his miracles to be signs of His sonship and the coming of the Spirit. They were destined to give and increase faith, not to provide a utopia upon the earth. His followers were to see signs and to believe and not see signs for their selfish purposes." The important question is how to represent God as agents of healing in this world. Jesus could in many instances heal without any demand on the sufferer's faith, thereby displaying that healing was an act of grace and not essentially of one's faith. In fact, Jesus saw healing as a shared enterprise where he provided an opportunity for faith and divine power to coalesce in creating a new order (Woodward 1995:94).

It is important to note that physical pain and suffering may not be completely resolved in this world; therefore coping with persisting illness would to a great degree be determined by one's mental attitude and the way inner strength carries the outer challenges. Heil (1992:13) argues that the miraculous healings and exorcism ministry of Jesus represent the definite breaking in of the kingdom of God in triumph over the kingdom of Satan. Whereas in various healing miracles Jesus expels the demonic powers causing disease, in his exorcisms he cast out demons who had gained total control over people. Jesus performed healings to manifest God's power over evil, as illustrated in the discourse of Luke 11:18-20. In commenting about the accusers who claimed that Jesus performed miracles by power of Beelzouboul, Kealy (1979:287) emphatically states that "if God and his power are at work in Jesus, then they must draw the obvious conclusion that God's rule or the kingdom of God's spirit (4:18, Acts 1:2,5ff) is here in the power which conquers the kingdom, which makes men victims." Lartey *et al* (1994:145-146) remark that as the world was under the dominion of evil, and the human beings incapable of defeating this, so by God's creative and redemptive power he was attacking evil, as it affects the moral, mental and physical dimensions of the people.

Mark doesn't try to show the sonship of Christ through his healing recordings; rather, he wanted to express Jesus' rule over the cosmic forces and demonic world. Carroll (1995:130) indicates that "healing miracles figure prominently in Mark's Gospel. They encompass four exorcisms, eight healings, and one apparent raising from the dead; in addition, one finds three summaries of healing. Important as these healing miracles are, they are nevertheless subordinate to the Markan Jesus' primary mission, which is to teach and proclaim God's sovereign rule." The healings in the Gospels were not the means in themselves, but were confirming the preaching of Jesus Christ.

The purpose of Jesus' miracles was demonstrating signs to authenticate his divinity and to announce the coming of God's kingdom in Christ. They were not just done for the sake of the spectacular or to put focus upon him. Many times, he did not even want them to be revealed. Jesus' healings were pointing to the confrontation of his purposes to bring hope and life against the devil's evil intentions and control of the world.

Jesus releases the healing power to heal in totality and to usher in spaciousness of health for mankind. Jesus said in John 10:10 that he has come to give life, and this life in abundance.

Jesus came for his sheep to have life, and to have it abundantly. “Have life” suggests to “have eternal life,” to be saved (10:9). Köstenberger (2005:305) explains that the inference was not only for life hereafter, as many Jews believed, but that Jesus gives life that starts already in the here and now. This is not implying a life without persecution (cf. 15:18-25). The imagery used by John is similar to the Old Testament usage, especially of the prophet Ezekiel, as he envisions pastures and abundant life for God’s people (cf. Ezek. 34:12-15, 25-31). Jesus is portrayed as a good shepherd, who gives his sheep not merely enough, but more than plenty - cf. Ps. 23; Ezek. 34 (Köstenberger 2005:304). The use of Old Testament imagery by the Gospel writers for Jesus, as stated previously, is also highlighted by the significance of Jesus’ Jewish name “Joshua”, which emphasises the idea of deliverance from bondage and deliverance to liberty. Jesus’ name in its root form in Hebrew is Yeshua or Joshua, which means “*Yahweh saves*” (Arnold 2001:331). The meaning to save or to heal suggests the unleashing of power that brings life for humankind and society. This power of Jesus creates new possibilities, in which all members are delivered to perform their full and purposeful function. This explosive force is present in the act of creation and in nature, and uses even suffering for eventual good and deals with setbacks in transformative nature (Maddocks 1981:9).

The New Testament has a high view of spiritual health, which reflected that illness of the soul surpasses the illness of the body. For example, Jesus alluded to this in Mark 10:28 when he states “*not to fear the one who can kill only the body, but the one that has the power to destroy both the body and the soul.*” The immortal nature of the soul is also affirmed by Sanford (1992:120), as “the soul carries our fundamental Self, that mysterious, enduring part of us that is able to survive death and achieve union with God.” Sin affects the health of a soul, however, freedom from sin is a gift from God that should be received with gratitude, sincerity and courage to bear whatever suffering is allotted to in life. Therefore, Jesus’ healings were more than mere physical wellness, it was about restoring a suffering person to experience the *shalom* of God, the liberation of soul, body and spirit.

The objective of this chapter is to engage task three of the practical theological methodology that deals with the normative interpretative task by emphasising three aspects: The biblical interpretation of illness and healing, the approach and practice of Jesus and the Early Church to illness and healing and finally, the theological interpretation of illness and healing. The

New Testament Church has carried out their mission mandate, including the healing practice, on the teachings of Jesus Christ and the commission he gave to his disciples in the gospels and the book of Acts. Hence, the reflection on the healing practices of the Early Church in the New Testament follows.

#### 5.4. Reflecting on the healing practice from the Early Church's ministry

The reason for the Church's existence is to bring healing in a broader sense to the broken world. Being Church is being light and being salt in the world (Colson 1992:343-373). The Church is mandated<sup>26</sup> to be the agents of spiritual and social transformation, inaugurating the reign of Christ over His creation. The promise (Acts 1:8) "*You will receive power when the Holy Spirit has come upon you*", suggests a parallel between the conception of Jesus in Luke 1:35 and the birth of the Church in Acts. This demonstrates the continuation of the life of Jesus, within which the Spirit was at work, and the life of the Church, in which the same Spirit is at work (Farmer *et al* 1998:1510). The implication for the disciples of the presence of the Spirit was the manifestation of the power<sup>27</sup> of God in their midst. Faith healing practitioners view their ministry as the continuation of the mandate given to the Church by Christ (McGee 1997:278; Anderson 2002:524).

In order to reflect upon the modern healing practice, especially on the impact of faith healing practice on healing seekers who are "unhealed", we need to have some grasp of what the nature and the scope of the healing ministry in the New Testament Church was in the first centuries of the New Testament Church's existence. Those with some healing gifts did not advertise their healing gifts, nor did they invite people for healing encounters as today's faith

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<sup>26</sup> The Church's mandate comes from Mathew 28:16-20 and Acts 1:4-8, whereby she is commissioned with the transforming gospel. This Great Commission is given to the eleven disciples, as chosen representatives of Israel, and as Mount Zion in Jerusalem was under judgement, they are appropriately sent to go and start their mission in the place Jesus began his ministry, "the Galilee of the gentiles" (Farmer *et al* 1998:1329). Jesus introduced an important shift to his disciples, to broaden their scope: "The disciples are now ordered to go to Israelites living among "all nations," not just the region of 'the house of Israel' in Galilee, Perea, and Judea as in Matt 10:5" (Malina & Rohrbaugh 2003:141). In Acts 1:8, Jesus further broadens the horizon of his disciples that when the spirit has come upon them they will be witnesses in Jerusalem, throughout Judea, and Samaria and even to the earth's remotest end.

<sup>27</sup> This power is shown most characteristically in the healings and wonders worked by Jesus, see Luke 5:17, 6:19, Acts 10:38. So also the apostles, once they received the power of the Spirit, worked wonders and healed the sick (4:29-31, 33:cf. 3:12; 4:7; 6:8). The power of the Spirit is the witness of God to support the preaching of the apostles. Furthermore, the healings worked by his power attack the powers of evil, see 10:38 and also Luke 10:17-19 (Farmer *et al* 1998:1510).

healers do. The Church community went out in obedience to Christ's commission and modelled the ministry of healing accordingly (Thomas 1994:15). They were merely discharging their calling as prophets, priests, messengers, apostles and disciples, and the Holy Spirit was confirming their mission with signs and wonders. Healing was not seen as an end in itself, but rather as a means to an end, which was primarily to announce the reign and demands of the King (Jesus) for a fallen and desperate world. Miracles were signs pointing to the reign of the King and His kingdom (Carroll 1995:30f).

The New Testament Church, among other reasons, was called into being to carry on with Christ's ministry after his return to heaven. Thus, the apostles proclaimed the kingdom message and manifested healings throughout the book of Acts (Lartey *et al* 1994:146). There are different healing gestures mentioned in the New Testament, namely 'touch' and 'laying on of hands' and anointing with oil. The significance of touch was not in its power, as there was no magical transference in it. Generally, touch has a great therapeutic significance. Thomas (1994:14-16) observes that although in his teachings about spiritual gifts Paul suggested that some persons are called with the gift of healing (1 Cor 12: 4-11), it was never considered to be a gift owned by a particular group. Paul recognises the diverse allocation of various spiritual gifts, as in the opening verses 4-11, but he attested that whatever gift one has is not for oneself, but rather for the common good of believers (1 Cor 12:7). Gifts are therefore not for self entertainment, but for the community of believers (Keck 2001:944). The idea that the gift of the laying on of hands can be controlled as personal property was not encouraged by practices such as in Acts 8:18-19. Here, the importance of gifts for the common good is again emphasised against personal self-aggrandisement in the way that Simon, the sorcerer, is rebuked (Keck 2001:139).

If the main purpose for the ministering of gifts is for the common good of believers, then there is a question mark around the ministry of many faith healers, who are not linked to any denomination, but are operating in the public space. The gift is given to the whole community of faith (Thomas 1994:16). This is an important indicator and yardstick for the faith healing practice. There is synergy in teamwork, and it also releases various gifts for holistic ministry. The need for care and counselling can only be catered for effectively within a teamwork setup.

The disciples were not all trained in health care; yet they were sent out to preach and to heal. The model text and formula for the Church's healing ministry is James 5:14-16, which shows the total community of faith as being responsible for this task. The Greek word James used for sick is *astheneō*, which means weakness, in this case, physical weaknesses, like illness (Arnold 2002:116). Elders as spiritual leaders were to come and anoint a sick person with oil. Anointing with oil was a custom used in the ancient world for medicinal purposes. James uses the word *aleiphō* for anointing, instead of *chriō*, which was commonly used. James probably avoided *chriō* as it ceased to refer in the New Testament to a physical action. James wanted the anointing elders to perform an actual physical action as a way to assure the ill person of God's special attention to him/her as prayers are offered (Arnold 2002:116-117). There are myriads of biblical accounts about healing people of all kinds of diseases. The fact is that in all healings, whether through medication, surgery, proper diet, exercise or divine intervention, whatever the means, ultimately the body receives its healing from the Lord who has created it (Dunn 1997:93). Lessons from the Early Church are highlighted, particularly the approach to healing practice, which will inform the modern healing practice.

#### 5.4.1. Lessons emanating from the Early Church

The Early Church's obedience was translated both in the way they proclaimed the Gospel of Jesus Christ and exercised the healing ministry (Hacking 2006:232-236). The Church is also given the same mandate today (Luke 10): In this chapter it is encouraging to note that Jesus' sending includes provision and competence to achieve the missionary end for those sent. Also, curing the sick is done in the context of the ministry of exorcism (10:9). This is a reminder of the link between the disease and the diabolic oppression in Lucan thought (Green 1997:410), and is an important point to note, as psychosomatic diseases do go beyond the obvious illness and may have some evil or spiritual connotation. It is therefore important to engage a person grappling with illness in a series of counselling to reveal the cause of illness, which may take a great deal more than a quick prayer, as it may have a deeper cause than anticipated. The point here is that the authorisation given by Jesus to his disciples and later to his Church is modelled on his own three-fold approach to the world, namely: teaching, proclaiming and healing.

The disciples knew that they were granted the gift to proclaim the risen Christ and to call people to faith in Christ. They understood that the mighty works of Christ was the sign of the inaugurated Kingdom of God. The apostles used the same methods as the Master to preach

and heal, as they combined word and deed for the ministry of proclaiming God's kingdom. Jesus did not use healing as a secondary means, but in fact, made use of it to usher in God's rule or God's kingdom. Warrington (2005:26, 96) views Jesus' healings as directly linked to his mission to inaugurate his kingdom. In addition, he states that his unique role and unique mission are in a certain way unrepeatable. Thus, he argues that Jesus' healing ministry should not be used as the basis for contemporary healing practice. Warrington (2005:128-148, 148-179) further suggests that the best biblical accounts for establishing the modern healing ministry are from the writings of Paul and James.

This researcher partially agrees that Jesus' ministry could not be the basis for modern healing practice. Especially when considering that Jesus' mission was unique in various ways, particularly as it revealed his divine sonship and prepared him for his atoning sacrifice. Warrington (2007:193) indicates that "with regard to the healing mission of Jesus is not that believers may not learn from him nor follow in the healing mission as initiated by him but that his mission was unique. He healed in order to demonstrate his person (as Messiah and the Son of God) and message (of salvation and the initiation of the Kingdom)." In that sense, it cannot be copied, but the principles of healing and the way he approaches healing could be studied and applied in current ministry.

The main feature of the Early Church was their fellowship and togetherness. The gifts were also given within the context of the body of Christ. Individual gifts were to build up the body unto maturity (Eph. 4:11-13). Gedler (2007:27) indicates that this fellowship is therapeutic in nature, just like being in the company of Jesus. The healing ministry of the Early Church helped with the spreading of the Gospel. It had a missional<sup>28</sup> focus to various parts of the world. In other words, the Church by nature is missional; every congregation lives in a missional context, and every congregation is responsible for participation in God's mission in that context.

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<sup>28</sup> Missional focus has to do with the Church's realization of the "Missio Dei", which realises that the Trinitarian God is involved in the Church and wants his Church to be part of his mission. It is a perspective that brings together the "Missio Dei" concept with the theme of kingdom of God. "God has a mission in the world that looks toward the whole of the created existence, and the Church participates in this mission by living into and announcing the redemptive reign of God in Christ- the kingdom of God" (Gelder 2007:20).

There are many biblical texts (Acts 2:42-43, 5:12-16 & 19:11-12) and examples to prove that healing was part and parcel of the Early Church's ministry. David Petersen (2009:160, 215) observes that signs and wonders were particularly performed by apostles as Christ's agents. He further states that the healing miracles of the apostles parallels that of Jesus in many ways, such as the popular interest for what was taking place (cf. Mark 6:35). The layout in James 5:14-16 reflects an important portion of how the healing sacrament was officiated in the Early Church. This Scripture reads:

*Is any of you sick? He should call the elders of the church to pray over him and anoint him with oil in the name of the Lord. And the prayer offered in faith will make the sick person well; the Lord will raise him up. If he has sinned, he will be forgiven. Therefore confess your sins to each other and pray for each other so that you may be healed. The prayer of a righteous man is powerful and effective.*

The readers of James are reminded that their lives are shared by mutual affection, as a result of their shared relationship of Christ. Prayers of faith and praying for each other has the potential not only to heal the individual spiritually, but also to benefit the community as a whole (Mays 2000:1167). Christians are encouraged to call elders when they are sick. This is not speaking against going for medical treatment, but seems to suggest that prayer should be the obvious place to start when faced with sickness. After reflecting on James 5:14-16 previously, there are two conclusions to make:

- Firstly, the sick person must call the elders, and exercise some faith that God will manifest healing through his servants and therefore call on them.
- Secondly, the faith according to James 5:14-16 that is used to bring about healing is not individual faith; it is not the faith of the sick person or the pastor alone. It is the corporate faith of the whole Church, involving all the leaders (elders). It is very important to note that God is the healer and the faith of the Church; the body of believers is merely the medium.

Healing is a dynamic activity; however despite fervent prayers, the laying on of hands and anointing with oil, all are not healed, at least physically. Ervin (2002:77) states that some are healed; some are not healed, and he further shows how this is replicated in the New

Testament. There are situations where people seemed to have suffered with perpetual illnesses, for example: 2 Corinthians 12:7 - the thorn in the flesh of Paul - this *skolops tē sarki*- “thorn for the flesh,” is not explained clearly, and it can mean many things: either severe head pains, or tormenting of some kind by Satan. It seems that no one knows the exact meaning of this text. What is clear however, is that he experienced some discomfort, which God used to keep him from pride (Matere 2003:281-292).

The following examples demonstrated that people became ill and suffered with illness, even during the times of the apostles:

- 1 Timothy 5:23 - Timothy is encouraged to use wine for his recurring ailment. In the ancient times, wine was viewed as a medicinal ingredient. In fact, the Jewish elders believed in wine as a primary medicine. This advice of Paul indicated that people in New Testament times did not see medicine as being in any opposition to their authority. They worked with medicine while they also persisted in prayer for healing. Collins (2002:149) argues that where there is no wine, people seek drugs.
- Paul left behind Trophimus in Miletus, as recorded in 2 Timothy 4:20. The fact that he was left behind in Miletus because of his illness (*asthenounta*), suggested that there were ailing persons among the leaders of Christian communities in the post-Pauline era (Collins 2002:290).
- In Philippians 2:25-30: Epaphroditus, a co-worker of Paul, was sick as unto death. Paul experienced the agony of seeing his friend nearly dying, but thanked God for his mercy that enabled his friend to survive. This record of God’s merciful intervention when Epaphroditus was near death is an encouragement to pray for others, a motivation to depend upon God’s mercies when discovery doesn’t happen, and to give glory to God when healing comes through (Hansen 2009:205).

Therefore, illness is not something we can completely obliterate. Even for the apostles, who were powerfully used by God in healing and the performing of many miracles, illness was a reality they could not just pray away.

Howard Ervin (2002:75 & 76) remarks that faith is a manifestation of the Holy Spirit and that this faith cannot be quantified. He explicitly says that faith cannot be increased exponentially by human effort. Faith as the manifestation of the Holy Spirit is the one that works miracles.

It is clear that the Early Church did not go around advertising healing, but understood it to be part and parcel of their commissioning and preaching of the gospel. All of these assertions go against the practice of faith healing in the modern era, as modern practice is being popularised and used as the end in itself. It is also based on individual personalities, unlike the Early Church's focus, which was a corporate ministry. The New Testament views illness as part of human weakness, feebleness and general helplessness, and scriptures such as Luke 13:11, Matt. 10:8, Jn. 4:46, Acts 9:37 speak to this reality. Louw (2005:112-115) argues that healing will embrace the whole concept of *shalom* principle, which is based on God's covenantal faithfulness of the Old Testament and the concept of renewal and restoration through Christ from the effects of sin in the New Testament. Therefore, the basis for the healing praxis must emanate from the relationship with Christ and go beyond physical wellness to wholesome healing.

The previous discussion on illness and its consequences has introduced the whole debate on the purpose and meaning of illness for a suffering person. Is there any good in illness? Does God choose some people to suffer through illness for a greater good or for higher purpose? Thus, a theological discussion on issues of illness and suffering is employed.

#### 5.5. Theological reflection on illness

The question regarding meaning in suffering is about the purpose and direction of one's life. Louw (1994:173) indicates that God is more than the sumtotal of meaning; rather, it is the discovery of a God whom one can trust and who can bring meaning to life because of actual involvement and engagement with these existential realities that threatens humans at the very core of their beings.

Christians who experience illness should not merely pray for removal of the suffering, but should also seek the deeper understanding and transformation that comes with such suffering. By doing so, the sick person is not only a victim, but becomes an agent of hope and healing for others in similar situations. Stoeber (2005:54) indicates that "through spiritual identification with Christ, suffering is permeated by the love and joy of divine Presence which is witnessed and experienced in creation. Grief becomes grounded in the awesome healing power of redemptive, divine Love. Resurrection experience, the suffering Christian

mystic is reborn out of the ego-death of kenotic crucifixion, into the loving light of new life.” Although suffering is real, there is untold comfort and spiritual solace for those who are willing to embrace the virtues of Christ in their pain. Stoeber (2005:55) argues that “the human likeness of God is only achieved gradually, through the painful human experience and overcoming of suffering, a travail that requires a relatedness to others both for its experience and its transformation, through a kenotic self-opening to God and hence to others.” The purpose of suffering is defined from the faithfulness of God, who identifies with human suffering and understands the human existential needs, such as anxiety for death, sense of helplessness and hopelessness as a result of doubt and despair, guilt and need for liberation (Louw 1995:173).

The biblical picture of *shalom* must be understood from the background of this imperfect, fallen world with its strains and challenges. Since the Garden of Eden, this world has displayed an ambiguity of beauty and brokenness (Atkinson *et al* 1995:89-90). The fall has caused alienation and tainted all relationships, including with God, with others, the environment and with the self. The reality is that disease, suffering and death are part and parcel of a sin-infected world (Atkinson *et al* 1995:90). Suffering is complex, multi-faceted and very difficult to summarize in one sentence (Louw 2000:9). It affects every aspect of being human, as well as spiritual dimensions, and evokes questions of identity, significance and the role of God in suffering.

The theology of illness is dealt with by discussing the question of theodicy and how this relates to human suffering.

#### 5.5.1. The place of God in illness and suffering

Regarding the question of suffering, biblical scholar Peter Hicks (2006:211) advocates that the Bible is more concerned about the ‘how’ of suffering, than the ‘why’ of suffering. Hicks argues that building a theology of suffering is meaningless if it doesn’t enable people to live positively in the midst of suffering. The way illness, healing and wholeness relates to the will of God is never easy to explain. The question of theodicy is not easy to deal with, as there are various viewpoints held on it from a wide range of perspectives, including theistic and atheistic viewpoints (Hicks 2006:148-151).

The literature has highlighted the fact that illness and suffering affects all facets of being human, ranging from personal, societal, cultural to religious. The mystery of suffering and the fact that evil sometimes befalls innocent people is puzzling and therefore calls for serious reflection. This has implications for the way God is perceived in suffering; hence, need to reflect upon the concept of theodicy. Theodicy is a philosophical concept that rationally tries to justify God in the midst of evil (Louw 2000:21). It is not a scriptural term, although Scripture has many inferences to theodicy. Theodicy creates a tension between God's omnipotence and his omni-benevolence (Louw 2000:28). The question is whether evil and suffering is caused by God or by an outside source. The dilemma is that if God causes evil, then he can't be good; and if he is not the cause of evil, then he can't be omnipotent.

There are two approaches that theologians have propagated over time in regard to theodicy. These are the inclusive approach and the exclusive approach (Louw 2000:28).

- The inclusive approach connects God to evil to safeguard his omnipotence. The argument states that as the Almighty one, he is linked to all human events, including evil.
- On the other hand, the exclusive approach is a reaction against the static model, which depicts God as unsympathetic to suffering. Here, God is portrayed as compassionate and opposed to all forms of evil and suffering. This argument identifies God with suffering and caution against necessarily attributing evil to him.

The concept of theodicy is a delicate issue to deal with, as suffering people need assurance of God's loving care and control over their predicament. The way to deal with this issue is profoundly stated by Louw (2000:40):

The main problem in theodicy arises from the fact that the tension existing between whether or not God wills suffering, presupposes a rational division between God's omnipotence and his love. Such a division does not reckon with the fact that love and omnipotence are not two different entities or attributes, but that both are manifestations of God's faithfulness towards humankind. They are not in opposition, but are an expression of God's active involvement in our history and his identification with our human predicament.

It becomes clear from this quotation that different approaches to God's role in suffering shouldn't be dealt with in a simplistic way. Christian scholars have always maintained

different viewpoints (Boyd 2001:210) about God's involvement in the world. Some propagated that God is distant and not involve in the affairs of his creation (e.g. deism), while others affirmed his continuous involvement in creation (e.g. Biblical theism). According to the viewpoint of biblical theism (Boyd 2001:210) "God miraculously intervenes in world history and responds to the prayers of his people." Biblical theism emphasises, among other things, the omnipotence of God, submitting thereby that God can intervene in the world at anytime and anywhere for his divine reason and purpose. Boyd (2001:210) further amplifies this by stating that "if God wants, it is reasoned, he can prevent any particular event from taking place. Hence, there must always be a divine reason as to why God intervenes when he does and does not intervene when he does not. If one person is healed, for example, and another is not, the final reason for this difference must be located in God's will. If one child is protected, while another is allowed to be abducted, it must ultimately be because it fits God's plan to protect the first but not the second."

The basic questions human beings grapple with during illness or any catastrophe is why God allows evil to triumph over good if he is a good God, and why there is so much suffering in the world? It is a given that most Christians battling illness will ask the question of where God is in all these? Pembroke (2006:97) states "we want God to bring healing and relief that we have been praying for. In the meantime, we want to know that God is feeling with us in our pain." It is an encouragement for a hurting person to know that God sympathises and suffers along with them in their pain. During times of loss, grief, crisis of deep pain, as human beings we grappled with the following fundamental questions (Louw 2000:16-20):

- Firstly, the *why* questions, which wants some explanation for the suffering.
- Secondly, the *how* questions, dealing with the reality around God's faithfulness and his love. It is about God's identification, mode, function and style (Louw 2000:16).
- Thirdly, the *where* questions, which deals with God's will and his role in human pain.
- Fourthly, *what* questions, which leans towards the purpose and meaning of suffering.

These questions deal directly with the nature and the character of God and whether there is another evil source that operates outside control of God. The question is whether illness has any significance and if so, what that is; or is it a meaningless event that is devoid of any significance? Sanford (1992:7) asks whether certain attitudes towards illness will help to gain a deeper meaning of illness, or is there nothing spiritual in illness other than to endure it to the best of our abilities? Stoeber (2005:5) makes a valuable contribution, stating that not all

suffering is transformative; some suffering is destructive in nature and such destructive suffering needs to be resisted, as it is not redemptive, although perhaps somewhere the end goal might be good. He makes a distinction between destructive and transformative suffering: The former inhibits, blocks the person from growing through it in one or other way, while transformative suffering has a positive impetus in the personal and social growth of a person. This could be called redemptive suffering.

Suffering and the nature of illness have value; even though in many instances suffering and illness may not disappear, there is grace to cope and live lives in fullness (Aldridge 2000:35; Ganzevoort 1998:269-275; Carr & Morris 1996:14, 1, 71- 81). Illness brings with it inescapable questions, such as “why?” “Why me?” “Why now?” “How long?” “What is to become of me?” In a profound way, Louw (2000:398) indicates that “in suffering, the believer’s focal point moves from the question concerning the origin of suffering: ‘Why?’ to the meaning in suffering: ‘To what end?’ God wills suffering insofar as it changes the person’s perspective and attitude and enables the person to experience his loving care and presence. God’s will in suffering is not the suffering as such, but that which could take place in the heart of a sufferer: Trust in God’s faithfulness to his promises.” Louw (1994:175) indicates that the solution to the question “Why?” and “For what purpose?” is not a clear cut-answer, but a process and task that challenges one’s basic attitude, value system, belief and philosophy in life. Suffering becomes meaningful within the process of acceptance and taking responsibility. In the light of Christ’s vicarious suffering and his high-priestly compassion (God’s pathos), a person can discover and impart meaning to suffering. In illness and suffering, people grapple with deeper, existential questions of identity, the meaning of suffering and the purpose of life and living. These are important considerations and unless they are resolved in a satisfactory manner, result in confusion and disillusionment for people grappling with illness.

In fact, these questions make only sense when the people troubled by illness reflect upon them from the theology of the cross, which depicts human suffering from the point of God identifying with it. The main question the interviewees grappled with was the “why” question, although this did not lead to agnosticism or the questioning of God’s love and justice. The question was more out of the confusion of not understanding why healing is not happening despite prayers and exercising faith for healing. The fundamental questions as

demonstrated from the foregoing highlight the desperate pleas of hurting souls that need some response or solace. It is comforting when a person suffering from illness comes to the realisation that God is not impartial to his/ her suffering, but in fact reaches out with compassion and love to distraught souls.

