

https://dspace.org/

An analysis of indigenous healing in suburban Johannesburg

Farrand, Dorothy

2015-03-11
http://hdl.handle.net/10539/17247

Downloaded from a DSpace repository. https://dspace.org/

AN ANALYSIS OF INDIGENOUS HEALING IN SUBURBAN JOHANNESBURG

by

DOROTHY FARRAND

Dissertation submitted to the Department of Psychology, University of the Witwatersrand, in partial fulfilment of the requirements for the degree of M.A.

March, 1980.

CONTENTS

		PAGE
I	Introduction	1
II	Methodology	9
	Research approach used in the present study	9
	Informants	10
	Procedure	15
III	Results	18
	Biographical Data	18
	Pretraining Symptoms	25
	Training	27
	Divination	38
	Ancestors	45
IV	Discussion	47
	Biographical Data	47
	Pre-training Symptoms	53
	Training	54
	Practice of Healers	61
	Ancestors	64
V	Conclusion	66
VI	References	67
VII	Appendices	80
	Appendix A : Western Medicine and Indigenous Healing	80
	Appendix B : The world-view of Black South Africans	84
	Appendix C : Indigenous Beliefs about the Spirit World and Related Aspects	88
	Appendix D : Indigenous Beliefs relating to Spirit Possession	95
	Appendix E : Indigenous Healing and Parapsychology	107
	Appendix F : Indigenous Healing and Western Psychotherapy	113
	Appendix G : Interview	120
	Appendix H : Biographical Data of Urban Informants	122

ACKNOWLEDGEMENTS

I would like to express my sincere thanks to the following people for their respective contributions to this dissertation:

My supervisor, Len Holdstock, for his encouragement, support and invaluable assistance with every aspect of the study. However, above all, I have valued the friendship he has shown me over the past few years.

The indigenous healers and other black people who so willingly and enthusiastically participated in this research. Without their co-operation this dissertation would not have been possible. A special thanks is due to Rosie K. who acted as my friend, advisor and assistant.

Mrs. June Fullagar, for her encouragement, kindness and patience in typing and re-typing.

Clive Fullagar, for his long suffering (and much needed) support during the writing of the report, and his assistance in proof-reading.

My family who encouraged me out of many setbacks and moments of despair. A special thanks is due to my sister for her patience and help in the writing of the report.

The financial assistance of the Human Sciences Research Council towards the costs of this research is hereby acknowledged. Opinions expressed and conclusions reached are those of the author and are not to be regarded as a reflection of the opinions and conclusions of the Human Sciences Research Council.

ABSTRACT

The present study investigated the differences between urban izangoma and izinyanga, as well as the differences between male and female healers in terms of the following criteria: biographical data, pre-training symptoms, training, divination and the ancestors. Data were gained from interviews with 45 urban healers, as well as from observation of the work, ceremonies, rituals and behaviour of many urban healers. A quantitative analysis of the interviews was combined with a qualitative analysis of the healers' phenomenological reports.

Results showed firstly, that izangoma and izinyanga differ significantly in their training, but not in their pre-training experiences or practices; secondly, that male and female healers do not differ significantly; and thirdly, that with urbanization there has been a trend towards shorter training on a part-time basis and an emergence of two new categories of healer - female izinyanga and male izangoma.

It was concluded that, irrespective of their differences in training, izangoma and izinyanga have a similar and very vital role in urban black society.

I. INTRODUCTION

In many cultures indigenous healers, who work in the context of indigenous beliefs, are consulted in preference to Western doctors (Bannerman, 1977a, 1977b; Boshier and Costello, 1975; Harding, 1977). The success of indigenous healers, however, has only recently been recognised and documented (Ampofo, 1977; Kurup, 1977; Udupu, 1977). In the 1970's the World Health Organisation implemented programmes to incorporate healers into primary health services, and to develop training and research in indigenous medicine (Bannerman, 1977a, 1977b). Stress has also been laid on the importance of indigenous healers to the mental health field in indigenous societies (Bührmann, 1977b; Holdstock, 1977, 1979; Lambo, 1974; Duath, 1977; Mishlove, 1975).

The primary orientation of psychology towards the Western scientific tradition has been severely criticised as being totally inappropriate in non-Western societies (Abdi, 1975; Hsu, 1973; Lystad, 1968). Attention has been drawn to the urgent need to internationalise training programmes in the field of psychology (Giorgis and Helms, 1978).

As indigenous healers are so important to the medical field, not only in South Africa but also throughout the world, a detailed examination of indigenous healing and Western medicine, and more specifically of indigenous healing in the South African context, is given in Appendix A.

South Africa has persevered with a Western orientated health service despite the fact that the majority of its population consult indigenous healers (BEMBO, 1976; Boshier and Costello, 1975; Robbertze, 1978). Ironically the official attitude towards these healers is one of total condemnation, although there are indications that this may be changing (Lachman and Price, 1978).

A change in attitude towards indigenous healers can only be truly achieved, however, if they are studied within a context of an indigenous, ratner than Western scientific, world view. Indigenous healing in South Africa is based on the animistic beliefs that:-

(a) all things - words, acts, thought, deeds - have an inherent vital power or force which can influence people (Bührmann, 1977a),

(b) reality is not definable in rational terms or acceptable only because of proven conclusions (Berglund, 1976), and includes phenomena like spirit possession, precognition and life after death, and

(c) the universe is not dichotomized into natural and supernatural. Everything - ancestor, dream, plant and body- belongs together in one undivided world (Kruger, 1974).