The discussion dealing with the theology of illness and suffering is structured as follows:

- Firstly, the question on the impassibility of God will be explored and linked to human suffering and its application for pastoral care and counselling.
- Secondly, illness and the resulting effects are common realities most Africans grapple with on a daily basis. Therefore, the concept of suffering as conceptualised in the African reality will be explored in view of God's impassibility. This is quite important, as understanding God's presence or his silence in illness and suffering has implications for the road to restoration and meaningful living for affected individuals. The cry of an ill person is "where is God in my suffering?" This is a genuine cry that has a direct link to the question of whether God is in any way involved in human suffering.

The discussion of the doctrine of the impassibility of God deals with the question of God's role in human suffering.

#### 5.5.2. The doctrine of the impassibility of God

This is an important doctrine to consider, as it contributes to a type of caring framework and intervention strategies that will be employed. Pembroke (2006:98) indicates that this doctrine was maintained, especially by early theologians on the basis that "God is the 'unmoved mover', and since to suffer means being influenced or 'moved' by something outside the self, God cannot suffer. God is perfection, and as suffering involves change God must be exempted. How can a perfect being change? (Impassibility and immutability are two sides of the one coin). God is love and mercy and acts to relieve our suffering, but cannot suffer with us."

The perception of God plays a big role in dealing with illness and suffering. Lewis (1984:553) indicates that "God is not capable of being acted upon or affected emotionally by anything in creation." The root word is from the Latin "*impassibilis*", meaning not capable to

suffer, thus devoid of emotion. Gavriluyuk (2004:2) states that “a standard line of criticism places divine impassibility in the conceptual realm of Hellenistic philosophy, where the term allegedly meant the absence of emotions and indifference in the world, and then concludes that impassibility in this sense cannot be an attribute of the Christian God.” The Greek equivalent word “*apathes*” was used by Greek philosophers to describe God as being above pleasure and pain (Penner 2004:88). Ascribing emotions to God suggests that he is subject to change; this was intolerable, as God was viewed as a perfect, tranquil and unchanging deity.

Ohlrich (1982:40,41) demonstrates that “in twentieth century especially, there has been a general turning away from the traditional view of impassibility with a growing number of respected Bible scholars, theologians, and Christian philosophers arguing most strenuously for divine passibility or, at the very least, for a redefinition of impassibility.” In recent times, the view of impassibility was also refuted as it contradicts the imagery of a personal being as portrait in the Bible. The atrocities and human agonies of recent centuries, through acts such as the Holocaust, called for a re-visitation of traditionally held views. Pembroke (2006:98) argues that “most theologians have found it impossible to accept the notion of a God who sits aloof in heavenly bliss. God must be right there in the midst of our pain and distress.” There is a fear that ascribing suffering to God will ascribe to him an attribute that is inconsistent to his omnipotence and immutability. Some people may view a suffering God as a weak and frustrated being. On the contrary, however, this need not be the case, as demonstrated by Ohlrich (1982:57) that “many objections to passibility would be dispelled if we would keep in mind that God chooses to suffer; the God of suffering does not passively endure pain, but actively choose to embrace it.”

Therefore, if impassibility is properly understood, it means that God cannot be forced against his will by inside or outside influences; and that he is also not a helpless victim of circumstance, actions and emotions. Further, that God cannot be forced to act contrary to his character or other revelations (Penner 2004:89). God is known as a compassionate God, whereby the Latin word *compassio* carries the idea of suffering- with (Gavriluyuk 2004:6). In showing compassion to an ill person, Christ is not affected by the ill person’s suffering, but he rather transforms suffering. Gavriluyuk (2004:10) mentions that “a compassionate person is not conquered by suffering; whereas the sufferer is weak and helpless. The compassionate person is able to help precisely because he is not susceptible to the degree to which the victim

is. In this sense the compassionate person must remain impassable, unconquered by suffering.”

In conclusion, a person that shows compassion should both be impassable, so to help the sufferer and also be able to suffer if the situation demands it. This has become true in Christ through his incarnation, by which he shared in humanity, his crucifixion and sacrificial death, and his resurrection, by which he overcame sin, death and every curse that were put upon mankind (Louw 2000:20). In the African context, certain realities are taken as given and the concept of the suffering God is quite an intriguing concept in a continent with so much hurt, pain and suffering. Hence, the following section explores in some detail the concept of the suffering God from an African perspective. Thus, the African concept of God as it relates to illness and evil and how these are reconciled with the view of suffering God will be explored.

### 5.5.3. The concept of a suffering God in African Christianity

The African worldview perceives evil and suffering from holistic cosmology, which considers reality as a coherent whole and unity. African realities consists of different opposing features such as good/ bad, fortune/ misfortune, cursing/ blessing, grief/ joy, life/ death and comfort and suffering, to mention but a few. These realities are accepted as part and parcel of life, yet not in fatalistic way; the whole community is expected to promote what is good and well and to dispel evil and suffering. Mbiti (1990:199) states that African people are well aware of evil in the world and are determined to fight it. In the African understanding, God is not the source of evil; Busia (1998:197) argues that “for the supreme being of the African is the creator, the source of life, but between him and the humankind lie many powers and principalities, good and bad, gods, spirits, magical forces and witches to account for the strange happenings in the world.”

There were six interviewees who stated that their illnesses were somehow linked to demonic operations or witchcraft. This is 24% of the interviewees and demonstrated the African reality that belief in spirits and spiritual forces. All the respondents were Christians and did not necessarily interpret their illnesses from a cultural or traditional viewpoint, but rather viewed their situation from a biblical perspective. To a certain degree, human responsibility is also attributed to evil, as humankind transgressed the divine command and gave foothold to evil to permeate the world (Dau 2002:159). In the African viewpoint, disasters, including natural

causes, do not just happen, they are caused. This is reflected by Dau (2002:162) in the following way “but again, nothing in African society just happens without being caused by somebody or something. It is because of this that possible explanations of whatever befalls humans are always given. Soul- searching and witch- hunting inevitably ensues in the community if only to find a scapegoat.”

In pursuit of bringing balance and harmony, African people offer sacrifices, prayers, and all sorts of rituals to appease God and other divinities in the hope of getting the desired outcomes. Prayer is quite important and takes centre stage in African religious realities. It covers all aspects of living and is offered in life and death, in sickness and health, in prosperity and poverty, etc. African religious prayers, songs and dirges consist in many cases of the language of protest and lament, however it is not in any sense atheistic or revolutionary of tone and nature. The place of God in relation to the problem of evil and suffering is still obscured in African cosmology. Wiredu (1998:199) states “the African view, in the context of cosmological reflection, maintains a doctrine of the unqualified omnipotence of God in regard to issues with direct bearing on the fate of humans on earth. But it also maintains a diminution of God’s omnipotence, a reduction of God’s omnipotence to the level of human potentate.” In light of this, rituals and sacrifices play a big role in appeasing ancestors to intercede on behalf of the living. These rituals become the centrifugal point of worship and that God despite his omnipotence act favourably towards his subjects when rituals are performed, as noted by Wiredu previously. God is sympathetic to the cause of poor and vulnerable, including people suffering ongoing illness. Wiredu (1998:199) further illustrates that God is both immanent and transcendent, which suggests his presence and involvement in the affairs of human beings. Therefore, by virtue of his character, God is open to embrace human suffering and pain.

On the immanence and transcendence of God, Lartey (2003:62) remarks “If this be so, then the task of healing, in pastoral terms, involves a recognition and facilitation of the activity of ‘transcendent in the midst’ of life. The God who heals is not the one who is far away. Instead, such a God is present all the time and bears all the pain and anguish of a sufferer. But this God is also willing to help.” The considerations by Wiredu and Lartey on God’s immanence and transcendence as applied to human suffering give hope for ill persons and the ministry of pastoral care.

The concept of the cross and resurrection are quite important for the healing ministry. Underwood (2006:10) argues that the “resurrection is the kind of promise that precedes itself, a future that invades the present, all of which threaten to destroy the person, body and soul. The power of this promise of resurrection, however, is no self-serving vision or avoiding the pain and sufferings of this life or the suffering to which Christian witness calls us. Rather it is the vision that empowers us to suffer and die.”

The Scripture reference in Hebrews 12:2 points to Jesus as person *par excellence*, who suffered shame and pain with joy for the purpose of our salvation. The depiction of the cross becomes crucial, both for the suffering person and for the Church as a missionary agency. Christ’s atoning death on the cross brought life, both for the present and the eternal dimensions of human existence. The cross and resurrection thus inaugurated the theology of wholeness. Underwood (2006:11) states that “led by the living presence in our midst of one who suffered for all, we are called to ministries of compassion and hope with growing numbers of persons living with persistent pain.” Although God is involved in human affairs, including suffering, Lartey (2003:63) remarks that we do not know God’s intention or the form in which his presence will take place; this calls for openness and attentiveness. The Cross of Christ, and for that matter his suffering are concepts well understood in African living, where the majority of people struggle daily for basic amenities, in a continent ravaged by wars, drought, starvation and diseases. Christ becomes the epitome of all suffering and the model of hope for a better life for Africa’s vast populace.

The aforementioned reflections have quite important implications in dealing with illness, seeking to understand how illness transforms a person positively, or whether it completely destroys his/her faith, personality and character. Stoeber (2005:61) expresses the hope that those caught up in destructive sufferings will ultimately experience healing and continue their spiritual journey free of major hindrances. The story of righteous Job and his sufferings demonstrate the fact that bad experiences are difficult to handle for any human being. There is always a tendency to apportion blame to God. It is especially hard to comprehend the seeming silence of God in suffering, as God is a sovereign, moral and omnipotent being. It is very difficult to reconcile the sovereignty of God, over and against the desire to see loved ones healed and restored to full health. The tension in the healing debate, according to Woodward (1995:89), is “how the head relates to the heart.” Illness breeds fear because of

the incapacitating nature of illness and the impact it may have on the quality of life and on future aspirations. Dunn (1997:19) states that “the underlying fear of ill health is our insecurity about where God fits into the picture.” Times of illness are times where human frailty and hopelessness come to the fore, and God may become the only surety and hope at such times of distress. Keck (2000:41) argues that “human suffering or misfortune and affliction must not be confused with sin, however - quite the opposite. Identifying with God, with the gospel, assures one of encountering distress and suffering, and that very affliction becomes the locus where God’s consolation, comfort, and encouragement find abundant expression.” The deeper understanding of God’s purpose and calling seems to become clearer at the lowest and most vulnerable place of humanity. Although the unfolding of God’s purpose can manifest in various ways, it is clearer in times of illness. In 2 Corinthians 1:3-8, the apostle Paul testified of his afflictions in Asia that seemed to be life-threatening. Yet through them all, he learned to trust more and depend upon the Lord. He developed a profound relationship with Christ through his sufferings (Matera 2003:42-43).

During illness and pain, it is hard to see God in it; nevertheless, the hope of the Christian faith is to know and to comprehend that in the midst of it all, the Lord is right there, as Romans 8:38-39 indicates: “*Nothing can separate us from the love of God which is in Christ Jesus.*” Regarding this verse, Keck (2002:615) comments that “time present and time future, space high and low - the whole world, as we say, of space and time as it stretches out before us - can have no power as the love God has for those in the Messiah.” The reality is not to see God as a miniature that is at human mercy or as a being that we can manipulate with our faith. God remains sovereign, self-existent and does whatever he does for his glory. He never does anything unless it glorifies him. Peterman (1974:68) makes a rhetorical statement when he asks whether God tolerates disease, suffering, unhappiness, brokenness, or sorrow in heaven? He answered that God does not will or tolerate suffering anywhere, anytime. This statement of Peterman makes some sense if considered from the point of logic; however it doesn’t answer why Christians and good people in general suffer if God is vehemently opposed to any suffering. The problem is that such views give quite a simplistic response to very complex issues. Keith Warrington (2005:195,196ff) seeks balance between suffering and care-free living as a Christian by contributing in his book towards the formation of a more sound theoretical basis to healing ministry. Warrington (2005:195,196ff) mentions that Jesus’ ministry was not aimed at obliterating suffering, but rather offers ongoing empathy

from God to human suffering through the presence of the Spirit. The understanding is that Satan zeros in on exemplary righteous people in the hope of leading them astray, so that they fail before God. Paul seemed to perceived his situation in 2 Corinthians 12:7-9 in this manner, however, he came also to the realisation that (Keck 2000:165-166) “though God doesn’t cause all things, God does work in all things for good unto those who love God, as expressed in Rom 8:28.”

The chapter has reflected on terms and concepts related to illness and health throughout the scriptures, as well as on how Jesus Christ and the early church understood and approached the issue of illness and health.

#### 5.6. Conclusion

The normative task, according to Richard Osmer’s methodology that investigates “what ought to be going on?” was the focus of this chapter. Reflecting on this question, it became evident that the question of faith healing and its theological and practical implications indicated that the gift of healing was practiced throughout the Christian Church, although some indications are that it was not as common as it was with the First Church. The terms ‘faith healer’ or ‘divine healer’ were not used in the history of the Christian Church. The term faith healing is linked to healing practice of the modern Christian healers (Anderson 2002:523).

This chapter has demonstrated the fact that any healing mode that only concentrates on one aspect of human composition, without taking account of human complexity and the totality of humankind as soul, spirit and body into account, comes dismally short of being effective in any healing attempt. This doesn’t compromise on the divine aspect or intervention of God with miraculous and spontaneous healing, but rather shows that illness is sometimes deeper than the perceived symptoms and needs an integrated, holistic approach.

The third task of practical theological methodology, “what ought to be going on?” has demonstrated the need for a sound theological and theoretical framework for the practice of faith healing. The exercise of faith healing is a popular reality in Africa, and it is understandable to the approach and hermeneutical framework applied by faith healers. People

are seeking for the life-giving and transforming power that gives wholeness and fulfilment to their brokenness and emptiness. They are looking for the power that manifests in justice, freedom and peace, which is contrary to the hate, injustice and bondage they experience in the world (Migliore 1983:16). The fact that some people leave healing services without being healed, after much anticipation, has led to disillusionment in many instances. Often, this is made worst by healing practitioners who blame those not being healed and stating that their faith is too weak (Bates 1995:59). The biblical and theological interpretation and application of how illness were dealt with throughout the scriptures have pointed out that: Any healing practice that is self glorifying and based on human power and will is missing the goal of the biblical understanding and application of healing. Illness and healing are complex issues that need to be dealt with through proper biblical and theological hermeneutics in order to respond in holistic manner to suffering of people.

The biblical references that were discussed in the chapter have illustrated that healing is not predictable or guaranteed. There are certain realities human beings do not have control over, but they have only to trust God and do what is humanly speaking possible. Mother Angelica (1999) states that “he (*Jesus* inserted) wanted His Apostles and His followers never questioned that He was truly the Son of God. He wanted them to feel free to ask Him anything, knowing that He had the power to accomplish the miraculous. But never for a moment did He wish anyone to demand anything from the Father. He gave us His example in the Garden of Olives. He asked for the impossible and accepted the Father’s ‘No’ with courage, love and trust.” Therefore, the normative task of what ought to be going on has further suggested the attitude of faith, humbleness and obedience as the basis for approaching God during illness. A person grappling with illness becomes a vessel of God’s grace that experience God’s tender love and care, even when illness prevails.

The chapter has further contributed to the fact that no healing ministry can happen without taking the cultural context seriously. Healing must be done within the concept of *shalom*, so that it emanates from a quest for wholeness on all levels of human existence. Faith healing has its place within African realities, but needs to be balanced scripturally and be culturally relevant; this is a real challenge for the development of strategies that are restorative in nature. A solid basis was established that forms the theological underpinning for the whole research.

Chapter 6 covers the pragmatic task of practical theological methodology and employs aspects of pastoral care to ensure durable and responsive intervention for people facing ill health. Thus, Chapter 6 proposes a pastoral approach of hope and compassion for people suffering ongoing illness.

## Chapter 6 Towards a pastoral approach of hope and compassion

### 6.1. Introduction

The previous chapter has created the theological disposition for general healing ministry in biblical terms, especially in view of Jesus' understanding and executing of his mission. Further, it explored the New Testament understanding of healing and how the Church of Christ has engaged in healing practices throughout the centuries. Finally, a theological interpretation was employed to assess the role and place of God in illness and suffering.

Thus, in the light of what chapters 1- 5 have contributed in relation to illness and health and how persons grappling with illnesses manage their conditions, this chapter introduces a pastoral care approach. This chapter integrates the various aspects that emanate on issues related to illness and health, with the view to introduce a pastoral support approach of hope and compassion for people affected by illness. The hope is that such an approach will be responsive to difficulties and trauma caused by illness. It will also broaden the understanding and scope to deal with ongoing illness, even when faith healing practice did not ensure the desired healing for healing seekers.

The chapter deals with task four of practical theological methodology: The pragmatic task, which determines strategies or action that will influence situations in ways that is desirable and constructive for conversation to create new possibilities (Osmer 2008:4). The question addressed here, is "how might we respond?" A person suffering with ongoing illness constantly reflects on personal experience of illness and seeks ways to respond in meaningful ways to challenges of ill health. The following goal is employed to establish the objective of the chapter:

- To establish a theoretical motif for pastoral care ministry that will inform the envisaged pastoral approach of hope and compassion.

The chapter builds on the previous chapters and culminates these inputs in pursuance of pastoral approach of hope and compassion. This is done by firstly discussing the philosophical and theoretical context of pastoral care. Secondly, by exploring the complexities illness causes and ways to respond through pastoral care. Thirdly, by introducing and exploring a pastoral care approach of hope and compassion.

## 6.2. Pastoral care in context of suffering

Pastoral care is more than simply helping those in need; it is also about care givers sharing their lives, times and energy with their patients. Therefore, those caring for others need to have interpersonal skills that hold together in homogenous way. Pembroke (2006:21) compares these skills to polyphony<sup>29</sup>, highlighting the balanced and mature attitude caregivers should have towards their patients. It is about developing the skill of listening and being available to patients, as this is a ministry based on trust relationship. The need to integrate techniques of both counselling and the personality of a counsellor is indicated by Richardson (2009:185) as that “becoming a chaplain involves not only skills and knowledge in counselling and the use of appropriate words, but also the use of one’s own pastoral identity in relationship with other people and their needs.” The counsellor is an important contact for a person facing ongoing illness, especially when it seems like faith healing practice have not warranted desired results. The desire of a suffering person is primarily for healing and meaningful living.

Thus, the concepts of healing and cure are integral to pastoral care ministry for people grappling with illness and hurt. In other words, the pastoral care should embrace the whole person as body, spirit and soul. This understanding and approach is of essence, especially when considering that pandemic such as HIV and AIDS has no cure as of yet. Bate (1995:281) states that “illness can be caused by physical, psychological, cultural, social, economic, political and theological factors. Consequently, we have determined that both illness and health are holistic phenomena involving the whole humanity, body, soul, spirit, person, family, community and society.” To strengthen his case, Bate (1995:281) further notes what he calls “the weakness and culture conditionedness of western model of sickness and health and the need to develop an adequate cultural response to sickness and healing.” He seems to suggest that Western medicine is culture conditioned, in the sense that it is based on treating a patient as an independent and separate being, which conforms to the Western worldview of individualism. Bate (1995:281) views individualised treatment as a weakness, as it ignores the whole dynamics of family, community and society in treating an individual as stated by his understanding of illness and health in the aforementioned quotations. As

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<sup>29</sup> Polyphony is a musical term that refers to simultaneous singing or playing of two or more melodic lines that fits together as equally important parts in the overall structure of a piece (Pembroke 2006:21).

much as pastoral care in African context is based on communal aspects, such is the utilisation of metaphors or imageries.

The following imageries, as suggested by Alastair Campbell (1986:15-23), are important to depict pastoral ministry and caregiving. There are three central images to pastoral care, which many in the field of pastoral care have found helpful. The images are *toughness and tenderness of a shepherd*, *wounded and health of a wounded healer*, and the *wisdom and folly in the wise fool*.

These imageries are important, as they concretise the roles of pastoral ministry in tangible ways. This is especially significant in the African context, where symbols are important vessels of communication and healing. Louw (2000:6) insightfully comments on this when he states that “God- images are influenced contextually and culturally.” This underscores the logic for the researcher to concentrate on those images that are relevant to the African context. The researcher only deals with the first two images, as they are most relevant to African imagery and also applicable to pastoral ministry within the African context. The two images of the shepherd and wounded healer, according to Campbell (1986:15ff), are broadly used and accepted in the pastoral care paradigm. Chapter 2, which discussed the African cosmology, has stated various metaphors that Africans used in relation to Jesus Christ, while these two imageries (shepherd and wounded healer) are central to understanding the pastoral approach in the African context. A short description of these two images is as follows:

- Berinyuu (1989:3) indicates “in Africa, the Biblical image of the pastor as a shepherd is being used. The shepherd image emphasizes the caring and protection aspect”. In fact, pastoral theology should embrace God- images that (Louw 2000:50) “convey the meaning of compassion, help and consultation in terms of God’s involvement with existential issues.” The *shepherd image* is within the traditional understanding of what pastoral care resembles. In the Ancient Near Eastern world, a shepherd was needed to provide tender care to their flock but at same time, needed to be tough to withstand the climatic conditions of Palestine. The sheep were moved around from place to place in search of green pastures and water, which were scarce in the Near Eastern region. During these migrations, sheep were exposed to all kinds of adversaries. Pembroke (2006:24) states that “while on the move, the shepherd had to content with the threats from robbers and wild beasts. To be sure, he needed to care gently for his flock, but also needed to be robust enough to deal with attacks of human and the

beast.” The shepherd metaphor is important for pastoral care and its application to pastoral function. Louw (2000:51) remarks that “in the shepherding function, pastoral care concretely represents God’s caring support for people in need. Thus, the mode of pastoral care is about more than human sympathy, i.e. about the compassion of the covenantal God Himself. Because of sheep’s defencelessness in God’s flock, his guidance, cherishing and protection simultaneously imply the entire congregation to be Lord’s flock.”

- The *wounded healer image* depicts a picture of the pastoral carer’s own frailties, failures and vulnerabilities, and proposes to use what seemed to be liabilities as resources that foster growth, reflection and development for those under our care (Campbell 1986:18-21). The real healing in this imagery is not so much in our wounds, but rather than in the way that we use these experiences as means of hope that bring life to others in shadow of despair and pain. Louw (2000:54) indicates that it is the ability to make peace with one’s own pain in order to make room for the pain of others. The significance Africans give to symbols and imagery is a building block to convey ways of illness and health reality. Just like in the case of a wounded healer, healing cost both the receiver and the giver something. It needs a trusted shepherd that is not out there to abuse the weak and the vulnerable, but to nurture, protect and nourish. All of these aspects need the wisdom and discernment of a person who understands and cares for each patient with his/ her own unique needs.

Le Roux (2011:126), in his book *Church and Mission*, states that Zionist and Pentecostal movements have gone a long way towards meeting the physical, emotional and spiritual needs of African people, offering solutions to life’s problems and ways of coping in a threatening and hostile world. The healing practice seems to be an easier and quicker methodological approach to counselling in solving challenges such as anxiety, fear, attack of evil spirits and also a way to escape the socio-economical and political realities of African living (Kalu 2008:263). The word plays an important role in therapeutic healing in Africa<sup>30</sup>.

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<sup>30</sup> In Africa, disease and death are always seen as caused by an outside source and not necessarily by observed clinical symptoms. Contrary to Western physicians, who make use of analytical autopsy, traditional healers make use of more synthetic and comprehensive treatment methods. The African traditional healers seek to

This is why faith healing movements emphasise positive confession and attitude when praying for healing.

However, the so called “name and claim” confession or to pray and expect instant healing by faith may be a simplistic solution to a problem of a broader scope, which needs an all-inclusive approach of pastoral care and therapy. For example, chronic illness is a condition that demands readjustment of life patterns, behaviour patterns and priorities. Kluwer (1998:20) defines chronic illness and disabilities as “conditions that affect daily functioning for more than three months per year, cause hospitalisation for one month per year, or require the use of adaptive devices.” A holistic pastoral care approach is required to respond to people living with challenges of ongoing illness. Therefore, applying pastoral care of hope and compassion is one way of responding to the question of task four that deals with “how might we respond?” This question further prompts a response that is geared towards positive ways to manage ongoing illness.

Illness creates doubt and uncertainty in the affected person on how to reconcile the love and power of God in the midst of pain and trauma. These are troubling concerns for the hurting person, as it impinges on the meaningful and productive functioning of this person. There is a need to discuss the theoretical basis and role of pastoral care in the context of illness and suffering.

#### 6.2.1. Theoretical basis for pastoral care for people suffering ill- health

There are no easy answers or quick fix solutions to the hurt and pain that people experience; however, there is need to seriously engage with people facing ongoing illness. This is even true in view of the all loving and all powerful God whom many in distress thought as not taking notice of their plight. Commenting on the mystery of why God rescues some people from their various situations while others suffer calamities or diseases, sicknesses or even natural catastrophes Boyd (2001:212) indicates that “God genuinely faces in every particular situation a reality distinct from himself that has some say-so over against him. By giving every free agent an irrevocable domain of genuine say-so in the flow of history, God has to that extent limited his own unilateral say-so in the flow of history. God is everywhere and at

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understand the human being in his/ her totality through utterances, including his/ her environment and social relationships (Kolić, in Schreiter 1989:138).

all times present in his creation maintaining good and minimizing evil. But to the extent that he has given creatures say-so, God has restricted the exercise of his own omnipotence.” The statement points to the responsibility that human beings have to their lives; in other words, the choices people make may be constructive or destructive to healthy living. On the other hand, we are finite human beings and cannot give answers to all questions. Our humanness limits us in many respects, but also serves as a basis for putting our trust in God, who is all-knowing and all-powerful. Merry (2006:75-76) argues that the main source of sickness and sufferings in the world are caused by human freedom. God is viewed as all good and the cause of all good and therefore not capable for evil. However, it is quite difficult to maintain this viewpoint consistently, as it may on the flipside suggest that human will is above the control of God. Niklas and Stefanics (1982:137) warn about “easily attributing every catastrophe, especially death as God’s will as this could lead to a construed view of God for those who are left behind. It is extremely dangerous because it sometimes causes the family to hate that all- powerful God who took away their loved one. It could cause them to reject God entirely because they want nothing to do with a God who is supposed to be all good yet permits tragedy.”

Through the interviews, some respondents held the view that God is not the cause of any illness, as this is contrary to his love and goodness. This viewpoint creates tension between the love of God and the power of God, which may result in a faith crisis if not balanced. The book of Job is a good example of the fact (Boyd 2001:220) that “evil must remain a mystery precisely because we are so small while the creation is so vast and complex.” One thing that is clear is that God empowers his people in the midst of trials and suffering towards responsible personhood. In line with the process of empowerment, Boyd (2001:233) states that “God thus seeks not only to influence us but also to empower us to the extent that we can influence him. Prayer is central aspect of this realm of influence. It preserves our personhood over and against our omnipotent Creator.”

The fact that many people who receive intercessory prayers still remain ill must be seen in the light of God’s ultimate purpose with his creation. If God has made everything for a specific reason, then we may assume that there are good reasons for the prayers he answered in affirmation, as well as for those where desired result are not granted. The faith healing

emphasis added an extra variable by saying that God actually wills healing, but the person praying did not have enough faith to make the prayers effective (Boyd 2001:235). This is based on the belief that God never wills things like sickness or poverty; they attribute sickness and poverty to lack of faith (MacGregor 2007:88). This type of understanding “blames the victim” and can lead to extreme emotional hurt to the unhealed. Boyd (2001:234) compares “this theological understanding to the unambiguous representatives of the theology of Job’s friends, which the book of Job refutes!” Keeping unreservedly to such faith healing viewpoints may cause many people grappling with illness to suffer spiritual and psychological wounds, coupled by unresolved physical conditions. This may have serious ramifications for a person’s faith and social living, as doubt and sense of worthlessness are subsequent results.

Talking about the love of God to a suffering person becomes a real challenge. People do not hear properly when they are hurting, especially when bitter or angry because of ongoing illness. Kirkwood (1995:204) indicates that “how we speak about God, therefore, becomes of critical importance when a person is suffering, or a relative is angry and grieving over a loved one who has died.” When a suffering person asks questions such as “why me?” the tendency is to try and defend God or to give reasons, such as “it must be God’s will” or “there is nothing to do about it”. These kinds of answers are destructive and less helpful; it is better to be honest and to say “I don’t know why this has happened.” Kirkwood (1995:205) profoundly states about the danger of ascribing every suffering to God that “simply saying if God’s will does not accord with the concept that God is love. It does not allow the person to really get to know God in his fullness. Tucked away in the mind are unanswerable reservations. This type of acceptance virtually lays the charge in the subconscious that God has perpetrated evil. It may be argued that when this is the case there is deep down ambivalence between loving and hating God. The possibility of an intimate relationship with God is minimized.” Blaming God for every illness and suffering may cause people to abandon any religion and seek their solace and help at other places. Louw (2000:11) remarks that pain and suffering wrenches one out of complacent existence and exposes one’s false securities. He further states that not all results from suffering are negative, as suffering can also generate patience and endurance. It can release one from overly self-focus, and make one aware of the needs of others.

Therefore, in the midst of ongoing illness and suffering, the role of pastoral ministry is explored.

#### 6.2.2. The role of pastoral ministry to people not healed through prayers

Faith healing deals with the question of illness by means of offering fervent prayers on behalf of the sick. This is done with solid conviction that prayers of righteous person will avail and heal the sick from his/ her infirmity. Boyd (2001:227) observes that “the bottom line is that conviction about the urgency of prayer and confidence in the power of petitionary prayer lies at the heart of biblical faith.” The hard part of suffering in many instances is not the misfortune, sense of injustice or the pain, but rather the sense of God-forsakenness. The question really is where God is in the midst of one’s cries, as he seems to be silent, unwilling or even unable to do anything about our afflictions. Louw (2000:16) indicates that “suffering reveals our deep longing to locate God in our human history in terms of providence. Hence the question: where is God in my pain and what is his will?”

The literature review has reflected various viewpoints on the issue of healing in the modern church, some sympathetic and others critical sources. This was done to strike a balance that is vital for the study to carry some credibility, especially noting the fact that the study did not set out to prove the authenticity or questionability of faith healing practice, but rather its impact on the healing seekers. Walter Wink (1992:309) argues that some unanswered prayers, are not because God doesn’t will it or because of a person’s weak faith. He justifies this by citing the example in the book of Daniel 10:12-13 *“then he continued, ‘do not be afraid, Daniel, since the first day that you set your mind to gain understanding and to humble yourself before your God, your words were heard, and I have come in response to them. But the prince of the Persian kingdom resisted me twenty one days. Then, Michael, one of the chief princes, came to help me, because I was detained there with the king of Persia.’”*

In this case, Daniel prayed with faith and God was willing to answer him. Although God granted his request on his initial prayer, the affirmation by God to his plea was withheld from him. In relation to this incident, Wink (1992:309) indicates “what we have left out of equation is the Principalities and Powers.” It is clear from Wink’s statement that prayer doesn’t serve as a magic solution to problems, as various factors and variables are involved in the determination of its outcomes. James 5:15-19 suggests procedures for praying for the sick, which were supposedly followed by the first Christians. Even this “prayer of faith”, with its solid promises of healing and forgiveness as taught by James, need guidance, discernment

and carefulness for proper application. Healing doesn't simply take place just because of a fervent prayer; according to Merry (2004:80) some people die "often after a bout with a slow, gut-wrenching illness", while prayers are made throughout. Du Plessis (2007:6) observes *"dit is gevolglik belangrik dat gebed nie beskou moet word as 'n kitsoplossing of vermyding van die noodsaaklike groeiproses nie. Gebed is eerder die weg na progressiewe groei en ontsluit die krag van die evangelie in die betrokke person se lewe ten einde hom uiteindelik te begelei na 'n lewe van oorwinning en vryheid."*

Therefore, pastoral caregivers must understand these dynamics in dealing with people experiencing various emotions as a result of unanswered prayers. People are prayed for by faith healers at "miracle crusades" and what happened after the prayers are solely left in the hands of the individuals. The interviewees have alluded to the fact that there are no supporting structures or follow up programmes to support people who are being prayed for within the faith healing churches. Mpolo (1994:15) states that "healing through prayer alone would impoverish the pastoral ministry and the witness of the Church in Africa and isolate it from the mainstream of forces that should contribute to the development and liberation of African people." It's therefore important to counsel and comfort people who struggle with illness, even after undergoing faith healing practice to cope with their condition. Counselling must deal with issues related to God's character and his attributes, issues of faith and issues of suffering and afflictions as a Christian. The interviews have further revealed the emotional turbulences illness brought about and also the need for supporting structures to help people towards their healing and restoration. The areas of support were identified as teaching, counselling and encouragement. Interviewees felt that people suffering illness need teaching about the character of God, the virtues of patience and endurance, and how to stand in faith in midst of illness. This holistic caring approach must seriously respond to emotional and spiritual challenges of being ill. Du Plessis (2007:19), in responding to spiritual and emotional challenges, remarks *"met betrekking tot die proses van innerlike genesing is die gebed om insig en wysheid wat in Jak 1:5-8 aan die orde gestel word besonder van toepassing. Vir die berader is wyer insig met betrekking tot die dieper oorsake van emosionele seer en pyn by die beradene van deurslaggewende belang. Gebed kan vervolgens beskryf word as die opening waardeur die realiteite rondom die beradene se pynlike herinneringe en seer verstaan kan word."*

The best way to engage Jesus through faith healing practice is from a sense of unworthiness and not so much from the place of demand of rights as children of God. Faith healing practice seems to overemphasise the value and rights of a believer in receiving healing. This can easily lead to a self-righteous attitude that wants God to do things for someone on the basis of his/ her righteousness, instead of God's own benevolence and providential love. The narrative of the heathen woman who made a plea for healing to Jesus conveyed some important lessons<sup>31</sup> about conduct and attitude in beseeching the Lord for healing. This story of Jesus and the Syrophenician woman in Mark 7:24-30 is open to different interpretations. Her persistence in conversing with Jesus while all odds were against her as a woman, for that matter a gentile, is brave, considering cultural historical setting of the times which denied rights to women. Steinhoff Smith (1999:21) remarks "so for the Lord to condescend, to come down (*descend*) from his place of high status, cleanliness, holiness, and power in order to share his power with (*con*) her and daughter, who are unclean, unholy, and without power-lowly." The truth is that Jesus dealt with people, especially the vulnerable, in a gentle and sensible way. All the healing encounters recorded about Jesus in the gospels show that Jesus was treating people with dignity and was affirming the value of their humanity (Fuchs 1993:45). Jesus recognized the need and responded to it by extending grace of healing, exorcism of demons and offering forgiveness to the needy.

There are certain patterns or ways in which people respond to suffering. Steinhoff Smith (1999:103-104) states that "we took the persistence of suffering to mean that we had somehow failed, betraying our assumption (and also our discomfort with this assumption) that we should eliminate suffering. Connected to the notion that suffering is fixable is the idea that it and its causes are located or isolated in someone else." That's where faith healing teachings come short: Suffering and unanswered prayers are not necessarily an indication of failure or lack of faith. There are deeper complexities with regard to illness and although we believe in prayer as a means of engaging heaven in earthly issues, it was never meant to completely obliterate pain and suffering from this world. Jesudasan and Rüppel (2005:9) argue "even if we are not cured physically, often we are healed of wounds we carry in our souls. Those who have not been cured of their physical diseases but whose souls have been

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<sup>31</sup> The woman seemed to be determined and stood her ground against Jesus in dignity. Eventually Jesus recognizes her as a "worthy opponent or partner in the definition of what he must and should do. Jesus grants her original request, but not as a superior condescending to the inferior. Instead, he recognises her essential participation in the healing" (Steinhoff Smith 1999:21).

healed say that this kind of healing is what really matters.” In fact, the ministry of prayer and healing is meant to enable the person who is hurting physically, emotionally and spiritually to experience the Lord meeting her/ his need (Thomas 1983:9).

The influence of faith healing doctrines that advocate positive confession after healing prayers, even when signs of illness are evident, had influenced many interviewees. Most of them do believe that their illnesses are momentary and that with faith and perseverance, they ultimately will receive healing in this life. Seeking deeper meaning in illness or that being ill may possibly be a way to glorify Christ in this life was not popularly held. Thus, the importance of pastoral care is to guide and support people to be equipped for possibilities of living for the rest of their lives with illness. Steinhoff Smith (1999:104) remarks that “to consider another’s suffering as fixable is to construe that other person is an object we control, in other words to dominate that other by denying her or his subjectivity and agency.” The caregiver is not a master who has the right answers at hand, but as a fellow human being “wait, watch and hope” (Musgrave & Bickle 2003:88), while being weary that every day with a person grappling illness has its own new challenges. As illness becomes more serious, people may either resign or accept their condition in quietness; or may show signs of anger, defiance and despair with utterances of doubt, such as “Oh God, why have you forsaken me?” Musgrave & Bickle (2003:89) states that whatever resolution may come from the stillness, the spiritual ministry can be a sign of hope and trust that enable revival of faltering faith in the loving and healing presence of God.

The fact that God identifies with the fate of a person suffering with illness and his/ her vulnerability, is a strong basis for pastoral ministry of hope and compassion. Thus, a discussion on the reality of illness and how to respond to resultant challenges as a pathway to healing follows.

### 6.3. Facing reality of illness as pathway to healing

The primary goal of pastoral care must strive to enable persons facing illness to make sense of life and its challenges. This is partially a cognitive function, but more profoundly, reorientation of the person is envisioned that affects both emotions and will in a hopeful way (Aden & Hughes 2002:51). It is a hard reality that in many situations restoration from illness

to the former health or strength and ability is not possible. This fact is not easily accepted by all suffering persons. Lartey (2003:63) states that “in fact, the struggle to survive, which often takes the form of the quest for healing through whatever means possible, seems to be an inbuilt tendency within humanity.” Serious suffering and traumatic experiences seldom put faith under pressure and stifles personal growth. Louw (2000:117) states it as follows “sufferers often regard disturbing factors in life as a contradiction to faith, and an indication that God is not really interested and does not care. Suffering almost becomes an indication of God’s absence, rather than his presence.” Invariably, people respond differently to pain; some people do not even like to speak about it, but the fact of the matter is that a person suffering ongoing illness is a hurting person. Oates and Oates (1985:11) demonstrate that “some of these people, wherever they are, talk with you about their pain. Some talk about little else but their pain. Others who are in pain may never- or rarely- mention it.” The fundamental questions of *why, how, where, what* often have polarizing effect (Louw 2000:117). The questions cause contradictions in a suffering person, such as: Why an omnipresent and almighty God is reflected by the reality of pain as powerless and inefficient? As such, ministering to hurting people is not only about responding to the physical pain, but also carries psychological and spiritual dimensions. Louw (2000:73) observes that suffering also touches the very fabric of Christian spirituality. It affects not only ones identity, but questions God’s identity.

The aforementioned statements concerning suffering as a Christian and seeking meaning in suffering are not regularly accepted in contemporary Christian religion. Underwood (2006:3) states that today’s Christianity is often preoccupied with emphasis on health, wealth and prosperity and overlook the role chronic pain plays in forming the soul. To emphasise only the positive aspects of life and health, denies a person suffering with illness to go through stages of grief and eventually to make peace with his or her condition. People have all kinds of beliefs about what causes pain and the meaning of it, such as witchcraft, bad luck and curses, and about ways to cure or relief their pain. Underwood (2006:4) remarks that “to a varying degree these meanings reflect fundamental beliefs about self, life, and God.” If people are not allowed or enabled to express their feelings and to deal with them, there will be no growth and no eventual healing.

The people suffering from HIV infection had stated in the interviews that sometimes resentment and anger took hold of them, especially towards the person who was responsible for their condition. However, the commitment and understanding was there to deal with these negative feelings and to release those who have wronged them. Aden and Hughes (2002:12) indicate that “suffering and its concomitant emotions evoke intellectual distress in believers and cause a state of disequilibrium.” Pastoral care must seriously engage people on emotional and psychological levels. The inner pain is not often observed, but is very destructive and inhibiting. Spiritual and emotional problems need more than just prayer; there is a need to deal with issues such as fear of dying, stigmatisation and living positively with the HIV virus.

In dealing with spiritual and emotional needs of a patient, pastoral caregivers must understand that there are different levels of pain, namely acute, chronic and terminal and that each phase requires a different approach. It is important to note that not all pain is destructive; some pain serves a deeper meaning as it raises the issues of meaning, purpose and vocation to an individual. Pastoral care aims at bringing hope and helping individuals to reflect upon deeper questions of life and its purposefulness and to answer the question of *quo vadis?* – Where the person is heading to? Underwood (2006:8) states that “without hope, compassion is enervated. With hope compassion is renewed and invigorated. Hope without compassionate care and a measure of realism is denial of pain and suffering and so become rejection of people who live with realities of pain and suffering.”

Swinburne (1998:217) remarks that the pain of one person creates growth opportunity for others in one way or another. The sovereignty of God in relationship to illness is quite an important consideration in suffering. There is a real struggle to understand why God has allowed illness and why he can't stop the resulting suffering. One thing that is a common characteristic of those who are seeking religious healing is the desire to get well. However, the fact is that not everyone gets well or is healed from their infirmities. Pattison (1989:54) observes that “healers of all kinds acknowledge that while healings really do take place, it is difficult to predict whether they will happen immediately and who will experience them. People may be healed in different ways from those they expect. Frequently, healing is not constant. Sometimes, it may appear not to happen at all.” To confirm the fact that desired physical healing may not even happen at all, McCullough (1995:15-29) indicates the puzzling reality of healing prayer and its outcomes as revealed by centuries was that some people

remain sick despite being prayed for and others even die. The author and researcher, Diane Stinton (2004:69-71), wrote in her book *Jesus of Africa*, about people who had experienced the healing power of Jesus, either personally or witnessing of others being healed. In the book, she recalled the words of Pastor Masinde (2004:71) as he states “see, you have got to realize, physical healing is not our aim. Our aim is to serve God with our lives and glorify him in our death. And if God’s going to take someone home through the way of sickness and disease, I won’t question him. That doesn’t stop him from being a healer. I will preach him as a healer.” It becomes clear that the mysterious element of healing is tied to God’s own wisdom and purposes. That is what Jesus instructed in the prayer he taught his disciples “*let your will be done, on earth as it’s done in heaven*” (Matt. 6:10). Sometimes even with strong, fervent prayers for healing, prayers may be unanswered. Often faith healers and those praying for the sick become insensitive to the pain of those suffering. A professor of pastoral counselling, Edward Wimberley (1990:11), remarks that “healing is God’s work and there is no healing without God. Therefore, through prayer we can come into an intimate contact with God, the source of all healing, bringing our lives into line with God’s healing activity.” The deeper essence and significance of healing is only comprehended by the cultivation of a closer relationship with God that may happen while grappling with challenges of illness.

Atkinson *et al* (1995:90) propose that “we need a view of suffering which acknowledges both its pain and its goal. There can be a pain which heals, a suffering which is a sharing in the suffering of Christ.” Relating to the purposefulness of the Christian faith, Louw (1994:173) observes that “*telic*” is derived from the Greek word *teleion*, which implies purposefulness, and it is used in Scripture in connection with direction and maturity of faith. Maturity implies an overcoming of inflexibility, rigidity and resignation that enables the internalization of suffering. Furthermore, maturity entails the dynamics of anticipation, prospective action, and openness towards the future.” Similarly, Atkinson *et al* (1995:90) state that part of the Christian understanding of growth to maturity in Christ involves an acknowledgement that “suffering produces perseverance, perseverance character; character hope”, as illustrated in Romans 5:3-4. The anxiety, fear and debilitating nature of illness make it very difficult to see or to seek any good in suffering. In fact, a proper perspective and balanced view of life and its challenges are pivotal to cope with illness and to make meaning out of it.

Pastoral care is geared towards the supporting and sustaining of the inner strength of a hurting person, in the midst of adversity. It is to help people to face the reality of illness with the available resources and courage to persevere through the trauma resulting from illness; with the hope to be gradually restored to productive living. This kind of ministry is primarily about compassion and hope. These important considerations as previously discussed are integral to fostering an environment that will enable healing strategies to be employed. As demonstrated here, illness has various impact levels (spiritual, psychological, social, cultural and physical), which affects not only the body, but also the soul and the spirit of an ill person. The further reality dealt with is how negative feelings and attitudes such as unforgiveness, hatred and bitterness have adverse impact on physical health. Therefore, an environment that enhances positive support systems, geared towards meaningful growth is underscored. In this sense, creating such an enabling environment where hope and compassion are fostered for people facing ongoing illness despite being exposed to faith healing practice is needed.

#### 6.4. Creating conducive environment of hope and compassion

The pastoral care aims to guide people suffering with illness to discover hope and meaning on their journey to healing and restoration. It is about hope, care and the endeavour how to give meaning to life within the reality of suffering, our human vulnerability, and the ever existing predicament of trauma, illness and sickness (Louw 2008:11). In other words, pastoral care expresses the encounter between God and human beings through the confronting effect of God's grace, presence and identification with human need and suffering. This confrontation is such that the care of God translates into hope and generates faith (Louw 1998:99). Compassion is equally important as hope in employing pastoral care to people suffering with illness. In this regard, Louw (2008:14) explains that one of people's deepest needs is compassion. Compassion implies suffering with others, by coming alongside and sharing in their suffering. Thus, pastoral care environment that fosters hope and courage will involve:

- Firstly, discussing ways to consolidate caring relationships to the healing seeking person.
- Secondly, the discussion of various elements necessary for ensuring an environment of hope and compassion for people suffering with ongoing illness.

#### 6.4.1. Connecting with people suffering illness through caring relationships

The literature study has indicated the importance of building relationship of warmth, trust and mutual respect between the counsellor and the counsellor, as well as maintaining and securing confidentiality as basis for therapy. Wicks and Estadt (1993:76) note that “a caring, emphatic, non-judgemental attitude on the part of pastoral counsellor certainly has a profoundly positive effect on the relationship.”

Caregivers need to be empowered and informed with skills to assist parishioners who come to them with their problems (West *et al* 2006:18). The pastoral function of the church as a caring community must embrace a holistic ministry addressing physical, emotional, social and spiritual needs of a hurting person. For example, the impact of HIV and AIDS on African societies as discussed in chapter 2, and the way people who are infected are treated, rejected and stigmatised in many communities is unfortunate. Therefore, pastoral caregivers must be able to build relationships and trust and confidence with people grappling with illness, especially in the context of HIV and AIDS challenges. This is quite significant in the Southern African context, which is ravaged by high HIV and AIDS prevalence. HIV-positive people grapple with an overriding emotion of fear, which is aggravated by stigmatisation experienced by infected people in our region (Mash 2009:20-26). This notion is also confirmed by Smith and Baker (n.d. internet), about stigmatisation in Namibia. They state that people who have a perceived higher HIV risk and stigma are sidelined from involvement in community groups that can offer support and needed resources.

The pastoral ministry of empathy and compassion is eloquently stated by Aden and Hughes (2002:9) that “the pastor can properly and helpfully address suffering only if he or she stands alongside the sufferer. Anything less than this turns the sufferer off or may even increase his or her distress.” It is ministers’ responsibility to know their parishioners and the struggles they are facing, in order to be of better service to those in need of diaconal services (Mash 2009:13-15). The role of a congregation is summarised by Howard Stone (1993:91) as “whenever *koinonia* exists within a Christian community, pastoral care naturally becomes a function of the entire congregation; people reach out to each other in their crisis as well as in their day- to- day troubles, despair, hope and joy.” The same notion of congregational care to people in trauma is reiterated by Louw (1998:274), as follows: “The congregational *koinonia* should be empowered so that parishioners become actively involved in crisis.” A strong drive to inform and educate both the infected and affected about the virus must become an

important agenda point of Church's mission. Obviously, HIV and AIDS is not the only sickness or disease that African people seek healing from, but as a result of its devastating and enormous impact on African communities, it warranted a concerted effort from various congregations to effectively combat and reverse the onslaught. Challenges HIV and AIDS offers, because of its incurable nature, makes pastoral counselling mandatory. The pandemic of HIV and AIDS, coupled with socio-economic injustice, genocide, wars and ecological disasters incurred by human beings, gives justification for the Church's healing ministry and demands redefinition of what the Church's ministry should be and what it means (Jesudasan & Rüppell 2005:7). Redefining of Church's mission, especially in the context of offering hope and compassion to suffering people, must empower people to appreciate the presence of God and his faithfulness. Thus, the Church's theological motivation must build on God who identifies with the suffering of others through love and compassion. Louw (1998:275) states: "Agape love, with its character of unconditional acceptance, priestly involvement and sacrificial service, plays a major role in making parishioners aware of God's consolation."

#### 6.4.2. Elements necessary to foster hope and compassion for people grappling illness

Van Dyk (2005:92-94), points out the role that attitude plays in the process of behavioural change and healing in her book, *HIV/AIDS Care and Counselling*. In order to change people's mindset, change must happen in cognitive structures that govern a specific behaviour. A person's norms and views determine which approach would be employed in healing and therapy. The creation of space and place are important for being human, and especially for healing therapy. The Greek word *chora* means space or place. *Chora* indicates the way human beings filled space with beliefs, norms and values in order to create a dynamic relational environment and systemic modes of interaction where language, symbols and metaphor determine the meaning and essence of life's discourse. Cilliers (2007:15) indicates that *chora* "means space or place and could also be interpreted as the attitude through which humans fill space with values, perceptions and associations, resulting in a created relational environment, a systemic and hermeneutical arena for living with meaning and dignity. *Chora* represents a nourishing and maternal receptacle, a womb that defines the quality of the places (*topoi*) where we encounter one another. Indeed it is a space we cannot exist without one another; it is where we meet in our diversity and unity, but also as perpetrators and victims". The importance of *chora* in pastoral care is that it becomes a tool for caring and nurturing. Thus, space determines the quality of place and subsequently, one's

experience of meaning and dignity from pastoral viewpoint. Louw (2008:27) indicates that “in order to be healed, we need to change the space so that we can live in a very specific place. We can do this even if that place is a hospital, a frail-care unit, or a family home.”

In theological terms, a theology of space and theology of place are by nature incarnational. On one side, it symbolises Christ’s embodied presence as an event of cosmic recreation; and on other side, it constitutes eschatological space with tension of the hopeful dynamic of already and not yet (Louw 2008:28). By essence, such a theological disposition speaks to the hurting and suffering person about Christ’s presence in the midst of suffering and positive anticipation of ultimate release from such pain. This is in essence a theology of affirmation, which is a continuation of human identity in terms of ontological salvation (the corporate reality of our new being in Christ) and our transformed status as children of God (Louw 2008:28).

Affirmation theology embraces the recent development in psychology that emphasises the positive psychology and its variant, *fortology*. This important concept of fortology focuses on therapies of constructive enforcement and purposefully moves away from pathology. Strümpfer (2006:11-36) points out the importance of fortigenesis<sup>32</sup> in adult life. Strümpfer further states that putting emphasis on strength is really to enable the patient to move away from pathogenic thinking and to visualise health as coherence, personality hardness, inner potency, stamina or learned resourcefulness (1995:83). In a theology of affirmation, fortigenesis leans more towards existential and ontological categories, and not just mere inner strength and positive behavioural changes. It is about the ontic state of being, whereby one’s very being is affirmed by eschatology. Louw (2008:32) informs that “to be a new being in Christ means to be strengthened by the *charisma* (fruit) of the Spirit in order to live life with courage and through a vivid hope. Spiritual fortigenesis and fortology refer to that kind of spiritual strength and courage that emanate from our new being in Christ.” To a great extent, the battle of illness is won or lost in the mind and attitude of an ill person. Thought patterns must be aligned to the reality of bodily condition, so that realistic expectations are made, but hope and faith is also kept for healing from infirmity. Louw (2008:23) indicates “the patients’ personal identity (quality of being functions), growth potential and faith potential are decisive in their reaction to afflictions and the quality of their health.” The inner strength and personal

relationship with Christ are important to look beyond the physical pain to deeper meaningfulness and purpose even in the midst of pain and suffering. The elements of space and positioning were alluded to previously when the Greek word *chora* was introduced. *Chora* is an empowering concept to ill or hurting persons who are enabled to express themselves in a non-threatening environment.

People who experience pain or trauma may suffer a great deal emotionally/ psychologically, spiritually and socially/ culturally (Aden & Hughes 2002:74ff). Consequently, it calls upon care givers to seriously reflect upon the best possible pastoral responses to it. Louw (2008:34) indicates that “the dynamics of space are important for care giving, because they can help the caregiver to assess his/ her own attitudes (and thus responses) within pastoral situation.” This will enable a hurting person to grow and embrace human dignity in the midst of pain and hurt. The reality is that to some respect pain and suffering are part and parcel of human reality and cannot be overcome in this world. Whatever dimension illness is viewed from, whether physical, psychological, social or cultural, it may be used as a tool that cultivates a deeper, transcendent pathway to renewal and spiritual maturity. Barnes (2007:2) observes that “it can be an opportunity for transformation that beckons the person to grow to another stage of personal awareness or into a deeper relationship with the universe, meaning, humanity or the transcendent.” The following observations must be taken seriously in the pursuit of a pastoral care approach that is geared towards the fostering of hope and comfort in the midst of trials and illness:

- To attempt healing without sustaining or even to attempt cure without caring systems, is short-term, superficial and ineffective. Louw (2000:157) warns against hope that creates cheap optimism and superficial euphoria, as such a resurrection perspective in pastorate takes the easy route out of the problem of suffering. This type of approach may leave the patient with high sense of miraculous expectations, which if it doesn't materialise may result in disillusionment.
- Healing is more than functional wholeness; it is a wholeness that comes from renewed revelation of God. The essence of wholeness is the restoration of the soul, which often transcends pain. Therefore, it is important to listen to a hurting person's beliefs and

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<sup>32</sup> Fortigenesis (fortis= strong), is about strength perspective, which shows the correlation between human wellness to positive aspect of human behaviour. The focus is on aspects of human wellness that create strength, courage, and positive approach to the demands of life.

feelings, especially how he/ she tries to make meaning out of suffering. Attentive listening, prayers and showing empathy are much needed by the sick. It is about sharing in the suffering and pain of others.

- People facing chronic illness face the prospect of death every day (Kluwer 1998:20). People grappling with illness need education about their disorders and challenges. Thus, being empowered about their conditions, about disease-related complications and possible adjustments will prepare them better for the future (Kluwer 1998:22).
- Caregivers must guard against Spiritual jargon, as people in pain do not want to hear that God has a plan with their suffering; what really matters is to come alongside them with silent presence. Louw (1998:275) indicates that false assurances such as “never mind, don’t worry, in the end everything will be okay” must be guarded against. There is a need to assist people to connect in an intimate and deep way with the Lord and to make meaning of their reality at their own pace and by God’s grace, as they relate to Christ through it all. Greshake (1980:65) indicates that “hope and victory in suffering do not necessarily mean victory out of suffering. Rather, victory sometimes has to embrace the hope of not overcoming: That is, revealing the patient and long suffering nature of hope.” Caregivers are there to render support in difficult times, and should not feel pressurised to assure people of positive outcomes or make promises to that effect. They should rather facilitate coping mechanisms for suffering people to engage their condition realistically and courageously.

In the face of emotional instability and spiritual challenges caused by illness, emphasis must be placed on biblical virtues of hope, such as “patience, perseverance, longsuffering, and self-control” (Atkinson *et al* 1995:457). These virtues advocate courageous perseverance and being long suffering in illness, as instant results are not guaranteed. Such virtues are only attainable through the promise and hope that are embodied in Christ. Atkinson *et al* (1995:457) indicate that “freedom and joy are two of the fruits of a life shaped by Christian hope. Hope binds us to the future and thus frees us in the present. And both by assuring victory and relativizing the present, hope produce true joy in our lives.”

The elaboration on the concepts of hope and compassion in the context of a pastoral approach to people suffering with illness is discussed. In fact, task four of the practical theological methodology, which deals with “how might we respond?” is also addressing the strain and

discomfort illness causes, and opens up healing possibilities for suffering people towards growth. Thus, a closer engagement with the concepts of hope and compassion and their integration to pastoral approach as a way to sustain people through their pain and suffering is needed.

#### 6.5. Towards a pastoral approach of hope and compassion

This chapter has advocated for the implementation of a pastoral care approach that is based on the foundations of hope and compassion. A discussion on hope and compassion and how these two concepts are integrated for a pastoral approach now follows.

The word compassion originates from the Latin words “*patior*” and “*cum*”, which collectively mean ‘to suffer with’ (Boyle & Smith 2004:37). Thus, the particles “com” and “passion”, each carries some significance for relating to a suffering person. “Com”- implies ‘with’, which shows solidarity and closeness to the suffering person. Connecting is not done from a distance or by coercion the care giver exercise or through submission of the client. It is only possible by being close, being together and by co-operation.

“Passion”- implies the very attributes of God, passion and love (Olthuis 2001:44). It shows who God is and how he is. In Christ (Emmanuel), he has drawn close or near the suffering humanity and has demonstrated his unconditional love, while we were still far from him because of our sinfulness. God did not flee or ignore humanity in the midst of suffering. In fact, he suffers with the creation by entering into its brokenness. Olthuis (2001:45) states that “Christ enters into our brokenness in the Word made Flesh in solidarity with our pain, and holds us fast in the Spirit’s healing love.” Thus, caregivers must reflect the mercy, compassion and the love of God to people experiencing illness. By implication, care giving is about being compassionate like God. Therefore, dealing with people in their illness is about coming alongside them and ministering to them with the spirit of *ubuntu* and suffering love. This implies that caregivers must understand the suffering of others and also to allow themselves to suffer with those suffering, and stand alongside them. Van der Ven (2003:37) indicates that compassion is not something natural to human beings. Therefore, caregivers must apply themselves to compassion in a genuine, unselfish and loving way. Compassion is a truly biblical term, which is widely used in both Old and New Testaments. The vivid illustration of God’s compassion to humankind is demonstrated by Christ’s atoning death on the cross. In this regard, the theology of the cross reveals the passion and compassion of a

suffering God (Louw 2008:441). Therefore, the obligation is for caregivers to minister the same compassion of God to people suffering with illness. As Christian caregivers, compassion must be understood and derived from biblical meaning. Louw (2008:281) thus view compassion from biblical background by stating that “compassion indicates sensitivity. It describes the virtue of unconditional love and the willingness to become involved. Part and parcel of compassion is empathy, the capacity to enter, understand and respond to another’s frame of reference.” This is also confirmed by Johnson (2001:35), when alluding that the key component of compassion is empathy; that is, to feel what the other person is feeling.

On the other hand, hope is an indispensable component of faith in times of adversity. Aden and Hughes (2002:57) argue that faith does not guarantee that everything will turn out right, occasionally it does work out. However, even when it doesn’t, faith still relies upon the presence of the living Christ in word and sacrament, for strength, joy and hope. In a broad sense, hope is a positive attitude or disposition towards the future. Atkinson *et al* (1995:455) state that “in biblical terms, hope is confident expectation in God. The first distinctive of Christian hope is its confidence, grounded in a historical judgement (regarding Jesus Christ) and personal faith experience (of God’s presence in life). The second distinctive is its object: Christian hope is placed in God- not in science, technology, evolution, progress, human nature, the nation or anything else.” Growing in hope largely depends on receiving adequate information and options to manage debilitating effects of illness. Musgrave and Bickle (2003:20) indicates the “relationships that inhibit faith development and inhibit felling of hope are those that offer no voice, no medical opportunities, and no feeling of empowerment.” In other words, beliefs that view illness as chronic and pervasive may result in loss of hope and courage. That’s why it is important not to lose hope, even in the midst of life- threatening illness. Nolan (2010:5-6) states that “for Christian there is hope. There is always hope. In the words of Paul, we hope against hope- that is to say, we remain hopeful even when there appears to be no signs of hope at all. Why? Because our hope is not based upon signs. Our hope is based upon God and God alone.” The object of Christian hope is the coming of God’s kingdom or his reign on earth, as stated in the Lord’s Prayer: “Thy kingdom come and thy will be done on earth.” However, God’s will is not arbitrary (Nolan 2010:7); he is inviting a person suffering from illness to share in his vulnerability and to draw inspiration from him who is involved in human suffering. Knowing that God is involved in one’s suffering and illness gives hope. Nolan (2010:9-10) states that “God as the one who is

suffering with us. God is to be found among the victims of injustice, those who are sinned against, the poor and the marginalised, the sick and the outcast.” In the context of illness, Christian hope seeks the will of God in the pursuit of healing.

In pursuing a pastoral approach of hope and compassion, it is important to understand the different fears and anxieties people grappling with illness face. The need is to engage various changes and challenges that illness causes as it inhibits constructive and meaningful growth and actualisation. Stoeber (2005:20) observes that “emotional and moral integration and growth are closely connected to this spiritual ideal of self- transformation. Resentment, hatred, and fear, for example, inhibit positive spiritual change. These are self- isolating modes of consciousness which restrict one’s openness to the realities conducive to spiritual change. Compassion, love, and courage promote spiritual growth and are key aspects of the ideal.” Thus, to manage illness constructively, the affected person needs to undergo mental and spiritual transition. William Bridges (2001:5) identifies a link between change and illness, as well as between transition and change. In other words, life transitions, such as developmental and reactive changes forces change to happen, which also makes one vulnerable to illness. Considering this, there is a need to develop an understanding of illness in its different stages, as reflected by changes a person experience. Sharing fears and uncertainty caused by pain and suffering may in itself be liberating and life-giving, as shared burden is easier to carry. Stoeber (2005:27) argues that “traumatic suffering is overcome through a healing which itself is a very painful process. It involves de-repression of painful feelings and openness to a power which transforms the suffering into something creative and positive. The healing makes the person feel and function better physically, emotionally, and mentally.” Ultimately, transformative experiences make pain to become a means of wellness. A person grappling with illness must be supported to go beyond his/ her block and to see significance in suffering and draw on Christian hope. Pattison and Lee (2011:737) indicate that Christian hope has a wider meaning, which is not denying the importance of cure, but it is more than cure. Christian hope is also about life beyond death. This means that whatever the treatment outcome or level of suffering, there is hope of life beyond the disease. Pattison and Lee (2011:739) state that hope is multifaceted - it has spiritual, emotional, practical and somatic dimensions to it. The multidimensional and integrated approach to hope is important for a person suffering with illness.

Pastoral counselling has the potency to help the affected person broaden his or her emotional spectrum to understand deeper level of pain and pleasure. Barnes (2007:7) indicates that “it is like being coached to flex one’s muscles, and the more one stretches a muscle the greater the range of movement that is possible. So too when companioned to delve more deeply into meaning of the pain, more one is stretched and hopefully grows through the experience of pain. Consequently the pain may have a benefit that would have previously been beyond one’s comprehension and certainty beyond one’s apprehension.” Thus, pastoral ministry of hope and compassion must resemble Christ’s example, who suffered with and mourned with the broken and downtrodden. This is important when taking into account the remarks of Olthuis (2001:45), that “compassion cannot always alleviate or even prevent suffering; the hurt of suffering and the destruction that results from evil remain very real. Rather than removing pain, compassion lets it be shared.” Hope enables a person to endure in the face of illness, as it builds on love and concern of both God and Christian community. In other words, the beauty of hope and compassion is that it comes along the hurting person in the midst of suffering and lift up such soul from loneliness and brokenness. This happens by offering love and courage to withstand the disease caused by pain and to persevere in it all. The ultimate benefit of linking suffering to spiritual integration is actualised when (Stoeber 2005:29) “those who have transformed their illnesses are able and inclined to help others. That is to say, suffering in spiritual context is closely linked to the development and unfolding of empathy.” Burdens shared in the spirit of empathy makes the wounded person experience his or her suffering in a new way. Empathy is the ability to reach out to another and to feel his or her emotions, to relate to another person intimately through sharing of their thoughts and feelings. Stoeber (2005:29) indicates that “empathy is feeling-along-with others, while compassion is a feeling along- with the suffering of others through framework of love. Genuine compassion involves an affectionate sharing of the suffering of another person, whereby the sufferer might feel the support and receive it in this interchange of love.”

There seems to be a level of choice involved in the way a person deals with the issue of impending illness in his/ her life. The greatest desire of any hurting person is to get well soon, yet some people seem to discover the power of choice to view the transformative nature of their illness. This is only possible when a person grappling with illness receives compassionate care and emphatic love. To transform illness into choice has direct relation to spirituality. Tu (2006:1029) argues that “spirituality is an innate aspect of being human, and

every patient has the potential for spiritual growth through suffering from illness.” Delgado (2007:230) defines spirituality as a “quality of the person derived from the social and cultural environment that involves faith, a search for meaning, a sense of connections with others, and transcendence of self, resulting in a sense of inner peace and wellbeing.” The significance of illness is when transformative experience of illness is viewed as a blessing and struggles and discomfort of illness as (Puchalski 2006:364) “magical threads that weave our lives into wholeness.” The ultimate desire is for hurting person to discover sense of joy even in the midst of illness. This joy is deeper than happiness, and is possible by the resurrection power of Christ (Aden & Hughes 2002:51). Hope and compassionate suffering empower and revive a human spirit from crippling pain, gross abuse and destructive environment. Chi (2007:416) alludes that “hope is a profound feature of human life and allows the living to keep on living and the dying to die more easily and with dignity.” In order to create an atmosphere of hope and compassion, it is important to:

- Firstly, understand the experiential dimensions as perceived and experienced by person facing illness. Aden and Hughes (2002:74-75) state that “experiential side of illness, in what illness means to the person who has it. After all, it is the person’s reaction to, or experience of illness, that is of primary concern.” These dimensions of illness, such as the perceived causes and reasons for illness and emotional responses such as discomfort, sense of loss, grief, anger etc, were discussed in chapters 3-5.
- Secondly, determine the stage or the phase the person is in emotionally, spiritually, socially and economically to be of better assistance. Whitney *et al* (2008:444) observes that “after receiving bad news, the patient enters a turbulent period of attempted accommodation to dramatically changed life circumstances. This period may end in denial, in anger, or in acceptance. The patient who reaches acceptance has integrated the illness and the limitations it imposes by establishing new priorities and finding a renewed sense of purpose. This process is usually a challenge that requires personal growth on the part of the patient, perhaps assisted by family, friends, spiritual advisors and the physician.” The person will only open up when confidence is built and he or she can trust and know that the caregiver is genuinely and passionately concerned. It is about earning the right to counsel and guide the person and just by being available (approachable) for the person. Musgrave and Bickle (2003:18) indicate that “as partner in healing, one needs to understand the unique feelings of the individual who is experiencing illness, and discern the role- whether

supportive or non- supportive- that each of the individual's system is playing. It takes very little to be supportive: perhaps just a simple word, a simple action, or a minute of listening.”

- Thirdly, address the issues or concerns the person grapples with, such as anxiety, fear, care of family while being ill, uncertainty about future, questions about dying and about eternal life, questions about God and assurance of faith. People suffering with illness need to tell their stories of illness in order to mend their broken relationships. Musgrave and Bickle (2003:18) remark that “when people tell their stories, as the illness evolves, they begin to make illness part of their lives. The families, visitors, and those closest to the ill person are in the unique position of allowing these stories to be told.”
- Fourthly, a safe space must be created for hope and compassion to be nurtured for people who suffer with ongoing illness. Thesnaar (n.d:269-272) remarks that this space is not confined to a church service or a prayer meeting. This space must be created on all levels of ministry within the congregation: In the liturgy in a Sunday service where people in need for healing can experience the therapeutic value of the Holy Communion; through preaching of the word in a church service; in small group where believers meet, or in the office of the congregational leader. The goal of pastoral care is to link believers by means of Scripture to God's fulfilled promises (promissiotherapy) in order to accept their suffering as a challenge to demonstrate their faith. The distress of suffering becomes an opportunity to live God's victory and to demonstrate faith, hope, love and joy (Louw 2008: 103ff).

Taking the needs of people suffering with illness seriously in the pursuit of fostering hope and compassion is also acknowledged by health practitioners. For example, the oncologists Buckley and Herth (2004) have investigated what hope means to patients in the final stages of living with cancer and how they maintain and foster hope and employ strategies for survival. The sixteen terminally ill patients indicated that they have been hopeful despite nearness of death. The following seven strategies were identified as fostering hope: Love, family and friends, spirituality or having faith, setting goals and maintaining independence, positive relationships with professional caregivers, humour, personal characteristics and uplifting memories. The investigation has also identified three hope-hindering categories, namely: Abandonment and isolation, uncontrollable pain and discomfort and devaluation of

personhood. To assist patients in maintaining and fostering hope, the behaviour of professional caregivers according to Chi (2007: 422), must be “such as showing warmth and genuineness, being friendly and polite, and using thoughtful gestures, as these could significantly increase patients’ hope.” The caring presence of caregivers is also confirmed by Whitney *et al* (2008: 445) as “when the physician forms an emphatic emotional connection with the patient, it conveys an unspoken but important message of caring; the physician’s steady presence is an almost physical shelter in the emotional storm that often accompanies impending death.”

Therefore, it is imperative to value people as human beings and to grant them the necessary respect and acknowledgement in their illness. The basic needs of love, affirmation and self-esteem are integral to all humankind and should also be offered to people during times of illness. This will only be possible as people’s experiences of illness and pain are dealt with in a dignified way that enhance their humanity as caregivers welcome people grappling with illness into their space as fellow sharers of pain and suffering.

Therefore, the pastoral healer must listen deeply to the sighs and groans of a person grappling with illness. Lartey (2003:63) states that “the healer listens for, and is sensitive and open to, the transcendent in whatever form or shape, knowing that transcendence mediates love, support and help. The healers seek that their presence, words and activities become channels through which love, support and help immanent in transcendence is mediated.” The ultimate goal is to enable people to find healing and regain meaning through values of hope and compassion. To confirm this, Louw (2004) states “where two or more people encounter one another within a spirit of availability, acceptance (unconditional love) and appreciative awareness, a space of intimacy occurs. This is the kind of space, which human beings need to be healed and to grow to maturity. Within this space human dignity is safeguarded and fostered. The occurrence of space (intimacy) can be called the sacred space of encounter and the soulfulness of embracement. Within the space of intimacy (belongingness), meaning is discovered.”

The chapter as a whole has addressed the task four question that climax with the envisaged pastoral care approach. However, the pastoral approach still needs to be refined by developing specific and relevant supporting programmes for people to face the reality of illness through spiritual and moral tools. For any pastoral approach of hope and compassion

to be meaningful, it should seriously engage with the cultural milieu and African cosmology. The fact that research outcomes demonstrated the need for supporting structures that builds on teaching, equipping and counselling were important features for pastoral approach. In order to be contextual and applicable to the Namibian context, both the cultural dynamics and lessons learnt from the empirical research should be integrated in response to minister to suffering and hurting people. These are indispensable for designing programmes and action plans that will contribute to pastoral care approach of hope and compassion.

## 6.6. Conclusion

Richard Osmer's task four on "how might we respond?" has implied that there are certain things to do in order to enable a person struggling with ongoing illness to some functionality and effectiveness. The main responds to the question "how might we respond?" was to engage this chapter in its pursuit of a pastoral approach of hope and compassion that will benefit people grappling with illness in significant ways.

The fact that illness and health are central to African productive living and how African people respond to regain health has been discussed in chapters 2-4. The fact was also laboured that African healing seekers make use of various healing services (Magezi & Keya 2013:1). This is truer as people become desperate in their search for healing. Gwele (2004:50) indicates that "some go to traditional healers, some to faith healers, some to doctors and some to untrained private doctors to seek healing solutions." The plurality of healing options is not exclusively used, but many people mix health services. Gwele (2005:51) states that "people mix health systems, by seeking Western medicine first when they are sick, and when that fails they adopt another strategy, either together with or to the exclusion of biomedicine." The non- conventional healing practices, such as traditional doctors and spiritual healers are widely consulted in Africa. The faith healing is a vibrant practice among most African communities in Sub-Saharan Africa for its attraction as an alternative response to plight of poverty, diseases and illness Africans daily face. The fact that it speaks to the religious and cultural experience of African spirituality is a further endorsement of this practices in African continent which by far is religious with a rate of fast growing Christianity.

The problem with the modern healing ministry is that it is deprived of the congregational setting. Slowly, the role of an ordinary believer and the local church diminish. The elders are no longer called in to minister; people now attend tent meetings where an evangelist preaches and prays for healing (Land 1999:57). This is as a result of the influence of printed and visual media, especially television, thus the role of the local church is not appreciated enough and not developed according to biblical principles (Theron 1999:57). The nature of healing ministry is observed by Brown (1995: 244) as that “modern proponents of divine healing have often sensationalized and commercialized the ‘ministry’ of healing of the sick, and some have been outright charlatans. Public demonstrations of compassion and understanding have often been sadly lacking, and there has frequently been a corresponding lack of biblical exegesis.” There is a need to engage in serious discourse on the nature of healing practices in the faith healing movement. König (in de Villiers 1986: 88) indicates what he calls as ‘hard’ and ‘soft healings’ of today’s healing practice. He differentiated between these concepts by saying that ‘hard healings’ deal with visible and obvious cases of illnesses, such as a deformed person, a paralytic or mutilation of body part. These cases are empirically verifiable. In contrast, he also indicated that ‘soft healings’ deal with invisible, internal illnesses, such as cancer, headache, person with one shorter leg. These are difficult situations to verify objectively (König in de Villiers 1986:89). If faith healing is only dealing within the scope of what is called as ‘soft healings’, then faith healers do not really give solutions to real hard issues of human need and suffering.

Healing practices influence people dramatically, it builds the faith of those who attend these practices. The question of what happened to those who are not instantaneously healed however is left in vacuum (Theron 1999:57). Healing practice must still form an integral part for those seeking healing from faith healers; however such practices must be augmented through support structures at congregation level. Faith healing practice makes little effort to counsel and guide people through their illnesses and this creates a gap between healing prayers and pastoral care to people coming for healing practices. In the light of shortcomings of faith healing practice, pastoral care intervention to people grappling with ongoing illness is crucial. The pastoral care and counselling is at the heart of any ministry that reaches people facing illness or those in some sort of hurt, pain or trauma.

The need for pastoral approach that will seriously engage the human beings in a holistic manner is warranted. For this to happen, a pastoral approach should be developed that blend all the relevant areas into unison, namely the spiritual, social, emotional and economic so that healing attempt is not only based on one dimension. There is a need for such a pastoral approach that addresses peoples' needs in entirety, as this is the best way to respond to people who need healing through multi-faceted approach (Goodliff 1998:176-177). The pastoral approach that is based on hope and compassion is a dynamic intervention for people grappling with illness: It empowers hurting people to share in the compassionate love of God as it is resembled by care giver by referring comfort and guidance in practical ways. Christian hope is introduced to a person grappling with illness as a means to look beyond the present challenges of illness to eschatological and transcendental aspects of hope. Therefore, hope becomes a means to trust and have confidence that somehow some good will come through this trial of illness.

Thus, an integrated pastoral approach must bring together psychological and theological concepts into a specifically Christian methodology (Goodliff 1998:176). Such a complementary approach according to Atkinson and Bridger (1994:50), involves "a kind of critical perspectivalism in which no discipline is allowed hegemony or totality of explanation but in which all disciplines subject them to mutual criticism."

This chapter has discussed the theory of pastoral care and highlighted the pastoral care approach, based on hope and compassion for people suffering with ongoing illness. The final chapter of the study discusses the research findings and outcomes in relation to literature study to make conclusions and recommendations.

## Chapter 7 Research Outcomes, Conclusions and Recommendations

### 7.1. Introduction

The study has argued for a pastoral care approach of hope and compassion that aims to set up specific targets and design programmes responsive to the need of people grappling with illness. This is made possible by the engagement of the literature study and empirical research, as it consummate in a pastoral approach. The pastoral approach is introduced as a responsive intervention for people who have undergone faith healing practice but were not evidently healed.

This chapter serves as the culmination of the study by discussing poignant issues and findings and consequently reviewing outcomes, drawing conclusions and making recommendations. The study was drawn from two basic sources, namely literature research and field work interviews conducted in the city of Windhoek. The outcomes of empirical research are based on appendix F, which reflects the field research interviews and engages the processes of data coding, transcription and data analysis. The hypotheses and research goals were confirmed in most areas, but in some cases were also not wholly maintained by respondents.

The chapter outline will first indicate the research hypotheses and research goals as set out in Chapter 1 with the view to discuss and analyse whether they were achieved through the study.

Thereafter, outcomes will be discussed, conclusions drawn, and recommendations made.

Finally, themes and tendencies noted through the study will be highlighted and proposed for further study. As indicated before, the chapter revolves around research hypotheses and research goals, which were used to assess the findings and results. The following research hypotheses were stated for the research study:

- That promises of healing made by faith healers to people suffering from illnesses create high expectations, which may lead to a faith crisis and emotional instability when healing doesn't materialise.
- That when people are not healed they experience bitterness, pain and hurt that affects their emotional state and Christian effectiveness.

- That faith healers mainly deal with what can be called as psychosomatic illnesses when making claims for healing, and that these conditions are best treatable by pastoral care and counselling, other than faith prayers alone.

The setting of goals enables the researcher to be focussed and to work towards measurable outcomes. Goals are in correlation with the research hypotheses of the study. Thus, the research hypotheses were supported by following goals:

- To assess some of the main contributors to illnesses in Africa, namely poverty, unemployment and HIV and AIDS, and how these relate to faith healing practice.
- To assess what the impact of healing practice is on the spiritual and emotional state of healing seekers.
- To work towards an integrated pastoral approach of hope and compassion that deals with the challenges of living with ongoing illness, despite undergoing faith healing practices.

The research hypotheses and goals are discussed to ascertain the extent to which they were achieved or in cases they were not, what implications and lessons it has for the study. Both the research hypotheses and research goals are interpreted against the contributions of Chapters 2 to 6 and empirical research outcomes as indicated in appendix F.

## 7.2. The research hypotheses:

Each research hypothesis is discussed in relation to goals and objectives that were anticipated. An analysis is given on each hypothesis and corresponding goals to indicate if they were achieved and whether they were achieved based on the outcomes or otherwise.

### 7.2.1. Spiritual and emotional impact of faith healing

- The hypothesis that faith healers promise healing for every illness creates high expectations, which result in emotional and spiritual instability when healing doesn't happen.
- The second hypothesis on emotional and spiritual impact further stated that indiscreet use of healing methods cause pain, hurt and bitterness.

These hypotheses were key directives that warranted the research investigation as the researcher has a genuine concern for what may be called the “aftermath of faith healing practice.” This was not aimed at discrediting faith healing practice, but rather an emphatic plea for what was believed to be a neglected area in faith healing practice. The challenge within faith healing practice is the lack of reflection on “what happen to people who are not healed after promises of healing were made to them?” The loneliness and desperation that may result when faith healing practice doesn’t manifest in healing were not seriously engaged with on spiritual and emotional levels by those practicing faith healing. The hypotheses address real concerns and were therefore relevant and applicable within a context of the very popular practice of faith healing among African populace. These hypotheses and the research goal assessing the spiritual and emotional impact of healing prayers have brought out the following outcomes:

- ❖ The hypothesis that deals with the impact of faith healing on the spirituality of healing seekers who grapple with illnesses despite healing prayers has demonstrated that African spirituality is central to African cosmology; it defines the essence of African life and experiences. The respondents did not reflect any syncretism or link their spirituality to ancestors or to any African symbol to express their spirituality. Notwithstanding this, there was a strong conviction of simple, evangelical faith that takes God’s word on the face value of it. This is typical to the vibrancy of African Church with charismatic preaching, lively church services and strong emphasis on evangelism, although Christian maturity and discipleship is not grounded as could be. The interviewees had recognition for the role of evil spirits and viewed the origin of illness as demonic and motivated by Satan. In general, most respondents did not tolerate being ill, as they believe that the death of Christ has atoned for all sicknesses and that healing was attainable through faith in Christ. As illness attacks the core of human existence and human dignity, spirituality is used to emancipate human worth and identity and to ensure hope in the midst of illness and suffering. During the interviews the respondents have generally shown a positive spiritual attitude and sought deeper meaning and purpose in their suffering. The attributes of God, especially his compassion, love and his faithfulness, were viewed as strong elements by the respondents as they grapple with illness and in their pursuit of healing. Mostly, the respondents had questions of “why”, which showed that they struggled with issues

of doubt and uncertainty. Nevertheless, the majority of respondents maintain positive faith in the Lord and believe that they will be healed in God's own time. They perceived healing to be a mystery of God that cannot be predicted, as it happens when and how God wills. Therefore, the hypothesis that stated that the faith healing prayers have a negative spiritual impact on people that are not healed was not completely accurate.

- ❖ The hypothesis has further stated that there are adverse emotional effects as a result of unmet promises of healing and also that indiscreet practices faith healing may lead to emotional pain and hurt. The spiral effects of psychological hurt, sometimes accompanied by bitterness, unforgiveness and hatred have also been highlighted through the literature study and possible negative affects to a person's bodily health demonstrated. Therefore, the potential harm caused by psychological instability cannot be undermined in any way. The struggles to cope with negative emotional responses and attitude due to prolong illnesses were observable in many interviewees. This is somehow expected when considering the high expectations ill persons have to be healed, because of promises of healing made by faith healers that are not materialised. This ultimately left people vulnerable and few interviewees have expressed that they were despondent and disillusioned as a result of persistent illness. Although only a few respondents experienced serious doubt and uncertainty that caused them emotional instability that may have threatened their normal functioning, the research results have nevertheless demonstrated that ongoing illness causes emotional turbulence in any person. There were eight (8) responses made about experiencing bitterness and sense of disappointment for not being healed after trusting for healing. Although, these people did not question God or became agnostic, they felt let down and confused, as they are faithfully serving the Lord and genuinely believing in healing, which does not happen. Kalu (2008:265) indicates that when people are not healed, they experience relapse and issues of spiritual and credibility crisis follow. People do respond to trauma caused by illness in various ways, however, and some people are able to handle traumatic events with a certain degree of maturity and level-headedness, in contrast to others, who may easily have an emotional breakdown. It is therefore important to understand the different emotional stages a person suffering from illness may experience, as this will determine the type of help needed for

effective ministry. The faith healing approach that is primarily based on prayers is therefore missing an opportunity to respond to ill person's need in a holistic way. These observations are crucial for the nature of healing ministry that will effectively address the plight of ill persons. The hypothesis dealing with emotional instability that result from unmet expectations and unfulfilled promises of healing has some justifiable ground. The interviewees have indicated that most of them were not emotionally devastated, and this could be attributed to the fact that although they did not experience instant healing, they were still hopeful that healing will manifest as they prevail in faith. This corresponds to faith healing doctrine of receiving (accepting) healing by faith, even if the evidence is not yet visible, until such time manifestation (actual healing) happens (MacGregor 2007:88-113). However, the reality is that physical healing may not manifest as hoped for at all. McCullough observes (1995:16) that "some benefits of prayer may materialise only after life has become considerably worse than it was before praying." The person may remain chronically sick, yet consider that their life has indeed changed for better (Aldridge 2000:152).

#### 7.2.2. Psychosomatic diseases and faith healing

- The hypothesis states that faith healers mainly claim healings for illnesses in the category of psychosomatic diseases, and that these conditions are best treatable by counselling interventions, rather than prayer alone focus.

Psychosomatic diseases are difficult to verify medically and thus, there is no common understanding about them within Western science. This hypothesis is not easy to deal with and during the interviews, the researcher had to seek for connections that relates to this hypothesis. Most illnesses the interviewees suffered from had clear medical conditions; however, there were a few cases, such as a person that suffers from ulcers, who indicated that this was more a psychological battle. There were also six cases related to witchcraft. These cases together were approximately 28% of interviewees. The illnesses connected to mind-body interrelatedness, such as schizophrenia, are common in African societies and are deemed as evil possessions that are treated by African doctors. Psychosomatic diseases are in many ways similar to what is known as African diseases believed to be caused by witchcraft,

sorcery and magic, and for which Western medicine has no remedy. The fact that psychosomatic diseases relate to African epistemological realities and worldview gives some significance to this hypothesis.

The literature study has pointed out that illness is not necessarily caused by sin or the wrongdoing of an ill person, as there are multiple factors ranging from spiritual, psychological, cultural to social related to illness. The literature study has further revealed that not all illness or sufferings are destructive by nature. At times, suffering could be transformative, as it leads to character building and spiritual formation.

The field research did not clearly support this hypothesis, which states that the healings faith healers claim are mainly in psychosomatic sphere. Although the literature study demonstrated the link between psychosomatic diseases and certain African conditions, these were not reflected in the empirical research. However, witchcraft was mentioned as a way people experienced bodily dysfunction, hallucinations and unexplained manifestations that were difficult to treat medically, except through prayers and faith. The complications of psychosomatic diseases some people suffer with and how to relate this to faith healing practice is quite tricky, especially when considering the role of the placebo effect on such conditions.

As demonstrated in the study, the placebo effect has some role to play with what may be considered as “fake” healing experiences. This is documented by the medical field and also demonstrated in the study. The same effect is possible during healing services that people may experience “healing” with the excitement of the moment and even testify to that, but later discover that they still have the same symptoms or illness condition. Many respondents have testified to this during the interviews.

The hypotheses were supported by the research goals and therefore a need to assess whether the set out goals were achieved through the study. Hence, the following focus area gives a critical analysis of the research goals.

### 7.3. Research Goals

The goals were set out in Chapter 1 and are also stated at the beginning of this chapter. The goal that assesses the impact of healing practice on the spiritual and emotional state of healing seekers was sufficiently covered in the previous section dealing with the research hypotheses. Hence, the remaining two goals are discussed and indications made on whether the research outcomes were achieved or not and possible reasons for that:

#### 7.3.1. Contributors to illness in Africa

- The first goal was to assess the main contributors to illness in Africa, namely poverty, unemployment and HIV/ AIDS and how they relate to faith healing.

The study has defined poverty as part of illness, as it causes vulnerability in endangering an individual's productivity and life expectancy. It has dire consequences when coupled with unemployment and HIV and AIDS. These are major challenges people in Southern Africa face and which were also representative of respondents interviewed in Windhoek. The research has found that there was a direct correlation between poverty and diseases in Africa. The poorest of the poor are more prone to illnesses and even death, as they are at life risk from treatable and preventable diseases. HIV and AIDS is still a devastating pandemic that impinges on the vitality and productivity of vital African force. The majority of the target group came from townships of Katutura in Windhoek. This is a township that was built for Black people in the early 1960s, as people were forced to live in racial segregated locations. It is a low income area with high levels of unemployment, high social evils and some areas with very limited amenities. In fact, six unemployed people were from Katutura and most people interviewed will be categorised as poor. Katutura is also where most of the churches are concentrated, but also having a high prevalence rate of HIV and AIDS and other diseases. It was therefore not surprising that the majority of respondents suffering from illnesses were drawn from this township. This hypothesis was validated by the literature study that reflected on the high socio-economic disparities and poverty strickeness of the majority of the African population, as well as representation of interviews that were mostly from the low income group.

### 7.3.2. Supporting structures or pastoral framework

- The second goal was to ascertain whether there is a need for supporting mechanisms or intervention models for ill people.

The lack of holistic emphasis and counselling structures were highlighted as issues of concern with faith healing practice. Professor Jacques Theron (1999:57) indicates that “all is well and there is much rejoicing when people are touch in an instant. However, it can be asked whether all Pentecostal pastors and churches know how to apply their theory of both salvation and healing based in the same way on the same verse when care is needed for those who suffer over a prolonged period of time and to those who are not being healed at all”. The lack of supporting systems was identified within the faith healing practice. The effects of illness on spiritual, psychological, social and emotional levels mandated that faith healing that only concentrates on praying is falling dismally short to effectively respond to the needs of ill persons, which is far beyond merely physical wellness. The literature study and the empirical research have both identified the need for the formation of an integrated pastoral care and counselling approach for people grappling with illness. This pastoral approach need to build on the concepts of hope and compassion as basic elements that will empower and sustain people during their illness, whether they recover or succumb to their illness. The fact that hope and compassion enable a person suffering with illness to identify with compassionate and suffering love of God and have confident trust in God is a source of inspiration and courage. The lack or the weakness of faith healing churches to counsel, guide and nurture people with ongoing illnesses were outlined by respondents as the main drawback of this noble task of the healing practice. The conclusion was that prayers alone without follow-up and support programmes are an undesirable and irresponsible healing intervention. The tendency of faith healing practitioners to only concentrate on healing prayers without supporting resources is not doing justice to the quest of people grappling with illness.

Hence, Chapter 6 has created the necessary structure and basis for establishing a pastoral care approach of hope and compassion. The study is a reflection of the daily realities many African people face as they grapple with the harsh realities of poverty and diseases. The study did not paint a grim story of defeat and hopelessness, but rather a testimony of the African spirit that thrives in the midst of adverse conditions of poverty and illness.

#### 7.4. Conclusions

The conclusions are preceded by an introductory summary that reflects on the role of African cosmology and socio-economic realities in Africa and how these factors relate to impact of faith healing practice in African context.

##### 7.4.1. Introduction

The study has employed the practical theological methodology based on Richard Osmer's model with four tasks guided by four questions, namely: "What is going on?" "Why is this going on?" "What ought to be going on?" and "How might we respond?" This approach has enabled the study to develop from theoretical framework to practical application. The first task deals with the revealing question of "what is going on?" and this was dealt with in Chapters 2 and 3. The response to this question starts with African epistemology and its relation to issues of illness and health. This approach has suggested that an African perspective and motivation will be the underlying perspective to the study. This was not an easy task, especially in the Namibian context, which is still a small democracy (since March 1990), that came through centuries of colonialism and about fifty years of apartheid. These repressive systems have not only dehumanised ethnic people, but have also impacted on the traditions and cultures of the Namibian people. Therefore, it was a challenge to conduct a study from an African perspective in a nation that is only twenty two years into democracy and still trying to regain the lost ground, both economically and culturally.

Africa is a continent of extremes, with massive natural wealth but extreme poverty, warm-hearted people but ravaged by conflicts and wars, a continent with a young population, meant to be a vital and productive force, yet crippled by all kinds of diseases and a high HIV and AIDS prevalence (Koopman 2007:20). The literature study has illustrated the widespread effects of poverty and diseases that stretch far beyond the physical and physiological components of human existence to spiritual, cultural, economic and psychological dimensions.

The dynamic and fast growth of faith healing churches in African continent is attributed to many factors, but the main reasons were identified as their zeal for evangelism and emphasis on healing. Healing was found to be an attractive force to Africans for two main reasons:

Firstly, that the African worldview and cosmology is based on spirituality and mysticism and the understanding of the indispensable link between the spiritual and physical worlds, and the view that there is a constant contestation between evil and good spirits for the souls of an individual. Faith healers emphasise the power of God and the lordship of Jesus Christ over all forces, including evil, witchcraft and diseases. This kind of gospel is attractive to Africans, as it emphasises the supremacy and reign of God over the very things (diseases, evil spirits, poverty etc) that threaten life and productivity of African communities.

Secondly, faith healing practice seemed to be an alternative option of dealing with illness and pain, especially for poor people who cannot afford expensive medical treatment. More than this, desperation and pain will drive a person to receive intervention and help from wherever and at whatever cost.

The conclusions drawn from the study were discussed throughout the chapters, with special reference to the outcomes of empirical research as indicated in appendix F. The conclusion is divided into five key areas and discussed as follows:

#### 7.4.2. Conclusions on spirituality and illness/ health issues

The study has clearly illustrated that Africans have a high spirituality and religious allegiance. This fact is confirmed by Professor M.A. Masoga (2001:169), in the following words; “for an African, religion is not just a set of beliefs, but a way of life, the basis of culture, identity and moral values.” Christianity is growing at an alarming rate through vigorous evangelism efforts, however, the embodiment of a Christian ethos and morality within African societies is a farfetched dream. The obsession with the supernatural is embodied within the African culture and cosmology, which has a strong spiritual basis. The awareness of supernatural realities and influences of forces beyond human control are integrally maintained by African epistemology. Illness and misfortune are undesirable realities that need to be avoided through ritual sacrifices and the appeasement of ancestors and divine beings. Mpolo (1994:24) observes that destructive forces, which are at work and

causing misfortune, illness and barrenness, need to be overcome through the intervention of good spirits and mediums. Illness disturbs the equilibrium of harmony and wellness in the community. It is understood that misfortune befalls a person when the ancestors are not pleased, or as a result of the sin of an individual or the corporate sin of a community. Therefore, the indication through the study is that in a traditional African setting, there is a need to offer sacrifices and rituals to appease ancestors, and by so doing to restore relationships for good fortune and health.

As stated before, the African worldview is a nurturing ground for the healing ministry in Africa. The healing practices are engrossed in African spirituality and African religious experiences and therefore thrive on African believers' spirit of tenacity and hope, even in the midst of debilitating effects of illness. The ministry of healing is undoubtedly a powerful tool used by Africa Independent Churches and by Pentecostals to make inroads into African communities. The concern of the study was in particular on how this dynamic process of faith healing could become counterproductive to the total wellbeing of an ill person that desperately needs healing.

#### 7.4.3. Conclusions on impact of faith healing practice

The important contribution that came from the literature and empirical research on this question is the fact that illness affects various facets of human existence. It cannot therefore be treated with a single strategy that only concentrates on healing prayers, as much as this is important. The research hypothesis has suggested that many genuine and sincere Christians come to faith healers to receive promised healing from their illnesses, but when unhealed left disillusioned, emotionally and psychologically drained, and some even develop a crisis of their faith. Theron (1999:57) argues that such people may suffer silently and thus develop bitterness and resentment towards God and the faith healers. The research has validated this outcome, however in a modified way, as many people, contrary to the hypothesis, remain positive and strong in their faith, although feelings of disillusionment and disappointment were present. The indication from the study is that the plight of people suffering with illness need to be taken seriously and fears, anxieties and pressures that come with illness also catered for in healing interventions. There is need to make time to hear and listen to people and not just come with an already made recipe of an 'one size fits it all' approach.

Although most respondents attest to being disappointed and sometimes becoming disillusioned, most of them did not harbour bitterness towards God or to faith healers. The point was demonstrated that illness do not estrange people totally from God; they may go through a time of loneliness and isolation, but in the midst of confusion they still maintain hope and faith in God and his love. There were very few respondents that alluded to the possibility that some people may suffer in silence when not healed, because of fear of victimisation by healers or fear to be labelled as lacking faith. The study has indicated that praying doesn't automatically guarantee anticipated results; there are various factors involved in the healing process, which sometimes has to do with behaviour choices, personal responsibilities, and the purpose of God with human suffering. The sovereignty of God and place of faith healing had made some important observations in the study, hence the consideration as a way of conclusion.

#### 7.4.4. Conclusions on sovereignty of God and faith healing

The other important issue that has been considered is the sovereignty of God in the question of healing. God is in control of his people and is compassionate and sympathetic with human suffering. He is not subject to human will or desires, however, but act in a way best for his people and that ultimately bring glory to his name. As human beings, we must believe and pray for the healing of a sick person, yet leave room for God's sovereign working and his will to unfold over the person. God has many ways to answer prayers: Sometimes he may say yes, other times he may say to wait, or even no. The reality for some people is that they may not recover completely from their illness in this life, but they still need to be healed emotionally and spiritually to have meaningful and productive lives.

Faith healing practice has made real inroads into Africa societies, but the challenge has always been in the area of indigenisation. This is especially true of majority of Pentecostal and Charismatic healing practitioners, who make little effort to practice enculturation.

#### 7.4.5. Conclusions on inculturation and faith healing

The faith healing practitioners do not take any trouble to engage with the cultural dynamics of the people they prayed for. The fact that faith healers merely deal with healing from spiritual perspective, is a limitation in itself. This could be as a result of ignorance of cultural

significance for meaningful ministry or merely pure arrogance. The Evangelicals in general and faith healing practitioners in particular, need to seriously review their evangelism methodologies, which are mainly aimed at "soul saving" and consequently misses real opportunities to address Africans and their plight in a total and holistic manner. The tendency of the Evangelical Church to emphasise only the invisible aspects of the gospel, the salvation of the soul, and to exclude the visible elements, such as working for justice, demonstrating love, and exercising the power of God including healing ministry, has truly impoverished the Church (Le Roux 2011:86-89). There is a real need for a broad view that embraces all godly means, both supernatural and natural, in order to relieve the terrible suffering and pain caused by illness, epidemic, and disease in humankind. In the final analysis, the question of faith healing and how this relates to the sovereignty of God is central to how an ill person responds to emotions and feelings of disappointment when the desired healing outcome is unattainable was examined. The major shortcoming of faith healing practices was identified as lacking the resources to sustain people during their illness.

#### 7.4.6. Conclusions on supporting services

It has become evident that many faith healing churches do not have supporting structures and resources to assist people who come for prayers of healing. The faith healers mainly pray after some exhortation and leave people to their own fate thereafter. There is a need to have systems that take people through a process of equipping, teaching, encouragement, caring and counselling. The function of such services were expressed to deal with the many questions, uncertainties and doubt ill persons grapple with as they face the reality of their illness.

The key focus areas of the research has emphasised the same considerations and outcomes throughout the study. The conclusion of the research is that healing is to be broad and inclusive, which suggests wholeness or the *shalom* of God. *Shalom* is understood to be more than just being well; it speaks of God's peace in the midst of turbulence, illness or suffering. In that sense, persons grappling with illness are to be ministered to in ways that respond to their spiritual, physical, social and cultural needs. Therefore, the study has argued that healing is a broad concept that should embrace physical, emotional and spiritual dimensions (Thomas 1983:9). After considering the outcomes and conclusions, the following recommendations are made to enhance the quality of the research.

### 7.5. Recommendations

The research was based on the empirical observation of healing practice happening within Pentecostal churches in Namibia, and the influence faith healers exercise over the healing seeking individuals. The study has endeavoured to highlight the spiritual and emotional impact of faith healing practice on healing seekers, especially when desired healing does not materialise. This was done by investigating their perceived plight and responding with some strategies that will emancipate their dignity and enable productivity. Thus, the following are the recommendations of this study:

- It is recommended that an integrated pastoral care approach be implemented.

Research has revealed that churches practicing faith healing do not necessarily have such structures to assist ill persons. This pastoral care approach of hope and compassion will take cognisance of physical challenges, spiritual and emotional realities, as well as the social dynamics illness brought about.

- It is recommended that a pastoral approach based on strong cultural components and that is contextually relevant to Namibian situation be implemented.

The cultural and social backgrounds will contribute towards a responsive but all-inclusive pastoral care strategy for ill and hurting people. There is still a need to do further studies around the anthropological and religious undertones of Namibian Christianity to develop a unique and culturally relevant strategy that is based on the principles of love, hope, compassion and care. There must be a clear understanding of why certain ritual symbols are used within a given cultural milieu for effective counselling (Berinyuu 1989:12). Engaging African (Namibian) cosmologies in pursuit of culturally relevant interpretations will be boosted by the integration of Western concepts of psychotherapy. In fact, as Africa is a highly spiritual continent, where people believe that the ancestors influence the living, many Africans also believe in evil and witchcraft (Berinyuu 1989:13). All of these factors suggest that a pastoral care approach that sufficiently responds to the African context must include psychotherapy and an African spirituality with strong cultural and anthropological undertones. Berinyuu (1989:10-11) agrees with such an integration by advocating for deeply

rooted African therapeutic practices that critically dialogue and integrate Western forms of healing. After highlighting the recommendations, the researcher would like to suggest the following themes in consideration for further study.

#### 7.6. Further study consideration

Through literature study, the insufficiency of materials written on Namibian culture and worldview came to the fore. This is a serious shortfall, as it negatively affects credible research dealing with enculturation or indigenisation in the Namibian context. In fact, defining Namibian culture is not an easy task in a multi-national society with White, Coloured and Black nationals. Hence, the following considerations were made as further study possibilities:

- A comprehensive study of Namibian culture and anthropology is a prerequisite to establish a holistic and integrated pastoral approach, conversant and relevant to Namibian reality.

The need to have a broader understanding of various Namibian cultures and anthropology is indispensable to contribute towards a unique and culturally responsive pastoral support system. In order to achieve this, there is a need to do further studies in anthropology and Namibian culture. There are increasingly new theories and models developing, therefore updated and recent theories of psychotherapy and pastoral care must be considered for academic relevance.

- There is a need for further studies on integrated research dealing with psychosomatic diseases and African diseases from theological and medical perspectives.

This kind of research will undoubtedly add value to bridging the gap between cultural perspectives on illness and African health systems, and the medical interpretations and treatment of psychosomatic diseases, with special effort to relate this to African experiences.

- The relevance of African cultures in the modern world of globalisation is an important theme for further study.

It becomes more and more difficult to define what African culture and practices still need to be maintained in the modern era. The traditional African worldview and customs, some of which were discussed in Chapter 2, are not widely practiced in most Christian African homes, especially in the Namibian context. As already stated, the long colonial era and recent apartheid system has led to a great deal of suffering of Namibian cultures and coupled with this, is the fact that human beings are dynamic and evolving beings. This leaves the question on whether Africa needs to revert back to the past, which was by and large pre-Christian, or whether Africans should only emphasise the elements of the communal spirit of *ubuntu* and develop this further? The real question is what Africa culturally has to offer to the world in the context of globalisation?

## 8. References

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## 9. Appendices: A-F

### Appendix A: Request letter to pastors in Windhoek



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#### **STELLENBOSCH UNIVERSITY** **(Letter to church leader)**

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Dear Pastor

I greet you in the mighty name of our Lord and Redeemer, Jesus Christ. I am Reverend Martin Khoaseb, an ordained minister of the Apostolic Faith Mission of Namibia. I used to serve as the pastor the AFM Restoration Centre in Khomasdal, and also have been the principal of Namibia Evangelical Theological Seminary (NETS) for five years.

I am currently on fulltime studies at the Stellenbosch University, doing research for completion of Doctor of Theology degree in Practical Theology. The degree is obtained by writing of a research dissertation.

The title of my research is *The Practice of Faith Healing in Crisis Counselling: A Pastoral Assessment*.

The goal is to explore the extent of the faith healing prayers on the spiritual and psychological wholeness of healing seeking believers, especially in cases where instant healing do not manifest. The research focuses on the emotional and spiritual experiences and stories of such believers in the churches of Windhoek. The collected data will help to develop a holistic pastoral support programme of healing and wholeness.

As your church is involved in the healing ministry I will kindly like to request you to invite willing members from your congregation to take part in one- to-one interview session with me. The interviewees will share their stories, experiences and feelings around the question of healing. ***I will sincerely like to engage with people who are prayed for but still not experiencing the manifestation of their healing.*** There is a need to understand what such people go through both emotionally and spiritually. I believe your members that avail themselves to participate in the interviews will immensely help other people who are struggling with the question of healing.

I am planning to conduct these interviews from *15 to 23 July 2010 in Windhoek*. Interviews are unstructured; meaning that the questions will spontaneously flow from the conversation and each interview will approximately last for one hour and a half.

Although the interviews are unstructured I have designed the following questions as a guideline:

- What do you understand by faith healing?
- Would you like to share your experiences of faith healing sessions you have participated in?
- How did these sessions impact/ affect your emotional and spiritual life as you grapple with illness?
- How can the local church assist you in dealing with the emotional and spiritual trauma as you grapple with this illness?

Please kindly recruit some volunteers from your members that will like to partake in the interviews and furnish me with their contact numbers and email addresses, so that I may set up appointments with them prior to my arrival. Please be assured that all information collected during the interviews will be kept confidential and only use for research purpose.

I am doing my research under the supervision of Dr. Christo Thesnaar of Department of Practical Theology at the Stellenbosch University.

Thank you for your anticipated assistance. I value our partnership in the Kingdom of God.

Yours in Christ,



05 July 2010

\_\_\_\_\_  
Signature of Researcher

\_\_\_\_\_  
Date

REV. MARTIN KHOASEB  
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## Appendix B: Participants letter and consent form



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### **STELLENBOSCH UNIVERSITY CONSENT TO PARTICIPATE IN RESEARCH**

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#### **TITLE OF THE STUDY**

The practice of faith healing in crisis counseling: A pastoral approach.

#### **Consent Forms:**

The study is open to all age groups and will make use of following consent forms as deemed required:

- For parents of minors under the age of eighteen (18) years.
- For adult participants.
- For churches of volunteering members.

You are asked to participate in a research study conducted by Martin Khoaseb, a Doctoral of Theology degree (DTh) student at Stellenbosch University. The researcher has the following qualifications: Masters of Theology degree, Bachelor Honours of Theology degree, Licentiate in Theology and Education Diploma Primary.

The study is under the auspices of the Department of Practical Theology at Stellenbosch University. The results of the study will contribute towards the research paper dealing with the practice of faith healing in pastoral crisis, for partial completion of a doctoral degree in theology.

You were selected as a possible participant in this study because of your willingness to share your emotions, feelings and experiences on the question of healing as you grapple with your own illness. Your participation will help others who are struggling with the question of healing, especially in the way they deal with their emotions and faith in facing reality of illness.

#### **1. PURPOSE OF THE STUDY**

The primary focus of this research is to explore the spiritual and psychological impact of faith healing on healing seeking believers, especially in cases where instant healing do not materialise after being prayed for. The study results will contribute towards establishing a holistic model of healing and meaningful living in Christ.

## **2. PROCEDURES**

As you volunteered to participate in this study, you will be interviewed with the view to share some of your experiences, fears, frustrations and questions as you grapple with illness. The research will also benefit from your perception of God and his love as you grapple with the reality of illness.

### **2.1. Unstructured Interview:**

The interview is unstructured and the questions will develop from the conversation. However, following guiding questions will form basis during the interview:

- What do you understand by faith healing?
- Would you like to share your experiences of faith healing sessions you have participated in?
- How did these sessions impact/ affect your emotional and spiritual life as you grapple with illness?
- How can the local church assist you in dealing with the emotional and spiritual trauma in view of prevalent illness, despite faith healing prayers made to you?

Please kindly note that further questions will emanate as the interview develops. The purpose of the interview is to get an in-depth understanding of your feelings, fears and response in relation to unmet expectations of anticipated healing.

### **2.2. Rules:**

The interview will approximately be for one hour and a half (1½ hours).

## **3. POTENTIAL RISKS AND DISCOMFORTS**

There may be people who are reserved to speak openly about their illness for fear of stigmatization, for example, a person who is HIV positive.

Churches that belief in positive confession encourage those prayed for “to confess in faith that they are healed”, even though they may still feel ill. Such people may be under psychological pressure to acknowledge their illness for fear of being labeled as lacking faith. Some churches may not want to release members to participate as they may view the research as critical of faith healing and having the potential to negatively influence their members against healing prayers.

There may be people with financial and time constraints who want to be compensated to participate in the research.

## **4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY**

The participants have a safe space to express their emotions, faith crisis and questions that may serve in it as a healing factor. The researcher plans a feedback seminar at the end of the study to share with the subjects the outcomes or the results. Issues permeating from the feedback will be discussed and practical suggestions, such as referrals, made for those who may need further assistance. The researcher will like to publish some parts of the thesis into articles to benefit the society at large. The research will contribute to the scientific field as it reflects on the role faith plays in dealing with sickness and how it affects individual's psyche and spirituality will also be highlighted.

## **5. PAYMENT FOR PARTICIPATION**

There is no payment or remuneration provided for partaking in the study research.

## **6. CONFIDENTIALITY**

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law.

Confidentiality will be maintained by means of:

### **6.1. Confidentiality will be maintained by means of:**

Number codes being used for identification of respondents. This material only being made accessible to the researcher, the promoter and any person assigned by the examination panel of Stellenbosch University.

### **6.2. Tape- recorder and Typist:**

A typist will take notes of the proceedings. The discussion groups will also be audio- taped. The use of a typist and tape recorder will only be used once such permission is granted by you.

If you wish so, you have the right to review or edit the tapes before they are transcribe for research purposes. The data will be stored for a period of 5 years.

### **6.3. Publications:**

When the study results are published they will make use of pseudo names and pseudo places to maintain confidentiality and will not directly or indirectly give hints of any participants used in the study.

## **7. PARTICIPATION AND WITHDRAWAL**

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study.

## 8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact:

### The researcher- Martin Khoaseb

Cell: +264 81 2727 456 (Namibia), Cell: +27 790918492 (South Africa).

Email: [12749281@sun.ac.za](mailto:12749281@sun.ac.za)

### The Supervisor- Dr. Christo Thesnaar

Tel: +27 21 808 3257 Email: [cht@sun.ac.za](mailto:cht@sun.ac.za)

## 9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [[mfouche@sun.ac.za](mailto:mfouche@sun.ac.za); 021 808 4622] at the Division for Research Development.

### SIGNATURE OF RESEARCH PARTICIPANT/ LEGAL REPRESENTATIVE

The information above was described to [me \_\_\_\_\_] by Rev. Martin Khoaseb in [Afrikaans/English \_\_\_\_\_] and I am in command of this language or it was satisfactorily translated to me. I was given the opportunity to ask questions and these questions were answered to my satisfaction.

*[I hereby consent voluntarily to participate in this study/I hereby consent that the subject/participant may participate in this study]* I have been given a copy of this form.

\_\_\_\_\_  
• Name of Participant [Minor/ Adult]

\_\_\_\_\_  
**Name of Legal Representative (if applicable)**

\_\_\_\_\_  
• Signature of Participant or Legal Representative

\_\_\_\_\_  
Date

**SIGNATURE OF INVESTIGATOR**

I declare that I explained the information given in this document to \_\_\_\_\_  
[name of the participant] and/or [his/her] representative \_\_\_\_\_ [name of  
the representative]. [He/she] was encouraged and given ample time to ask me any questions.  
This conversation was conducted in [Afrikaans/ English/] and [no translator was used/this  
conversation was translated into \_\_\_\_\_ by \_\_\_\_\_].

\_\_\_\_\_  
Signature of Investigator

\_\_\_\_\_  
Date

## Appendix C: List of churches that volunteered members for interviewing

<b>Minister's Name</b>	<b>Church Affiliation</b>	<b>Cellular Number &amp; Email Address</b>
Dr.Serge Solomons	His People Ministries	<a href="mailto:drksolomons@hotmail.com">drksolomons@hotmail.com</a> 0811221970
Pastor John Hiyamaambo	Family Worship	<a href="mailto:hiamambo@yahoo.com">hiamambo@yahoo.com</a> 0812466147/224447
Pastor Kitching	Pentecostal Protestant Church	061-229830 (h), 23327 (w) <a href="mailto:ppchurch@iway.na">ppchurch@iway.na</a>
Bishop Wahl Abrahams	Covenant Celebration Church	<a href="mailto:bishopwfa@ncccm.org">bishopwfa@ncccm.org</a> 061-257986 0812414757
Pastor Fred Joseph	River of Life Community Church	<a href="mailto:afmfred@mweb.com.na">afmfred@mweb.com.na</a> 0811291675
Pastor Valentin Kaviro	Christ Church	<a href="mailto:kavirofamily@iway.na">kavirofamily@iway.na</a>
Pastor Hudson	Namibia Christian Mission	<a href="mailto:Hudson@mweb.com.na">Hudson@mweb.com.na</a> 0812337675
Pastor Ferdinand Otto	Living Waters Assembly	<a href="mailto:ferdi.otto@hotmail.com">ferdi.otto@hotmail.com</a> 0811240251, 061-222938
Apostle H. Goroh	Greater Love Ministries	<a href="mailto:hbgoroh@mweb.com.na">hbgoroh@mweb.com.na</a> 0811277305
Pastor Simon Xaba	Restoration Ministries	<a href="mailto:restmint@africaonline.com.na">restmint@africaonline.com.na</a> 0812148616
Pastor Chris Jonathan	Khomasdal Baptist Church	0813635454 0811284410
Pastor Aaron	Soweto AFM Church	<a href="mailto:ngcoboareseb@yahoo.com">ngcoboareseb@yahoo.com</a> 0812057235
Pastor JP Da Cruz	Hakanah Christian Centre	<a href="mailto:jpdacruz@iway.na">jpdacruz@iway.na</a>
Pastor Pumzile Magazi	AFM Rocky Crest	<a href="mailto:pmagazi@gcm.org.na">pmagazi@gcm.org.na</a> 0812607656
Pastor Seth Gariseb	Jesus Loves Ministries	<a href="mailto:saonab01@gmail.com">saonab01@gmail.com</a>
Manuel Ngaringombe	Followers of Christ	<a href="mailto:ngaringombe@hotmail.com">ngaringombe@hotmail.com</a>

Appendix D: University ethical clearance letter



UNIVERSITEIT•STELLENBOSCH•UNIVERSITY  
jou kennisvenoot • your knowledge partner

1 July 2010

Tel.: 021 - 808-9183  
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Reference No. 343/2010

Mr M Khoaseb  
Department of Practical Theology & Missiology  
University of Stellenbosch  
**STELLENBOSCH**  
7602

Mr M Khoaseb

**APPLICATION FOR ETHICAL CLEARANCE**

With regards to your application, I would like to inform you that the project, *The practice of faith healing in crisis counselling: a pastoral approach*, has been approved on condition that:

1. The researcher/s remain within the procedures and protocols indicated in the proposal;
2. The researcher/s stay within the boundaries of applicable national legislation, institutional guidelines, and applicable standards of scientific rigor that are followed within this field of study and that
3. Any substantive changes to this research project should be brought to the attention of the Ethics Committee with a view to obtain ethical clearance for it.

We wish you success with your research activities.

Best regards



**MR/SF ENGELBRECHT**

**Secretary: Research Ethics Committee: Human Research (Non-Health)**

---

Afdeling Navorsingontwikkeling • Division of Research Development  
Privaat Sak/Private Bag XI • Matieland 7602 • Suid-Afrika/South Africa  
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## Appendix E- Examples of transcribes

These are 5 examples out of 25 transcribed interviews:

1. Timothy (this is a pseudonym):                      Male                                      Date:14-12-2010

Interviewer: Did you receive any faith healing prayers for persistent illness?

Timothy: Uh, thank you pastor for this opportunity. I would like to say uh I thank God for the healing that took place in my life. Uh that was soon after my high school, eeh I was [?]. That only I realise after hee I was suffering from a sickness called ulcers. I suffered in that I did not do well. I did not work I have to go half day to work because of this illness. I was not aware of the seriousness. When I went to see the doctor I was given 7 days to stay at home (hee: interviewer). He said I should not eat some kinds of food that that's triggering this kind of disease, ulcers. So when that happened they told me that they have lost substantial amount in my absence of 6 days. When that happened yes i was a Christian. And uh I ask myself what is that. It was so devastating that I couldn't understand that, so now because some food I was not supposed to eat like tomatoes, because there is acid in it and lemon and oranges and Coke I could not take but some of the basic food if was forbidden to eat were things that were more affordable to me (hee: interviewer). And it was really very difficult for me to take. At church they were praying for me. I went to the church and pastors they prayed and healing took very much time to take place and the every time I was prayed for I was told I have to believe. But what I also realise was that as much as I was a believer I would be prayed for and go home. And after church hear how people say that how people suffer from ulcers, by thinking too much. I was too young, uh I was thinking a lot. It didn't confuse me this situation. There I was staying with my young brothers, three of them and then all of them were still at school that time and i was taking care of them. Maybe the job that I had and i lost gave me a lot of things to ponder about. How are we to sustain ourselves? But really because I was a Christian I never dwell on that, as the Bible also encourage that the birds of the air don't go and plough or harvest but God take care of them. But the reality at home wasn't as bad as that and i happened to learn how to do/ work with my own hands then to looking for it elsewhere. So i was being changed, making things that we can sell at home, but it wasn't enough. I suffered from these ulcers for number of years. I can tell them 7 or 8 years i was suffering from ulcers. And then I realise that after the healing has taken place, complete healing the moment that i going to church and prayed for I will still go back home and still face the situation. That probably I must be prayed for that I have better economic situation. So that was mostly I got a stage where i understand the reason I was suffering from ulcers. And the God that healed me for uh I still have friends that I know, way still older than me that still suffering from ulcers. And then when I was healed through learning and committing myself to God I want spiritual freedom as well as mental freedom and social freedom and the it's not about having a lot of money or food but is just to be happy with what god has given you (yeah: interviewer). So that is how the Lord has healed me through prayers and talking to other people who were suffering from ulcers. My my problem actually started that I was someone the world was crumbling upon me and the I didn't have anyone to speak to, people that I talk to were people from the church and my uncles and cousins around me. But all the same the question that I still had was why did the Lord take so long to heal me to the extent that I hee that you mention what happened in between. I can vividly remember what was

happening was that I was always asking myself whether there was any other remedy to heal me.

Interviewer: How did this struggle affected you emotionally?

Timothy: Actually when the healing started off slowly I started to asking myself aren't there any other ways. Can't somebody told me to heal these wounds once and for all. I was imagining there are wounds in my stomach and when I have wounds outside I have to put Vicks or something and it disappears. I imagining how could same thing like that inside happening. Where it took me to realise was someone in our church, an elder helped me to pray and told me I should never told people this is my sickness; not to mention and say I am suffering from ulcers for what it is doing to me was uh I will always feel it, maybe after few weeks I will take something like Coke or ginger juice. I will take in forbidden thing or maybe only what is available at that time. After taking it I will feel that my stomach is hot and burning so I feel like I will staying away from things that I must eat, but [pap?] is that I will never or that I will stay away but until now I still enjoy it (hmm: interviewer). What help me most but apart from trying to find out what it is, I never accepted that this is the illness [?]. I never let my conscious to control me. I will also explain it to man of God who is praying and the next thing they also told me to fast. Again the other thing was fasting; the moment you go into fasting I will suffering for there is nothing in the stomach (hee). Be it was I am so glad for I am free for three years I not suffering anything.

Interviewer: Yeah, psychologically what kind of struggles did you have, esp. knowing it's there but not mentioning it, not admitting but watching your diet?

Timothy: The tension was there but when I knew I was suffering from this, the only people that told me normally ulcers is for people more older age the you are. So normally I will be shy to tell people what i am suffering from (hee: interviewer). I was a bit younger and there was no one of my age I knew that was also suffering from it. But I should say that but safely, I can say that thinking was one of the things that contributed to it. When I was 21 years old I was looking after my four siblings. At 21 people are still living with their parents (yeah-interviewer) but it was not like that with me. It allow me to be vulnerable also to be convinced that I am suffering from this condition. On the other hand I was shy to tell people that I am suffering from ulcers for they will always make joke of it by saying someone in 50 we understand but 20. But I still believe that God will heal me and prayers that I received help me to deal with this suffering and also emotionally (yeah: interviewer).

Interviewer: Do you or are you still on special diet and if or not is there that fear that you may eat wrong and be affected again?

Timothy: It's a good question. I must say I have gone back to everything that I used to eat. Except one thing, that is chip. Uh, I started eating that I was still young and that is one thing that while in my early years of suffering from ulcers if I would just swallow it I will feel that pains of ulcers. After all I don't really like the smell of chips and I don't know why I should eat "(laugh: interviewer)." Everything else I eat, sometimes I will take Coke, as long as it has no gas, but I don't really enjoy Coke very much, I prefer Fanta. All these drinks are having carbon in it but I take those drinks, no problem. And I also learn that it's not like one day I will have money in my hand and everything will be alright. It's not like that, accepting Christ in your life and sometimes not worry as you make your prayer by saying you know what is ahead of me, everything is in your hands (yeah: interviewer). Whatever goes maybe wrong tomorrow, I know god is in control, so I grow to certain stage in my faith, which i didn't when I was suffering from ulcers (yeah, that's very good: interviewer).

Interviewer: How do you help a person being sick with the same ailment after various prayers, so he/ she can still be effective for the Lord?

Timothy: uh I don't know, but remind me of person that was demon possessed. Disciples asked who has sinned, him or his parents. Jesus said this is like that that God may manifest. There are some diseases if it starts people from home come with all kinds of help, be doctor or witch doctor. But this also takes time to prolong. We forget that only prayer is the answer and we run left, right and centre. It's taking that long before we realise that only God can heal as creator. My advice is to ask then what they think. To tell people God can heal them.

Interviewer: Are there support structures in our churches for hurting people?

Timothy: I think people need to go extra mile. We quickly say it is maybe punishment for sin. We must learn to accept that it's spirit of giving up that as leaders that pray for particular issue eh eh we have to learn that we don't want to continue or it's punishment to know there is no sin not forgiven able. We must go extra mile with people. The church needs to go more I can say.

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2. Sandra (this is a pseudonym):

Female

Date:14-12-2010

Interviewer: Any faith healing prayers for persistent illness?

Sandra: uh "(laugh)", yes thank you pastor Martin for your sincere involvement regarding studies that you are doing (Yes: interviewer). Yes, in your question I am or I have struggled with this sickness. Normally sickness have come and go, have a flu or something, you have no need for nobody to pray you go to your doctor, take medicine and you are well again. But the particular sickness I am talking of sharing for is this pandemic that all are suffering for, the nation is suffering, affected or infected. I was tested HIV positive where my husband was tested positive since 1995

. I struggled with that. We believe that we can be prayed for and receive healing but failed to understand how it is possible to claim and receive your healing. I hope what I share will enable you or give you the joy to finalise your research (yes: interviewer). I, particular in my case, it was very hard to accept, that now I am also part of the statistics "(laugh)". And being at that time also born again and accept Christ as my saviour I could find solace in Christ, that I am not alone in the fight (hee: interviewer). I really fight to go on, knowing who I am in Christ I have to resist everything that come, be it flu or particular sore you are struggling with. After being prayed for and still I am prayed I receive my healing by faith and I stand on that positive word of God (yes: interviewer). God's word said in Isaiah 45 something those that wait upon the Lord will renew the strength and will be able to soar on eagles wings (yes: interviewer). So I received my healing by faith. My husband had to fight with it since 1995 and give it up in 2000/2001. He said to himself I don't want to go on with this struggle. I have to face too many options, first of all you have to face stigma and then you have to face that questions you to accept that you are now also part of the statistics, so he actually decided he is going to die. His words "I am giving up". But I said you can make even if you claim healing you still have that thing that come back till you deal with and my word of dealing with it the word of God, taking medication, taking the drugs that they subscribe does not give you that comfort (hee: interviewer). What gives me that comfort through all these years, 14 years or 16 years that I claim I am healed but still daily I am under attack, not physically my body but mostly in the spirit, your mind you are attack (yeah: interviewer). The body isn't sick but your mind is always, you must be careful, you have flu or something. Anytime I have to go back to God's word and in all these years I am really at point that I I [?] don't know how many, I see many many people dying. At my own husband's death bed seeing him give

in. This is the one thing I believe faith is (not clear). Faith is one thing, if you don't have but you can take medicine and going to die. Get your your funeral arrangements in place, for you going to surely die. I do not claim that I will not die soon but I will live, His word in Psalm 118 says "I will live and i will not die" (yes: interviewer). And on that I am standing today. Staring my own business, only three months now but I can claim. I I claim my healing every day and I have somebody that back me up, it is God's word (yes: interviewer). And the one thing that I struggle with is fear. Fear is one of the greatest thing, not even the sickness. The the doctor said you have now diarrhoea or you have whatever TB or they diagnose you with extra sicknesses. What do you calling them now, "Wat noem jy dit?" (diseases: typist). Yeah, yeah these sicknesses that come and attack you (interviewer: opportunistic-. "(overlapping)" yeah, opportunistic diseases, they come. Now you have to struggle with diarrhoea and you have to struggle with TB. It's all things that I have to struggle with. As such it is so severe that I have to end up in hospital, shortly after my husband died, in the same year (hee: interviewer). He died in 2000 and I was also ready to die but I said on my sickbed "I will not die". I tell the enemy this is a fight not in physical that is more a spiritual fight for me. It was for me more spiritual fight then physical and I really have overcome it by the word of testimony of God's word and by the blood of the Lamb according to Revelation (hee: interviewer). And I can this today and say my family give up, I was totally at the point that I lost my mind. I was out of my mind. I will walk like a zombie in the house around, just walk like that can't even walk, but there was people in my life at that time, that god really design for me to be there for me. People that strong in their faith, who fully stand behind me still this day as pillars and encourage me. This is what you need, what everybody needs more a spiritual back up then medical back up. If your spiritual back up is weak then medically you will not survive. You will not be able to stand (hmm: interviewer). That I can say uh uh with how to you say (sure: Interviewer). Yes, with sure. Medical help you will not stand, you can help people make sure with extra vitamins and so on but won't help. In short what I can say is that faith, by faith we can claim our healing by faith. We can claim our healing by people praying over us. Many times we see people being anointed with oil and they come home and sudden attack by disease. They end up in hospital and soon they say it is not working (hmm). But if I cannot believe for myself the person that's praying for me is not responsible for my healing. If anybody pray for you, as Amos said if two walk together, how can they walk together unless they agree. If my pastor pray for me and walk with me and I am not sure that I want to walk, can you take this word (not clear), this is just a word. But I am really at the point to take the word. I have no alternative but to take the word of God (yes: interviewer). There is no other, personally for me, this is my experience that I have (hee: interviewer).

Interviewer: We have already touched on emotional responses this disease has brought, you said one is fear. Was this your only issue?

Sandra: Yeah, definitely stigma and isolation. In case of my husband he wanted us to isolate ourselves. He want no one to involve with us. For long time we stay in isolation, our children don't know about it. They just see we go in and out we are going to hospital. We isolate us totally from, from anybody and put on a mask and if people come in you are all well. If you sick it's just fever you said, when it is diarrhoea, you have so many excuses, you have to cover so much up and, and this was the reason he totally give up and then comes the stigma. Stigma is not so much the issue. You isolate yourself and then you stigmatise yourself and many times you want to give the fault to others; they don't do this, they don't give me (yeah: interviewer) and you shut yourself of help. You distance yourself of people who can come to you. These are one of the things, the first phase you struggle with. Isolation will not help us. He didn't want pastors to pray for us, but have a special friend I shared with and also prayed

with at the church. These people some of them know and the fact that they know also cause trouble between us. We have lot of emotional things, fight in the marriage, so many things, so he could not and although also born again he slipped also, and for him it was bad for him and the disease was easily attack the factions of his life. We put lot of emphasis on stigma and forget isolation.

Interviewer: Did you experience faith crisis and blame others for your condition?

Sandra: ooh, blame I believe you will try to know who is responsible for that. Knowing myself you start to point fingers. It's because of that, you didn't do this (hmm: interviewer). That's also thing that trouble marriage. That is also hardest thing that kill people. You become to be suicidal or to drink yourself into coma. Now you want to put blame on the others. I became born again long time ago and I made choices in my life. I have to unfortunately deal with choices that I made. I cannot say where was God, why did He allow it? I have to deal with choices I have made. It is human you want to ask God where were you? You said you are my father, why have you not protected me? (yes: interviewer). But many times things come our way. Culture and people suggest many things, esp. if your marriage is up and down, up and down. He is not there, is away for months, you don't know where he was, but now you have to be wife and woman for him. Uh many times counsellor suggest it's safe you as we are at early stage of HIV that you cannot see at the face who is infected. And people when they are drinking do not use protection. So, uh, surely I have surely I have to face these things spiritually. "How, where was God, why not protected? Why not allow that man to go away but still come back home?" Those things you struggle with and become resentful towards that person but you at the end decide to forgive. For not to forgive you imprison yourself. There are lots of things you have to deal with (yeah: interviewer).

Interviewer: Effectiveness in ministry, how did it in any affect you?

Sandra: This has challenged my faith of effectiveness as a person working in children. How can you speak about chastity and you have this life of being positive. First there resistance from people, especially not those affected, but you have to speak to the audience. This is my resistance about condoms, you have to distribute condoms to young people and say do safe sex. I tell them there is no such thing as safe sex and that is also resistance. I told them if you do sex, if you cannot abstain go on and use condoms (uha uha: interviewer). In the meantime my daughter got pregnant and I ask her where was the condoms? I ask that young man condoms are all over, where was the condom? They both don't drink but where was the condoms now? That shows that condoms are ineffective, so preach and tell people to abstain from sex.

Interviewer: Do people suffer in silence after being prayed for and being healed? Are there supporting structures in churches?

Sandra: yeah, my experience see it from my husband. He made a suggestion to deal with it in our own way. People must come out publicly otherwise many will die. People must be encourage, many people struggle but others have come to the church. But if the church doesn't have open space people will not come. Church must ask how to help these people? I will suggest, say best thing to do is not to invite people to pastor's office. It should not be the pastor's office. Now the pastor must have this burden when a person dies then the family blame the pastor for not telling them that my husband was sick. So they came and blame the pastor. The pastor said it was not my place to tell. We that are infected must know we have choices and we must take responsibility for whatever illness, even cancer (that's true-interviewer). If a parent dies children will say why haven't you tell us?

Interviewer: Is there need for support structures for people to live with the virus or is prayer of faith enough?

Sandra: I don't think it's enough just to pray. My feeling on grounds of the word of God, I just use the word of God. Pray for people and have structures for when they are attacked and weak in the body. Many things affect our bodies and you can be work also in your spirit. It is also your soul to deal with. Not just prayer, pray specific for the thing the person struggles with. If it "dobbel" or prostitution just call it for the Bible call it, why should we hide.

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3. Rachel (this is a pseudonym): Female 16-12-2010

Interviewer: Have you ever experienced an illness condition that prevailed with you for long time?

Rachel: uh, please switch off the recorder.

Interviewer: Oh, oh okay and switch off.

Rachel: Yes, I am struggling with eye sight. It has been for some time now. I did not go for any treatment first as I was trusting the Lord to heal me. I got lot of prayers from men of God and also trusted God for healing. uh, uh despite all my efforts one eye has become very weak and I am afraid that I will lose my sight. As a school teacher I am worried that it will affect my work and also that it could lead to blindness. It is now for many years that I have eye trouble but lately it has become serious. I am used to be positive and believing but I am struggling now.

Interviewer: How did it affect your emotions?

Rachel: uh, I am emotionally drained and very disappointed. Don't understand why this is happening as I really trusted and hope for God to heal me. I even went to Pastor Chris' healing services in Johannesburg but nothing seemed to help. I have spent some money to undertake the trip also with one of my children who had an addiction problem. I have made so much effort but it seems that nothing is working (...).

Interviewer: Hmm, how did it affect your faith?

Rachel: I still hold to my faith in the Lord but just confused. I do not question God as such but cannot understand why he doesn't help me. I am serving the Lord now for very long time and feel really confused. I have lots of ideas, uh, uh sometimes I think maybe it is God's will for me to be in this condition. I don't know. I am really down at times and think sometimes what the purpose is of praying more, because the situation is not improving. Despite it all my faith and trust is still in the Lord. I just wonder when God will come through for me.

Interviewer: Do think there is need for support groups for people hurting?

Rachel: Yes, this is an area that is not strong in the church; People are left alone and not be carried along with support groups. Hee, I think there is need for support groups to help people who are weak and struggling in their faith or with the question of why they are unhealed. If we have such groups then people's questions and doubts can be answered and dealt with.

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4. Noleen (this is a pseudonym): Female Date: 14-12-2010

Interviewer: Did you experience faith healing prayers for persisting illness?

Noleen: Yes I pastor already have chest problems and I went for intercession as I prayed for by many pastors in Namibia. I have also gone for intercession to pastors from other countries that came for services in Namibia. So I heard of Pastor Chris and I decided in 2008 that I

would go to South Africa for prayers. So I went to pastor Chris in January/ February 2008. Pastor Chris prayed for us after I went for two weeks teachings. He came on the last Sunday and prayed for us. I was assured and I believed that I was delivered from this chest condition. When I came back I so believe but in between I did not see any difference (hee hee: interviewer). The other problem I went to was also sleeplessness. I also mention this as one of the points for which I sought healing but when I came back there was no difference. I later went back to our doctors (hee hee: interviewer) and went for test again. They also test my sputum but they couldn't found anything wrong. The sputum test did not show any TB as it was clean and for sleeplessness I was also given pills to sleep but I refuse to take them (hee). I said I don't want to be addicted, so up to now I am still sleepless. So as I said from 2008 February there was no change. Maybe you become better but when you sit at a night vigil or get wet of rain the chest start again. (yeah, sorry to hear that but we believe God will give you victory in his own way: Interviewer)

Interviewer: This disappointment of expecting and not being healed, how did it affect you emotionally?

Noleen: Yes pastor it affected one, you become discouraged. I have questions I asked to God. I even said to the Lord I have made so many efforts and have spent so much money, money for accommodation, transport but there is no change. It discourages you and you think there's no reason than to serve God. You go to church but you also become despondent, esp. in June I was hospitalised and I was close to the grave (ooh: interviewer). I was under oxygen and on drip and Dr. Katjitae came for X-rays and said it is TB again. You look after yourself so well and are careful. My pastor is the one who encouraged me. He said I must not be discouraged by saying I was at Pastor Chris but nothing change. This helps me to go on (uh uh). He said one become disappointed but people really encourage me. You really say "I am serving the Lord and sacrificing but nothing happens". My pastor really encourages me to keep going.

Interviewer: Did you get to the level to question God or do you accept your situation?

Noleen: Yes as I always say God exist, but the doubt came that God doesn't answer your prayers maybe because of blockages or hindrances. Things like having unforgiving spirit etc (it's natural that you look for answers for what is going on: Interviewer).

Interviewer: Is there a reason in your mind why you are not healed?

Noleen: uh in that days when healing don't come I think of people I live in enmity with, either at work and I will contact that person. But even after doing those attempts and asking forgiveness there is still no change.

Interviewer: Does the persistent illness take away the liberty to be prayed for again?

Noleen: No, for me I don't go to that point. It does not take my liberty or freedom. I still go for prayers

Interviewer: Does one come to a place where stop going for prayers, suffer in silence and just pretend that you are fine?

Noleen: Yes, it's possible as pastor said. Even at work when I am paining and people ask how it is I just say it is good. Even if I pain I just carry on with work and when I come home will lay down and use painkillers. Or if someone ask or at work I don't take pills, I will just wait for lunch and lay down and pray to God to relieve me of this pain. Hee, you just keep it to yourself. Even when you pain, you will just put on a face and smile to people. However I didn't keep up even after being prayed for by person such as Pastor Chris. I just take it that he is maybe not the one the Lord will use to heal me. I still have that hope that healing will still happens. God will still use someone else to heal me.

Interviewer: Effectiveness in Christian witness, do you still have liberty to witness to others?

Noleen: No, freedom is there. I encourage, people's faith differ. Don't look at me; I didn't come to church because of illness. You must just have faith. It doesn't with hold him. The

pastor saw I have the gift of healing, I still pray for others. Even at hospital visitation I go and testify that god still heals. And as I said, just have faith. I told them the Lord also healed me and you will also be healed. Like last time a certain woman came to sisters' meeting. I could see she was in pain and I went to pray for her without her asking for it. I laid hands on her and the next day the lady had safe delivery. She was supposed to deliver in December but after the prayers things just happen and next day she delivered a baby.

5. Lena (this is a pseudonym):

Female

Date: 16-12-2010

Interviewer: Did you experience any faith healing prayers for a persistent illness?

Lena: Hee, okay, yeah I have this thing with right knee, hee I had four surgeries. It is given me problems (hee: interviewer). Since I was 11 years it is out of position and the worst when I was playing PS I jumped in the air and dislocate my knee.

Interviewer: you were playing?

Lena: Basket ball, it was at PT at school (soo soo: interviewer and typist). We were just bouncing the ball, while I was in the air that is when it did that. I had surgery immediately after that I went for medical surgery because I was living in the north at that time they told me they cannot cut me open, I have to wait until I was older (hmm: interviewer). So the problem keep on from the hip to the knee. My hip was supposed to 8 degree but mine was 20 degree with 8 degree out of position. So they put trusses with the hope to be corrected (hmm). So I started [press?] Surgery but I still manage to go to school. I, I travel and I had the following one now when I was 20 years. And everything was okay there, I used to find problem here and there. At that time I was not really into faith thing like I am now (hmm: interviewer). Sometimes in between I did in 2008 we were involved in a car accident and I was injured again and I had to go for surgery.

Interviewer: 2008?

Lena: Yeah, 2008 and since then I hadn't done x, I went through to motor vehicle accident fund, it took them six months to give me an answer, because I was calling them but didn't do anything, didn't say yes or no (hmm, hmm: interviewer). I needed to know whether they will do or so at that time I didn't have any medical insurance. So I needed whether I can go to state hospital. I waited them long. That day I was praying and at that day I was really fed up (hmm: interviewer). And as it was getting worst I just said I waited long enough I will just go to the state hospital and then they called me, God helped me and I had my surgery and the doctor did not do properly, he only did half of the job. The problem came instead of sending me to the previous one who worked on me; I went to a new one. Yeah, yeah and immediately after treated, I remember the last word that he said. Instead of get better he said "I hope you come back when you have problems" (wow: interviewer). I looked him in the face, I luckily knew of curses and Holy Spirit will bring it again and again to my attention and I broke it. It took me entire year to again go back to hospital. I was just doing prayer. I prayed and it did not get any better. I was now wondering to just pray or go for another surgery? I went for one which was now in 2009. 2009 was the first one and again in 2010 (yeah: interviewer). I went to Nupro? and I decide this one is the last. The knee doesn't want to be in position; it's just coming out and coming out. Sometimes I would walk and just like that collapse. And I notice prior to surgery it dislocated while I was crossing across the road and that brings back the worst of memories (no, no: interviewer). I am always careful of crossing. I am not better but I am still waiting for victory. I think something else I develop in between they called it arthritis. It's quite frustrating because it just became worst instead of getting better.

Interviewer: Yeah, yeah, well this is very interesting. You said you were born with the condition, so the accident that happened it made-

Lena: “(overlapping)” yeah, it made the injury worst.

Interviewer: you said at 11 you had already-

Lena: (overlapping)” I was 14, at 11 I started to have problems (okay: interviewer). When I was 14 it will just nap out and nap in. Nothing happened, no swelling, I will be running and the next thing I will be eating sand and I will get up and continue. So when I was 14 it completely went out (hee, wow, wow: interviewer).

Interviewer: How does it emotionally affect you as you are still struggling with the condition?

Lena: it’s frustrating (hee: interviewer). For sure your whole life is on hold. I cannot work anymore for if I stand for long period then it gets worst. So if I am working I might be standing and whatever I do, it swells all the time. So I can no longer be in the profession I treat people. You have to look at other careers. I choose beauty therapy for you always work with people. You are out and about but in the office. I need to be out not in the office. I plan to study next year, if all goes well to study through UNISA. But it’s frustrating and it makes you angry, especially when people comment all the time. I am tired to hear people’s comments like, “you are not healed because you have little faith” (hmm hmm: interviewer); or they come and complain “so and so had a problem and they believe and get healed”. Hee, I mean yeah waiting on the Lord it can be quite frustrating (hee: interviewer). It’s about time, I have got a daughter. I am not able to look after her; you always had to depend on other people. But your whole life is now on hold (hmm: interviewer).

Interviewer: Did you have type of questions or angry with someone else? Some saying you have little faith, how do you understand?

Lena Yeah, I mean I understand from their point of view but they don’t understand that people come from different kinds of levels or problems (yeah: interviewer). So I just sometimes have to work with doctors. I know some Christian’s moment you mention doctors, they question your faith.

Interviewer: So some people don’t want doctors?

Lena: No the moment you say the doctors say that and that then they say (..) yeah but is God saying. They say faith is over fact.

Interviewer: interesting, continue to answer about and like that, I will later come back to doctors.

Lena: No, no I am not angry, not regard to about healing. Uh (...) I know emotions like, uh unforgiveness hinder healing. I just put myself in the position that at least I haven’t broken my both legs. I am not in a wheelchair today. My limbs, I am still walking no matter what happened Jesus died on the Cross, you know and he got the keys for death and hell. He has got the power to me despite what happened (yes: interviewer). So being angry prevent you from going forward (hmm: interviewer). I know you have to wait (laugh) and I know all these things are teaching you. I know spiritually I have grown from how I was two years back to how I am now (yes: interviewer). So now it’s just a matter of I read lots of books on healing and on faith (yeah- interviewer), on anything and on power of confession. I got a book where I write stuff that the moment enemy starts to attack I go back to it. Like at this moment, I am just to focus on my faith. I still believe that he can heal me, and even if I don’t get well now I am looking forward to the time I will be right.

Interviewer: Your understanding of people not healed because of little faith- How do you understand that?

Lena: I, it does. If you really believe in God I believe the Lord heals you, no matter what you feel or no matter what or whatever circumstances you are going through. The whole focus is

on higher things. It depends who you are, where is your focus, do you believe God and to believe His word no matter what. And you know what God can really heal you.

Interview: Did it affect you effectiveness in the Lord?

Lena: This somehow limited my testimony to others. Hampers me to tell others that God heals, I feel not totally free. I do not feel any sense of guilt, just questions when the total healing will be. Becoming a bit impatient, because want to go out and live my life. Must still remind myself that God works in His own time and in His own way. I equip myself by reading various different literatures on the subject of faith healing.

## Appendix F: Chapter 3- the computer empirical field research output

Generator: [ATLAS.ti WIN 6.2 \(Build25\)](#) Date: 2012/06/28 08:14:20 AM

Original project (ATLAS.ti needed): [Interviews on impact of faith healing.acb](#) (Copy Bundle format)

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General:

**Author(s): Super**

Created: 2012/04/12 09:18:21 PM. Modified: 2012/06/26 11:22:52 AM.

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Statistics:

- Co-Authors: 0
  - Primary Texts: 25
  - Quotations: 165
  - Codes: 213
  - Codings: 334
  - Memos: 10
  - Primary Document Families: 19
  - Code Families: 12
  - Memo Families: 0
  - Network Views: 19
  - Code-Code Links: 24
  - Hyper-Links: 13
-

**Primary documents:**



**P 1: Amy on faith healing experience**

**File name:** \ (media type: rich text)

**7 quotations**

**Codes (13):** asking why questions?, be realistic in counselling, blame and guilt to unhealed person, disappointed and sad, emotionally stress and drained, feeling hopeless, stress and emotionally drained, gastric problem, not able to eat food, groups to care and encourage, healing by gifted and by own faith, healing can come through any one, Healing comes in different ways, No apparent diagnosis, prayers seemed not to help

**Memos (0):**



**P 2: Angelica on faith healing experience**

**File name:** \ (media type: rich text)

**6 quotations**

**Codes (16):** became strong emotionally, belief in God of love, belief in healing prayers, believe in positive confession, dreams and aspirations shattered, God's love source of hope, healing a process in God's timing, illness serves greater purpose, motor car accident, need assistance constantly, not questioning God, paralyse for 15 years, physically frail and dependant, struggled initially emotionally, view illness as from devil, worry about her child

**Memos (0):**



**P 3: Caroline on faith healing experience**

**File name:** \ (media type: rich text)

**5 quotations**

**Codes (12):** asking why questions?, belief in healing prayers, boldness and courage, demonic attacks and heart condition, disappointed and sad, discouraged and losing hope, groups for teaching and equipping, groups to care and encourage, healing by gifted and by own faith, keeping faith and hope for healing, prayers seemed not to help, some people having gift to heal

**Memos (0):**



**P 4: Elizabeth on faith healing experience**

**File name:** \ (media type: rich text)

**5 quotations**

**Codes (10):** asking why questions?, disappointed and sad, disillusionment and hopeless, groups to care and encourage, healing by gifted and by own faith, need for counselling, patience needed for healing, prayers seemed not to help, praying for pain to go, pregnancy complications

**Memos (0):**



**[P 5: Gloria on faith healing experience](#)**

**File name:** \ (media type: rich text)

**6 quotations**

**Codes (7):** belief in healing prayers, boldness and courage, feeling better after prayers, feeling hopeless, stress and emotionally drained, HIV positive since 1992, infected with HIV/AIDS, unemployed and no income

**Memos (0):**



**[P 6: Jacky on faith healing experience](#)**

**File name:** \ (media type: rich text)

**4 quotations**

**Codes (8):** asking why questions?, diabetes, high blood and heart condition, feeling hopeless, stress and emotionally drained, groups to care and encourage, healing a process in God's timing, healing by gifted and by own faith, illness serves greater purpose, want to quit

**Memos (0):**



**[P 7: Karl on faith healing experience](#)**

**File name:** \ (media type: rich text)

**8 quotations**

**Codes (10):** asking why questions?, boldness and courage, groups to care and encourage, healing by gifted and by own faith, living reckless before marriage, problem of sexual arousal, problem was witchcraft, relationship tense with wife, to quit if God doesn't help, wanted to divorce

**Memos (0):**



**[P 8: Lena on faith healing experience](#)**

**File name:** \ (media type: rich text)

**7 quotations**

**Codes (18):** annoyed when blame faith, belief in healing prayers, blame and guilt to unhealed person, boldness and courage, car accident aggravated problem, develop arthritis, frustrating, frustrating and limiting, grapple with fear, healing a process in God's timing, healing by gifted and by own faith, knee problem became worst, limited career options, not angry with God, patience needed for healing, problem from hip to knee, problem since 11 year old, right knee dislocation, several surgeries

**Memos (0):**



**[P 9: Letta on faith healing experience](#)**

**File name:** \ (media type: rich text) **4 quotations**

**Codes (7):** asking why questions?, disappointed and sad, feeling better now, groups to care and encourage, healing by gifted and by own faith, lump and hip problem, thought God not caring

**Memos (0):**



**[P10: Lucky on faith healing experience](#)**

**File name:** \ (media type: rich text) **9 quotations**

**Codes (24):** accident at young age, belief in healing prayers, believe in positive confession, blame and guilt to unhealed person, careful to stop medication, causing emotional wounds, didn't wear shorts, discernment and sensitivity needed, doctor causes fear and instability, feeling hopeless, stress and emotionally drained, gradual increase in self confidence, grapple with fear, groups for teaching and equipping, groups to care and encourage, healing a process in God's timing, healing by gifted and by own faith, healing could also be instantly, initially questioning why God?, learn to sympathise with others, pastors need training, prayers seemed not to help, preaching above healing, preaching must be central, stronger with spiritual growth

**Memos (0):**



**[P11: Martha on faith healing experience](#)**

**File name:** \ (media type: rich text) **7 quotations**

**Codes (8):** affect work performance, asking why questions?, believe in positive confession, feel dizzy at times, groups to care and encourage, healing a process in God's timing, migraine headaches, silent suffering possible

**Memos (0):**



**[P12: Maureen on faith healing experience](#)**

**File name:** \ (media type: rich text) **3 quotations**

**Codes (3):** belief in healing prayers, taking TB medication, TB sufferer for three years

**Memos (0):**



**[P13: Noleen on faith healing experience](#)**

**File name:** \ (media type: rich text) **7 quotations**

**Codes (15):** asking why questions?, assured by faith healer of healing, attended healing school, belief in healing prayers, boldness and courage, confused why suffering?, disappointed and sad, doubt and uncertainties, encouraged by own pastor, feeling hopeless, stress and emotionally drained, felt her efforts wasted, got prayed by various pastors, possible to suffer in silence, prayers seemed not to help, soul searching and cleansing

**Memos (0):**



**[P14: Rachel on faith healing experience](#)**

**File name:** \ (media type: rich text) **4 quotations**

**Codes (14):** asking why questions?, confused how faith works?, demotivated, not want to pray, disappointed and sad, grapple with fear, groups for teaching and equipping, groups to care and encourage, initially just praying, maintain faith and trust in God, may be God's will to be ill, prayers from various pastors, prayers seemed not to help, problem with eye sight, support structures lacking

**Memos (0):**



**[P15: Rosy on faith healing experience](#)**

**File name:** \ (media type: rich text) **5 quotations**

**Codes (11):** asking why questions?, encouraged by preaching, healing a process in God's timing, illness re-occur, illness serves greater purpose, pain much bearable now, prayers

seemed not to help, received various prayers, remain strong in faith, sharp foot pain, strong emotionally

**Memos (0):**



**[P16: Salome on faith healing experience](#)**

**File name:** \ (media type: rich text) **8 quotations**

**Codes (13):** abnormal pregnancy symptoms, asking why questions?, belief in healing prayers, deliverance prayers, doctors advised to be operated, evil spirit operation, evil spirit to leave completely, grapple with fear, prayers seemed not to help, scared by witchdoctor's words, some change through prayers, strange objects and occurrences, want deliverance from evil spirit

**Memos (0):**



**[P17: Sandra on faith healing experience](#)**

**File name:** \ (media type: rich text) **15 quotations**

**Codes (30):** affecting marriage, asking why questions?, becoming suicidal, belief in healing prayers, believe in positive confession, blame and guilt to unhealed person, boldness and courage, church to be a safe place, dealing with fear, declare your status, grapple with fear, hard to accept, hard to forgive, healing by gifted and by own faith, HIV/ AIDS infected, infected in 1995, living by pretence and excuses, mental battle, moral support more than medicine, more support needed, opportunistic diseases increase fear, overcome physical battle, prayers of others with own faith, praying alone is not enough, spiritual support and friends, standing in faith important to withstand, stigma a problem, stigma and isolation to guard against, struggle with opportunistic diseases, the how questions lead to resentment

**Memos (0):**



**[P18: Sebron on faith healing experience](#)**

**File name:** \ (media type: rich text) **5 quotations**

**Codes (7):** doubt and uncertainties, encourage to persevere, faith is important, groups to care and encourage, healing a process in God's timing, healing by gifted and by own faith, some healing only through gifted

**Memos (0):**



**P19: Susan on faith healing experience**

**File name:** \ (media type: rich text) **5 quotations**

**Codes (7):** God's faithfulness, grapple with fear, groups for some not all, healing by gifted and by own faith, heart pains, not dying prematurely, to see her child grown

**Memos (0):**



**P20: Tangeni on faith healing experience**

**File name:** \ (media type: rich text) **4 quotations**

**Codes (4):** bodily discomfort, groups to care and encourage, healing by gifted and by own faith, short illness, not affected

**Memos (0):**



**P21: Thandi on faith healing experience**

**File name:** \ (media type: rich text) **10 quotations**

**Codes (19):** became strong, belief in healing prayers, blame and guilt to unhealed person, counselling and prayers, exorcism of witchcraft, experiencing demonic attacks, feeling hopeless, stress and emotionally drained, grapple with fear, groups for teaching and equipping, groups to care and encourage, healing a process in God's timing, initially a headache, low self- esteem and low confidence, mental problems, resist demonic operations, saw as spiritual attack, spiritually drained, strange objects and occurrences, teachings on demonic operations

**Memos (0):**



**P22: Thomas on faith healing experience**

**File name:** \ (media type: rich text) **10 quotations**

**Codes (19):** All three healthy and HIV negative, belief in healing prayers, by God's own intervention healed and delivered, cried out to God, diagnose with HIV/AIDS, doubt and uncertainties, encounter with God, feeling hopeless, stress and emotionally drained, God's intervention, grapple with fear, groups to care and encourage, healing a process in God's timing, kept his HIV status to himself, many years now HIV negative, marriage and children,

negative results confirmed, pledge to serve God, pre and post testing counselling, return for further test

**Memos (0):**



**[P23: Timothy on faith healing experience](#)**

**File name:** \ (media type: rich text) **10 quotations**

**Codes (19):** alternative ways of healing, asking why questions?, belief in healing prayers, dealing with vicious cycle, difficult to understand, feeling hopeless, stress and emotionally drained, groups to care and encourage, had faith in God's provision, illness serves greater purpose, learning more, lost work, managing emotions, normal food, not personalising ulcers, prayed for several times by pastors, pressure of early responsibilities, subscription diet, tension and shame to have ulcers, under economic and social pressures

**Memos (0):**



**[P24: Wilma on faith healing experience](#)**

**File name:** \ (media type: rich text) **3 quotations**

**Codes (5):** healing through prayers, hospitalised for chest pains, no pain currently, pain at hospital, receiving prayers

**Memos (0):**



**[P25: Lolly on faith healing experience](#)**

**File name:** \ (media type: rich text) **8 quotations**

**Codes (13):** asking why questions?, believe in positive confession, boldness and courage, chest pains and hospital treatment, doubt, doubt and uncertainties, fasting and praying no results, groups for teaching and equipping, healing a process in God's timing, learn to help others, patience needed for healing, prayers seemed not to help, resolved to wait in faith

**Memos (0):**

**Codes Summary**

*(Commented codes are clickable)*

**All codes used:** abnormal pregnancy symptoms {1-0}, accident at young age {1-0}, affect work performance {1-0}, affecting marriage {1-0}, All three healthy and HIV negative {1-

0}, alternative ways of healing {1-0}, annoyed when blame faith {1-1}, asking why questions? {20-0}, assured by faith healer of healing {1-0}, attended healing school {1-0}, be realistic in counselling {1-2}, became strong {1-0}, became strong emotionally {1-0}, becoming suicidal {1-1}, belief in God of love {1-1}, belief in healing prayers {15-0}, believe in positive confession {6-0}, blame and guilt to unhealed person {6-0}, bodily discomfort {1-0}, boldness and courage {9-1}, by God's own intervention healed and delivered {1-0}, car accident aggravated problem {1-0}, careful to stop medication {1-0}, causing emotional wounds {1-0}, chest pains and hospital treatment {1-0}, church to be a safe place {1-3}, confused how faith works? {1-1}, confused why suffering? {1-0}, counselling and prayers {1-2}, cried out to God {1-1}, dealing with fear {1-0}, dealing with shyness {0-0}, dealing with vicious cycle {1-0}, declare your status {1-0}, deliverance prayers {1-0}, demonic attacks and heart condition {1-0}, demotivated, not want to pray {1-1}, develop arthritis, frustrating {1-0}, diabetes, high blood and heart condition {1-0}, diagnose with HIV/AIDS {1-0}, didn't wear shorts {1-0}, difficult to minister to young people as HIV infected {0-0}, difficult to understand {1-0}, disappointed and sad {6-3}, discernment and sensitivity needed {1-0}, discouraged and losing hope {1-1}, disillusionment and hopeless {1-1}, doctor causes fear and instability {1-0}, doctors advised to be operated {1-0}, doubt {1-1}, doubt and uncertainties {5-1}, dreams and aspirations shattered {1-0}, emotionally stress and drained {1-1}, encounter with God {1-1}, encourage to persevere {1-0}, encouraged by own pastor {1-0}, encouraged by preaching {1-0}, evil spirit operation {1-0}, evil spirit to leave completely {1-0}, exorcism of witchcraft {1-0}, experiencing demonic attacks {1-0}, faith is important {1-0}, fasting and praying no results {1-0}, feel dizzy at times {1-0}, feeling better after prayers {1-1}, feeling better now {1-2}, [feeling hopeless, stress and emotionally drained {10-1}~](#), felt her efforts wasted {1-0}, frustrating and limiting {1-1}, gastric problem, not able to eat food {1-0}, gastric problem, not able to eat food {0-0}, God's faithfulness {1-1}, God's intervention {1-0}, God's love source of hope {1-1}, got prayed by various pastors {1-0}, gradual increase in self confidence {1-1}, grapple with fear {9-1}, grateful and made pledge to serve God {0-0}, groups for some not all {1-0}, groups for teaching and equipping {5-1}, groups to care and encourage {14-1}, had faith in God's provision {1-1}, hard to accept {1-0}, hard to forgive {1-0}, [healing a process in God's timing {12-0}~](#), healing by gifted and by own faith {12-0}, healing can come through any one {1-0}, Healing comes in different ways {1-0}, healing could also be instantly {1-0}, healing through prayers {1-0}, heart pains {1-0}, HIV positive since 1992 {1-0}, HIV/ AIDS infected {1-0}, hospitalised for chest pains {1-0}, illness re-occur {1-0}, illness serves greater purpose {4-0}, infected in 1995 {1-0}, infected with HIV/AIDS {1-0}, initially a headache {1-0}, initially just praying {1-0}, initially questioning why God? {1-0}, initially started with headache {0-0}, keeping faith and hope for healing {1-1}, kept his HIV status to himself {1-0}, knee problem became worst {1-0}, learn to help others {1-1}, learn to sympathise with others {1-1}, learning more {1-0}, limited career options {1-0}, living by pretence and excuses {1-0}, living reckless before marriage {1-0}, lost work {1-0}, low self- esteem and low confidence {1-1}, lump and hip problem {1-0}, maintain faith and trust in God {1-1}, managing emotions {1-1}, many years now HIV negative {1-0}, marriage and children {1-0}, may be God's will to be ill {1-0}, mental battle {1-0}, mental problems {1-0}, migraine headaches {1-0}, moral support more than medicine {1-1}, more support needed {1-1}, motor car accident {1-0}, need assistance constantly {1-1}, need for counselling {1-2}, negative results confirmed {2-0}, No apparent diagnosis {1-0}, no pain currently {1-0}, normal food {1-0}, not angry with God {1-0}, not dying prematurely {1-0}, not personalising ulcers {1-0}, not questioning God {1-0}, opportunistic diseases increase fear {1-0}, overcome physical battle {1-0}, pain at hospital {1-0}, pain

much bearable now {1-0}, paralyse for 15 years {1-0}, pastors need training {1-0}, patience needed for healing {4-0}, physically frail and dependant {1-0}, pledge to serve God {1-0}, possible to suffer in silence {1-0}, prayed for and encouraged to believe {0-0}, prayed for several times by pastors {1-0}, prayers from various pastors {1-0}, prayers of others with own faith {1-0}, prayers seemed not to help {10-0}, praying alone is not enough {1-0}, praying for pain to go {1-0}, pre and post testing counselling {1-0}, preaching above healing {1-0}, preaching must be central {1-0}, pregnancy complications {1-0}, pressure of early responsibilities {1-0}, problem from hip to knee {1-0}, problem of sexual arousal {1-0}, problem since 11 year old {1-0}, problem was witchcraft {1-0}, problem with eye sight {1-0}, received various prayers {1-0}, receiving prayers {1-0}, relationship tense with wife {1-0}, remain strong in faith {1-0}, resist demonic operations {1-0}, resolved to wait in faith {1-0}, return for further test {1-0}, right knee dislocation {1-0}, saw as spiritual attack {1-0}, scared by witchdoctor's words {1-0}, several surgeries {1-0}, sharp foot pain {1-0}, short illness, not affected {1-0}, silent suffering possible {1-0}, some change through prayers {1-0}, some healing only through gifted {1-0}, some people having gift to heal {1-0}, soul searching and cleansing {1-0}, spiritual support and friends {1-0}, spiritually drained {1-0}, standing in faith important to withstand {1-0}, started with a headache {0-0}, stigma a problem {1-0}, stigma and isolation to guard against {1-0}, strange objects and occurrences {2-0}, strangely on further testing results turned out negative {0-0}, strong emotionally {1-2}, stronger with spiritual growth {1-0}, struggle with opportunistic diseases {1-0}, struggled initially emotionally {1-0}, subscription diet {1-0}, suffered since childhood from period pains {0-0}, suffering from diabetes, high blood pressure and heart condition {0-0}, support structures lacking {1-0}, taking TB medication {1-0}, TB sufferer for three years {1-0}, teachings on demonic operations {1-0}, tension and shame to have ulcers {1-0}, the how questions lead to resentment {1-0}, thought God not caring {1-0}, to quit if God doesn't help {1-0}, to see her child grown {1-0}, under economic and social pressures {1-0}, unemployed and no income {1-0}, view illness as from devil {1-0}, want deliverance from evil spirit {1-0}, want to quit {1-0}, wanted to divorce {1-0}, without faith prayers of others of no use {0-0}, worried not able to work {0-0}, worry about her child {1-0}

Codes sorted by Alphabet:

abnormal pregnancy symptoms {1-0}	▲
accident at young age {1-0}	
affect work performance {1-0}	
affecting marriage {1-0}	
All three healthy and HIV negative {1-0}	
alternative ways of healing {1-0}	
annoyed when blame faith {1-1}	
asking why questions? {20-0}	▼

Bottom of Form

Codes sorted by Groundedness:

asking why questions? {20-0}	▲
belief in healing prayers {15-0}	
groups to care and encourage {14-1}	
healing by gifted and by own faith {12-0}	
healing a process in God's timing {12-0}~	
feeling hopeless, stress and emotionally drained {10-1}~	
prayers seemed not to help {10-0}	
boldness and courage {9-1}	▼

Bottom of Form

Codes sorted by Density:

disappointed and sad {6-3}
church to be a safe place {1-3}
be realistic in counselling {1-2}
counselling and prayers {1-2}
need for counselling {1-2}
feeling better now {1-2}
strong emotionally {1-2}
demotivated, not want to pray {1-1}

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Commented Codes only:



**Feeling hopeless, stress and emotionally drained {10-1}~**

\*\*\* Merged Comment from: *feeling hopeless, stress and emotionally drained (2012-04-27T22:53:13)* \*\*\*

*feeling hopeless and stressful*



**Healing a process in God's timing {12-0}~**

\*\*\* Merged Comment from: *healing a process in God's timing (2012-04-28T12:28:14)* \*\*\*

*positive confession is the belief whereby healing is claimed by faith after being prayed for, no matter whether pain or illness is still felt. It is to confess healing in the name of Jesus Christ and on the basis of his atoning death on the cross; and thus not to acknowledge illness or pain in your body. It is believed that through ongoing positive confession, healing that has already happened through prayer will eventually manifest.*

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**Memos**



**African practices {0-Me-F} - Super**

Witchcraft and spiritism play a big role in many African cultures and customs, therefore sickness in many instances is linked to evil operations of those with malicious motifs and intentions.



**Correct interpretation {0-Me-F} - Martin**

Proper hermeneutic is necessary for proper application of scripture, as wrong interpretation on healing text may lead to wrong application



**Faith versus reality {0-Me-F} - Martin**

Unresolved conflict seems to exist between trusting for healing through prayers and facing the reality of one's condition of illness.



**Healing perspective {0-Me-F} - Martin**

Most respondents hope or belief that they will receive physical healing someday. Very few perceive their condition as permanent or unredeemable by God.



**Measure of faith {0-Me-F} - Martin**

There is a view that people are on different levels of faith and therefore healing happens in measure to one's faith. It is claimed that a person with "little faith" will not experience healing outcome on the same level as a person with "strong faith."



**Pain as intruder {0-Me-F} - Martin**

Human nature is intolerant to pain and suffering. In fact, prolong illness attacks human dignity and diminishes hope and aspirations an ill person may harbour.



**Positive outcomes? {0-Me-F} - Martin**

Is it justifiable to expect that exercising faith should automatically translate into healing or pain-free life?



**psychosomatic factors {0-Me-F} - Martin**

There seems to be a placebo effect or psychosomatic manifestation on people who claimed to be healed at a church service and when returning home found that their illness has re-occurred again. Many people experience different types of psychosomatic manifestations with no apparent symptoms. Stress and other life-related pressures can also have affect on body- mind harmony.



**Reality of illness {0-Me-F} - Super**

Although my research doesn't investigate the authenticity of healing ministry, there is need to understand the plight of an ill person. A person suffering from illness do not really theologise about healing, but like any human desire wants to get well at any cost. The question whether modern healing practices are relevant and biblical is a non- starter.



**Result of tension {0-Me-F} - Martin**

The tension between positive confessing, that claims healing by faith, and being face with the reality of persisting illness may lead to a splitted personality.

**PD Families**



Gender::Female

**Primary Docs (19):** P 1: Amy on faith healing experience, P 2: Angelica on faith healing experience, P 3: Caroline on faith healing experience, P 4: Elizabeth on faith healing experience, P 5: Gloria on faith healing experience, P 6: Jacky on faith healing experience, P 8: Lena on faith healing experience, P 9: Letta on faith healing experience, P11: Martha on faith healing experience, P12: Maureen on faith healing experience, P13: Noleen on faith healing experience, P14: Rachel on faith healing experience, P15: Rosy on faith healing experience, P16: Salome on faith healing experience, P17: Sandra on faith healing experience, P19: Susan on faith healing experience, P21: Thandi on faith healing experience, P24: Wilma on faith healing experience, P25: Lolly on faith healing experience



Gender::Male

**Primary Docs (6):** P 7: Karl on faith healing experience, P10: Lucky on faith healing experience, P18: Sebron on faith healing experience, P20: Tangeni on faith healing experience, P22: Thomas on faith healing experience, P23: Timothy on faith healing experience



Location::Katutura

**Primary Docs (13):** P 4: Elizabeth on faith healing experience, P 5: Gloria on faith healing experience, P 6: Jacky on faith healing experience, P 7: Karl on faith healing experience, P 8: Lena on faith healing experience, P 9: Letta on faith healing experience, P12: Maureen on faith healing experience, P13: Noleen on faith healing experience, P16: Salome on faith healing experience, P19: Susan on faith healing experience, P20: Tangeni on faith healing experience, P22: Thomas on faith healing experience, P24: Wilma on faith healing experience



Location::Khomasdal

**Primary Docs (4):** P 1: Amy on faith healing experience, P 3: Caroline on faith healing experience, P18: Sebron on faith healing experience, P25: Lolly on faith healing experience



Location::Windhoek

**Primary Docs (8):** P 2: Angelica on faith healing experience, P10: Lucky on faith healing experience, P11: Martha on faith healing experience, P14: Rachel on faith healing experience, P15: Rosy on faith healing experience, P17: Sandra on faith healing experience, P21: Thandi on faith healing experience, P23: Timothy on faith healing experience



Profession::Administrator

**Primary Docs (2):** P 5: Gloria on faith healing experience, P13: Noleen on faith healing experience



Profession::Banker

**Primary Docs (1):** P10: Lucky on faith healing experience



Profession::Beauty Therapist

**Primary Docs (1):** P 8: Lena on faith healing experience



Profession::Entrepreneur

**Primary Docs (1):** P23: Timothy on faith healing experience



Profession::Hair Stylist

**Primary Docs (1):** P11: Martha on faith healing experience



Profession::House wife

**Primary Docs (2):** P19: Susan on faith healing experience, P25: Lolly on faith healing experience



Profession::Labourer

**Primary Docs (2):** P 7: Karl on faith healing experience, P22: Thomas on faith healing experience



Profession::Nurse

**Primary Docs (1):** P 1: Amy on faith healing experience



Profession::Pastor

**Primary Docs (2):** P17: Sandra on faith healing experience, P20: Tangeni on faith healing experience



Profession::Sales manager

**Primary Docs (1):** P 2: Angelica on faith healing experience



Profession::Secretary

**Primary Docs (1):** P 6: Jacky on faith healing experience



Profession:: Self- employed

**Primary Docs (1):** P15: Rosy on faith healing experience



Profession::Teacher

**Primary Docs (3):** P 3: Caroline on faith healing experience, P14: Rachel on faith healing experience, P18: Sebron on faith healing experience



Profession::Unemployed

**Primary Docs(6):** P 4: Elizabeth on faith healing experience, P 9: Letta on faith healing experience, P12: Maureen on faith healing experience, P16: Salome on faith healing experience, P21: Thandi on faith healing experience, P24: Wilma on faith healing experience

### Code Families



Emotional impact

*In the process of seeking healing many people experience all kinds of emotions. The response on this question has shown that emotional wellness is an important issue that needed to be addressed even where physical healing is concerned. The holistic nature of being human calls for an approach that goes beyond mere praying for the sick.*

**Codes(44):** affecting marriage, annoyed when blame faith, became strong, became strong emotionally, becoming suicidal, blame and guilt to unhealed person, causing emotional wounds, cried out to God, dealing with fear, dealing with shyness, dealing with vicious cycle, demotivated, not want to pray, disappointed and sad, discouraged and losing hope, disillusionment and hopeless, doctor causes fear and instability, doubt, doubt and uncertainties, emotionally stress and drained, feel dizzy at times, feeling better after prayers, feeling better now, feeling hopeless, stress and emotionally drained, felt her efforts wasted, frustrating and limiting, gradual increase in self confidence, grapple with fear, hard to accept, hard to forgive, low self- esteem and low confidence, managing emotions, mental battle, mental problems, relationship tense with wife, scared by witchdoctor's words, short illness, not affected, stigma a problem, stigma and isolation to guard against, strong emotionally, struggled initially emotionally, tension and shame to have ulcers, the how questions lead to resentment, to quit if God doesn't help, worry about her child



Healing ways & mediums

*It is clear that there is no one formula for praying for sick people. Healing is understood to come in various ways from personal prayers, prayers by any believer and through those having the gift of healing. All interviewees attested to the fact that healing manifests through exercise of own faith and not through the faith of the one praying for you.*

**Codes(10):** alternative ways of healing, believe in positive confession, difficult to minister to young people as HIV infected, difficult to understand, healing a process in God's timing, healing by gifted and by own faith, healing can come through any one, Healing comes in different ways, healing could also be instantly, prayers of others with own faith



Ministry impact

*It was encouraging to note that though few, some people maintain positive attitude and are willing to live out their Christian witness despite facing the challenges of illness.*

**Codes(4):** boldness and courage, learn to help others, learn to sympathise with others, pledge to serve God



#### Negative emotions

*Most of those interviewed have struggled with their emotions in the way they relate to their illness. It seems that unmet expectations of healing easily resort to emotional instability which needs to be catered for if wholesome living is desired.*

**Codes(28):** affecting marriage, annoyed when blame faith, becoming suicidal, blame and guilt to unhealed person, causing emotional wounds, demotivated, not want to pray, disappointed and sad, discouraged and losing hope, disillusionment and hopeless, doubt, doubt and uncertainties, emotionally stress and drained, feel dizzy at times, feeling hopeless, stress and emotionally drained, felt her efforts wasted, frustrating and limiting, grapple with fear, hard to accept, hard to forgive, low self- esteem and low confidence, relationship tense with wife, spiritually drained, stigma a problem, stigma and isolation to guard against, tension and shame to have ulcers, the how questions lead to resentment, to quit if God doesn't help, want to quit



#### Positive emotions

*The interviewees experiencing positive emotional responses are quite low, if considered the high number of those who have experiencing negative emotions. This is somehow understandable as people are promised healing and thus come with high expectation. When instant healing is not experienced they struggle to cope emotionally with balancing the faith expectations to the reality of prevailing illness.*

**Codes(10):** became strong, became strong emotionally, dealing with fear, dealing with shyness, dealing with vicious cycle, feeling better after prayers, feeling better now, gradual increase in self confidence, managing emotions, strong emotionally



#### Prayers answered

**Codes(1):** by God's own intervention healed and delivered



#### Prayers offered

*The purpose of the research is focusing on those people who grapple with persistent illness in spite receiving healing prayers. Therefore, overwhelming number of interviewees fall either in the category of not healed or still waiting for healing to happen.*

**Codes(9):** got prayed by various pastors, initially just praying, prayed for and encouraged to believe, prayed for several times by pastors, prayers from various pastors, prayers seemed not to help, praying for pain to go, received various prayers, receiving prayers



#### Prayers unanswered

*The interviewees who deemed themselves to have received answers to healing prayers are very few then those who have a sense that prayers have failed or that they are still believing*

*for healing to manifest in the future. This is expected as the research focus was on people who suffer with persistent illness despite prayers, rather than those who were healed instantly through prayers.*

**Codes(3):** fasting and praying no results, illness re-occur, prayers seemed not to help



#### Prevailing illness

*People with different range of illnesses were interviewed. There were a significant number of people with HIV infection. This underscores the high prevalent rate of HIV/ AIDS in Southern Africa. The interviewees suffered from conditions ranging from chronic, acute, physical, mental, demonic, physical and natural.*

**Codes(41):** bodily discomfort, car accident aggravated problem, chest pains and hospital treatment, dealing with vicious cycle, demonic attacks and heart condition, develop arthritis, frustrating, diabetes, high blood and heart condition, diagnose with HIV/AIDS, experiencing demonic attacks, feel dizzy at times, gastric problem, not able to eat food, heart pains, HIV positive since 1992, HIV/ AIDS infected, hospitalised for chest pains, illness re-occur, infected in 1995, infected with HIV/AIDS, initially a headache, initially started with headache, knee problem became worst, lump and hip problem, migraine headaches, motor car accident, opportunistic diseases increase fear, pain much bearable now, paralyse for 15 years, physically frail and dependant, problem from hip to knee, problem of sexual arousal, problem since 11 year old, problem was witchcraft, problem with eye sight, right knee dislocation, several surgeries, sharp foot pain, started with a headache, struggle with opportunistic diseases, suffered since childhood from period pains, suffering from diabetes, high blood pressure and heart condition, TB sufferer for three years



#### Spiritual impact

*It was encouraging to note that many people have a higher understanding of their illnesses and try to understand the deeper meaning of it. The positive elements that were highlighted were that through illness: better approbation and empathy develop for suffering of others, people learn to serve and value others; and a deepened relationship with God was established.*

**Codes(14):** cried out to God, encounter with God, encourage to persevere, encouraged by preaching, illness serves greater purpose, learn to help others, learn to sympathise with others, learning more, patience needed for healing, pledge to serve God, resolved to wait in faith, soul searching and cleansing, spiritual support and friends, stronger with spiritual growth



#### Support structures

*Supporting resources were overwhelmingly seen as lacking in those doing faith healing prayers. Faith healing churches are strong on praying for people but to not have followed up mechanisms and supporting structures to carry people along the road to recovery or healing. The emotional and faith issues people grappled with are not catered for in a structured and responsive way.*

**Codes(9):** church to be a safe place, groups for some not all, groups for teaching and equipping, groups to care and encourage, moral support more than medicine, more support needed, need assistance constantly, need for counselling, support structures lacking



#### View of God

*Illness results in people asking lots of faith questions dealing with why they are not healed or why they suffer while faithfully serving the Lord. These questions affect their faith and tend to cause some doubt and uncertainty. Interviewees do not really question the character of God as loving and caring, but many were confused why they are not becoming well. They uphold the faithfulness of God and believe that God has his own time and ways to heal them. They resolved to wait patiently, believing that healing will ultimately come.*

**Codes(13):** asking why questions?, belief in God of love, confused why suffering?, God's faithfulness, God's intervention, God's love source of hope, had faith in God's provision, healing a process in God's timing, initially questioning why God?, maintain faith and trust in God, may be God's will to be ill, not questioning God, thought God not caring

#### Memo Families

No memo families were used or coded for research analysis.

#### Network Views

*Nodes are prefixed with a single letter denoting its type: C= Code, M = Memo, Q = Quotation, P = Primary Document*



#### Emotional impact

**Nodes (45):** CO: became strong emotionally {1-0}, CO: becoming suicidal {1-1}, CO: stigma and isolation to guard against {1-0}, CO: dealing with shyness {0-0}, CO: scared by witchdoctor's words {1-0}, CO: frustrating and limiting {1-1}, CO: hard to accept {1-0}, CO: doubt {1-1}, CO: feeling better now {1-2}, CO: grapple with fear {9-1}, CO: struggled initially emotionally {1-0}, CO: low self- esteem and low confidence {1-1}, CO: worry about her child {1-0}, CO: discouraged and losing hope {1-1}, CO: disillusionment and hopeless {1-1}, CO: feel dizzy at times {1-0}, CO: causing emotional wounds {1-0}, CO: hard to forgive {1-0}, CO: relationship tense with wife {1-0}, CO: disappointed and sad {6-3}, CO: managing emotions {1-1}, CO: demotivated, not want to pray {1-1}, CO: annoyed when blame faith {1-1}, CO: cried out to God {1-1}, CO: mental battle {1-0}, CO: dealing with vicious cycle {1-0}, CO: doubt and uncertainties {5-1}, CO: short illness, not affected {1-0}, CO: mental problems {1-0}, CO: tension and shame to have ulcers {1-0}, CO: to quit if God doesn't help {1-0}, CO: felt her efforts wasted {1-0}, CO: strong emotionally {1-2}, CO: gradual increase in self confidence {1-1}, CO: dealing with fear {1-0}, CO: stigma a problem {1-0}, CO: feeling better after prayers {1-1}, CO: doctor causes fear and instability {1-0}, CO: the how questions lead to resentment {1-0}, CO: emotionally stress and drained {1-1}, CO: blame and guilt to unhealed person {6-0}, CO: affecting marriage {1-0}, CO: became strong {1-0}, CO: feeling hopeless, stress and emotionally drained {10-1}~, CF: emotional impact (44)~



### Faith questions

**Nodes (12):** CO: maintain faith and trust in God {1-1}, CO: may be God's will to be ill {1-0}, CO: demotivated, not want to pray {1-1}, CO: asking why questions? {20-0}, CO: confused how faith works? {1-1}, QU:<8:4 Lena: it's frustrating (hee: i.. (13:13), QU:<23:5 But all the same the question .. (3:3), QU:>14:3 Rachel: I still hold to my fai.. (9:9), QU:<3:3 Caroline: uh, First, I was wea.. (7:7), QU:<1:4 Amy: It is not like you will r.. (7:7), QU:<7:4 Karl: I was asking questions t.. (13:13), QU:<13:3 Noleen: Yes as I always say Go.. (7:7)



### Faith responses to healing prayers

**Nodes (27):** CO: doubt {1-1}, CO: doubt and uncertainties {5-1}, CO: illness serves greater purpose {4-0}, CO: may be God's will to be ill {1-0}, CO: healing a process in God's timing {12-0}~, CO: keeping faith and hope for healing {1-1}, CO: confused how faith works? {1-1}, CO: annoyed when blame faith {1-1}, CO: maintain faith and trust in God {1-1}, CO: asking why questions? {20-0}, CO: remain strong in faith {1-0}, QU:<14:2 Rachel: uh, I am emotionally d.. (7:7), QU:>13:2 affect you emotionally? Noleen.. (4:5), QU:11:6 Martha: Yes, I will say that. .. (19:19), QU:<23:5 But all the same the question .. (3:3), QU:17:11 I cannot say where was God, wh.. (7:7), QU:16:8 Salome: She imagine herself an.. (22:22), QU:11:3 Martha: Yes, sometimes I quest.. (9:9), QU:15:2 Rosy: Yeah, how can I get a he.. (4:4), QU:<1:4 Amy: It is not like you will r.. (7:7), QU:>14:3 Rachel: I still hold to my fai.. (9:9), QU:<13:3 Noleen: Yes as I always say Go.. (7:7), QU:<4:2 Elizabeth: It was too emotiona.. (5:5), QU:9:1 Letta: Yes, I have a hip probl.. (3:3), QU:11:1 Martha: Yeah, I have for somet.. (3:3), QU:6:2 Jacky: Hu, while waiting for h.. (5:5), QU:<7:4 Karl: I was asking questions t.. (13:13)



### Healing ways & mediums

**Nodes (11):** CO: Healing comes in different ways {1-0}, CO: healing can come through any one {1-0}, CO: difficult to understand {1-0}, CO: believe in positive confession {6-0}, CO: healing could also be instantly {1-0}, CO: healing a process in God's timing {12-0}~, CO: difficult to minister to young people as HIV infected {0-0}, CO: prayers of others with own faith {1-0}, CO: alternative ways of healing {1-0}, CO: healing by gifted and by own faith {12-0}, CF: healing ways & mediums (10)~



### Ministry impact

**Nodes (5):** CO: pledge to serve God {1-0}, CO: learn to sympathise with others {1-1}, CO: learn to help others {1-1}, CO: boldness and courage {9-1}, CF: ministry impact (4)~



### Negative emotional experiences

**Nodes (25):** CO: low self- esteem and low confidence {1-1}, CO: grapple with fear {9-1}, CO: frustrating and limiting {1-1}, CO: confused why suffering? {1-0}, CO: felt her efforts wasted {1-0}, CO: thought God not caring {1-0}, CO: feeling hopeless, stress and emotionally drained {10-1}~, CO: disappointed and sad {6-3}, CO: demotivated, not want to pray {1-1}, CO: becoming suicidal {1-1}, CO: emotionally stress and drained {1-1}, CO: disillusionment and hopeless {1-1}, CO: discouraged and losing hope {1-1}, QU:>13:2 affect you emotionally? Noleen.. (4:5), QU:9:1 Letta: Yes, I have a hip probl.. (3:3), QU:4:3 Elizabeth: eeh for me I was a .. (7:7), QU:<14:2 Rachel: uh, I am emotionally d.. (7:7), QU:<4:2 Elizabeth: It was too emotiona.. (5:5), QU:22:1 Thomas: Yes, I myself was shoc.. (3:3), QU:<21:5 Thandi: Emotionally as a perso.. (5:5), QU:1:3 Amy: Yeah, eeh eeh, it will de.. (5:5), QU:8:3 The knee doesn't want to be in.. (7:7), QU:<1:4 Amy: It is not like you will r.. (7:7), QU:3:2 Caroline: yeah, I became sad a.. (5:5), QU:<14:1 Rachel: Yes, I am struggling w.. (5:5)



### Negative emotions

**Nodes (29):** CO: feel dizzy at times {1-0}, CO: spiritually drained {1-0}, CO: doubt {1-1}, CO: feeling hopeless, stress and emotionally drained {10-1}~, CO: discouraged and losing hope {1-1}, CO: grapple with fear {9-1}, CO: stigma a problem {1-0}, CO: disappointed and sad {6-3}, CO: felt her efforts wasted {1-0}, CO: relationship tense with wife {1-0}, CO: blame and guilt to unhealed person {6-0}, CO: low self- esteem and low confidence {1-1}, CO: disillusionment and hopeless {1-1}, CO: causing emotional wounds {1-0}, CO: want to quit {1-0}, CO: becoming suicidal {1-1}, CO: tension and shame to have ulcers {1-0}, CO: stigma and isolation to guard against {1-0}, CO: frustrating and limiting {1-1}, CO: annoyed when blame faith {1-1}, CO: the how questions lead to resentment {1-0}, CO: doubt and uncertainties {5-1}, CO: demotivated, not want to pray {1-1}, CO: hard to forgive {1-0}, CO:to quit if God doesn't help {1-0}, CO: emotionally stress and drained {1-1}, CO: hard to accept {1-0}, CO: affecting marriage {1-0}, CF: negative emotions (28)~



### Positive emotional experiences

**Nodes (18):** CO: feeling better now {1-2}, CO: feeling better after prayers {1-1}, CO: boldness and courage {9-1}, CO: strong emotionally {1-2}, CO: managing emotions {1-1}, CO: gradual increase in self confidence {1-1}, QU:25:4 Lolly: Yes, yes I got that cou.. (7:7), QU:17:13 Sandra: This has challenged my.. (9:9), QU:13:7 Noleen: No, freedom is there. .. (15:15), QU:10:3 Lucky: To tell the truth pasto.. (9:10), QU:23:7 Timothy: The tension was there.. (7:7), QU:15:3 Rosy: uh, fortunately this was.. (6:6), QU:7:5 Karl: Very difficult. I was wi.. (15:15), QU:5:5 Gloria: She is saying when she.. (16:16), QU:<3:3 Caroline: uh, First, I was wea.. (7:7), QU:13:5 Noleen: No, for me I don't go .. (11:11), QU:8:7 Lena: This somehow limited my .. (23:23), QU:7:6 Karl: After the day of prayer... (17:17)



### Positive emotions

**Nodes (11):** CO: dealing with vicious cycle {1-0}, CO: strong emotionally {1-2}, CO: gradual increase in self confidence {1-1}, CO: became strong {1-0}, CO: feeling better after prayers {1-1}, CO: became strong emotionally {1-0}, CO: dealing with shyness {0-0}, CO: dealing with fear {1-0}, CO: feeling better now {1-2}, CO: managing emotions {1-1}, CF: positive emotions (10)~



### Prayers answered

**Nodes (2):** CO: by God's own intervention healed and delivered {1-0}, CF: prayers answered (1)



### Prayers offered

**Nodes (10):** CO: prayed for and encouraged to believe {0-0}, CO: prayers from various pastors {1-0}, CO: receiving prayers {1-0}, CO: got prayed by various pastors {1-0}, CO: initially just praying {1-0}, CO: prayers seemed not to help {10-0}, CO: prayed for several times by pastors {1-0}, CO: praying for pain to go {1-0}, CO: received various prayers {1-0}, CF: prayers offered (9)~



### Prayers unanswered

**Nodes (4):** CO: illness re-occur {1-0}, CO: prayers seemed not to help {10-0}, CO: fasting and praying no results {1-0}, CF: prayers unanswered (3)~



### Prevailing illness

**Nodes (42):** CO: bodily discomfort {1-0}, CO: sharp foot pain {1-0}, CO: illness re-occur {1-0}, CO: problem was witchcraft {1-0}, CO: pain much bearable now {1-0}, CO: physically frail and dependant {1-0}, CO:HIV positive since 1992 {1-0}, CO: migraine headaches {1-0}, CO: started with a headache {0-0}, CO: paralyse for 15 years {1-0}, CO: diagnose with HIV/AIDS {1-0}, CO: chest pains and hospital treatment {1-0}, CO: motor car accident {1-0}, CO: feel dizzy at times {1-0}, CO: heart pains {1-0}, CO: gastric problem, not able to eat food {0-0}, CO: problem of sexual arousal {1-0}, CO:HIV/ AIDS infected {1-0}, CO: develop arthritis, frustrating {1-0}, CO: infected in 1995 {1-0}, CO: suffered since childhood from period pains {0-0}, CO: infected with HIV/AIDS {1-0}, CO: initially started with headache {0-0}, CO: several surgeries {1-0}, CO: knee problem became worst {1-0}, CO: opportunistic diseases increase fear {1-0}, CO: initially a headache {1-0}, CO: right knee dislocation {1-0}, CO: struggle with opportunistic diseases {1-0}, CO: dealing with vicious cycle {1-0}, CO: problem with eye sight {1-0}, CO: suffering from diabetes, high blood pressure and heart condition {0-0}, CO: problem since 11 year old {1-0}, CO: problem

from hip to knee {1-0}, CO: experiencing demonic attacks {1-0}, CO: diabetes, high blood and heart condition {1-0}, CO: hospitalised for chest pains {1-0}, CO: lump and hip problem {1-0}, CO: TB sufferer for three years {1-0}, CO: car accident aggravated problem {1-0}, CO: demonic attacks and heart condition {1-0}, CF: prevailing illness (41)~



### Spiritual impact

**Nodes (15):** CO: learn to help others {1-1}, CO: illness serves greater purpose {4-0}, CO: patience needed for healing {4-0}, CO: encouraged by preaching {1-0}, CO: stronger with spiritual growth {1-0}, CO: encounter with God {1-1}, CO: pledge to serve God {1-0}, CO: encourage to persevere {1-0}, CO: soul searching and cleansing {1-0}, CO: cried out to God {1-1}, CO: learning more {1-0}, CO: learn to sympathise with others {1-1}, CO: resolved to wait in faith {1-0}, CO: spiritual support and friends {1-0}, CF: spiritual impact (14)~



### Spirituality in view of illness

**Nodes (28):** CO: not questioning God {1-0}, CO: healing a process in God's timing {12-0}~, CO: want to quit {1-0}, CO: remain strong in faith {1-0}, CO: asking why questions? {20-0}, CO: view illness as from devil {1-0}, CO: grapple with fear {9-1}, CO: stronger with spiritual growth {1-0}, CO: initially questioning why God? {1-0}, CO: spiritually drained {1-0}, CO: encounter with God {1-1}, CO: encourage to persevere {1-0}, CO: belief in God of love {1-1}, CO: cried out to God {1-1}, CO: God's faithfulness {1-1}, CO: learn to help others {1-1}, CO: learn to sympathise with others {1-1}, CO:

God's love source of hope {1-1}, CO: illness serves greater purpose {4-0}, QU:15:2 Rosy: Yeah, how can I get a he.. (4:4), QU:23:9 And I also learn that it's not.. (9:9), QU:2:6 I am in no way questioning God.. (7:7), QU:6:2 Jacky: Hu, while waiting for h.. (5:5), QU:<21:5 Thandi: Emotionally as a perso.. (5:5), QU:19:2 Susan: uh I have that faith an.. (5:5), QU:10:8 Lucky: Yes, absolutely at the .. (20:20), QU:18:5 Know that we all go through to.. (13:13), QU:2:4 Angelica: Hee, I see God as lo.. (7:7)



### Support structures

**Nodes (10):** CO: groups for teaching and equipping {5-1}, CO: moral support more than medicine {1-1}, CO: support structures lacking {1-0}, CO: need for counselling {1-2}, CO: groups to care and encourage {14-1}, CO: church to be a safe place {1-3}, CO: groups for some not all {1-0}, CO: need assistance constantly {1-1}, CO: more support needed {1-1}, CF: support structures (9)~



### Supporting resources

**Nodes (31):** CO: counselling and prayers {1-2}, CO: moral support more than medicine {1-1}, CO: church to be a safe place {1-3}, CO: be realistic in counselling {1-2}, CO: more support needed {1-1}, CO: groups to care and encourage {14-1}, CO: groups for teaching

and equipping {5-1}, CO: need for counselling {1-2}, CO: need assistance constantly {1-1}, QU:18:4 Sebron: I will say definitely,.. (11:11), QU:20:4 Yes, I can say we need to have.. (11:11), QU:11:7 Martha: Pastors must go to peo.. (23:23), QU:7:7 Karl: Yes, there is a big need.. (21:21), QU:9:4 Letta: There is no such suppor.. (11:11), QU:21:8 Thandi: Yes, at the end of the.. (11:11), QU:17:14 People must come out publicly .. (11:11), QU:1:7 Amy: Yeah, pastor being in med.. (13:13), QU:21:3 Yeah I will pray and what I wi.. (3:3), QU:22:11 Thomas: I think support groups.. (13:13), QU:23:10 imothy: I think people need to.. (13:13), QU:14:4 Rachel: Yes, this is an area t.. (11:11), QU:21:10 about but with structures put .. (13:13), QU:10:9 Lucky: I do believe, I fully b.. (22:23), QU:2:2 uh, as you can imagine I canno.. (3:3), QU:3:5 Caroline: yeah, definitely the.. (11:11), QU:25:7 Lolly: Yes, it will be nice fo.. (13:13), QU:4:5 Elizabeth: Eeh, we do need gro.. (11:11), QU:6:4 Jacky: Actually if I say in Na.. (11:11), QU:1:6 Amy: Yeah, they are needed and.. (11:11), QU:17:7 People that strong in their fa.. (3:3), QU:17:15 Sandra: I don't think it's eno.. (13:13)



### Unmet expectations

**Nodes (12):** CO: disappointed and sad {6-3}, CO: felt her efforts wasted {1-0}, CO: asking why questions? {20-0}, CO: confused why suffering? {1-0}, QU:<8:4 Lena: it's frustrating (hee: i.. (13:13), QU:<2:3 Angelica: uh, it was very diff.. (5:5), QU:>13:2 affect you emotionally? Noleen.. (4:5), QU:<1:2 Amy: Yeah, eeh eeh, it will de.. (5:5), QU:<14:2 Rachel: uh, I am emotionally d.. (7:7), QU:<21:5 Thandi: Emotionally as a perso.. (5:5), QU:<14:1 Rachel: Yes, I am struggling w.. (5:5), QU:<4:2 Elizabeth: It was too emotiona.. (5:5)



### View of God

**Nodes (14):** CO: thought God not caring {1-0}, CO: healing a process in God's timing {12-0}~, CO: belief in God of love {1-1}, CO: confused why suffering? {1-0}, CO: not questioning God {1-0}, CO: maintain faith and trust in God {1-1}, CO: had faith in God's provision {1-1}, CO: God's intervention {1-0}, CO: asking why questions? {20-0}, CO: God's love source of hope {1-1}, CO: God's faithfulness {1-1}, CO: may be God's will to be ill {1-0}, CO: initially questioning why God? {1-0}, CF: view of God (13)~