As the indigenous world view is central to indigenous healing the reader is referred to Appendix B where the animistic world view is reviewed and validated in terms of newer conceptions in Western psychology. Theories which have been offered to explain the animistic belief system are also reviewed.

Associated with the animistic world view are beliefs about the ancestors and related phenomena. A knowledge of these beliefs is essential to an understanding of indigenous healing, consequently they are discussed briefly below. (The reader is referred to Appendix C for a more detailed discussion).

Of paramount importance to healers are beliefs about the spirit world. The most important spirits are the ancestral spirits who call healers to their professions, enter them when they divine, and guide them in their

work (Gelfand, 1964; Köhler, 1941). The ancestral spirits are believed to exist in a symbiotic relationship with their living descendants and are attributed with the power of being able to send their relatives good or bad fortune - depending upon the way they are remembered (Mönnig, 1967). It is interesting that in urban areas ancestral beliefs have increased rather than decreased over a twenty year period (Hellman, 1967; Pauw, 1974; Sundkler, 1961). A result of this increase is the upsurge of indigenous churches in urban areas (Parrinder, 1969; Pauw, 1975). These churches are popular because they both stress ancestral beliefs and combine a Biblical revivalism with indigenous beliefs to provide a framework for dealing with illness and misfortune (Krige, 1974). The present study indicated interesting new trends with regard to the role of indigenous healers in the urban indigenous churches.

Indigenous beliefs about the spirit world are intricately related with beliefs about dreams. Dreams are seen as channels through which the ancestors communicate with the living (Charlsley, 1973), and they form an important part of most indigenous healing processes. During sleep a person's spirit is understood to leave the body and actually undergo the dream experience (Berglund, 1972, 1976), thus many dreams do not require interpretation but are acted upon directly. One informant remarked about dreams: "You can't live if you don't dream ... if you dream you know you are alive ... dreams are your house." A review of Western research validating the therapeutic use of dreams, together with a report on the synchronicities between African dream beliefs and those of other cultures, is presented in Appendix C.

Beliefs about the spirit world are also bound up with beliefs concerning health and healing. Health has a far wider and more inclusive meaning in South Africa than in Western societies. For black people health

work (Gelfand, 1964; Köhler, 1941). The ancestral spirits are believed to exist in a symbiotic relationship with their living descendents and are attributed with the power of being able to send their relatives good or bad fortune - depending upon the way they are remembered (Mönnig, 1967). It is interesting that in urban areas ancestral beliefs have increased rather than decreased over a twenty year period (Hellman, 1967; Pauw, 1974; Sundkler, 1961). A result of this increase is the upsurge of indigenous churches in urban areas (Parrinder, 1969; Pauw, 1975). These churches are popular because they both stress ancestral beliefs and combine a Biblical revivalism with indigenous beliefs to provide a framework for dealing with illness and misfortune (Krige, 1974). The present study indicated interesting new trends with regard to the role of indigenous healers in the urban indigenous churches.

Indigenous beliefs about the spirit world are intricately related with beliefs about dreams. Dreams are seen as channels through which the ancestors communicate with the living (Charlsley, 1973), and they form an important part of most indigenous healing processes. During sleep a person's spirit is understood to leave the body and actually undergo the dream experience (Berglund, 1972, 1976), thus many dreams do not require interpretation but are acted upon directly. One informant remarked about dreams: "You can't live if you don't dream ... if you dream you know you are alive ... dreams are your house." A review of Western research validating the therapeutic use of dreams, together with a report on the synchronicities between African dream beliefs and those of other cultures, is presented in Appendix C.

Beliefs about the spirit world are also bound up with beliefs concerning health and healing. Health has a far wider and more inclusive meaning in South Africa than in Western societies. For black people health

is contingent upon a harmonious relationship between the person and his or her natural, social and spiritual environments (Ngubane, 1977). Illness can be caused by a disruption of this relationship. Healing then involves determining which traditional laws have been transgressed by the sick person and then symbolically, ritually, or ceremonially rectifying this.

Illness and misfortune can also be caused by witchcraft and sorcery. As the fear of these forces is very real in urban areas, they have served to increase the urban black peoples' need for indigenous healers (Cheetham, 1975; Sampson, 1969). The black persons' view of illness is related to their beliefs about medicine. While most medicines are understood to have a rationally explained, physiological influence, they are also believed to have a magical influence which is supernatural and has no rational explanation (Mönnig, 1969).

For healers the most vital beliefs about the spirit world are those concerning possession. This is because healers are called to their professions through 'possession' by their ancestors. Although spirit possession has been extensively investigated in South Africa it is still poorly understood (Byrant, 1966; Hammond-Tooke, 1975a; Hunter, 1936; Junod, 1962; Krige, 1950; Lewis, 1970). There appear to be two main categories of spirit possession in South Africa - one involves alien and the other ancestral spirit possession.

Alien spirit possession can lead to the states of amandiki and izizwe (or amabutho). These states are very amorphous in their characteristics and are poorly understood. Indeed they have been related by Western researchers, to disorders varying from epilepsy and hysteria (Byrant, 1966; Sundkler, 1961) to influenza and maleria (Lee, 1969; Sundkler, 1961). A review of the literature, together with reports of these states by urban informants, is presented in Appendix C.

Possession by ancestral spirits, which is the main focus of the present study, leads to initiation into the ukuthwasa or izangoma cult. Within this cult are several hierarchically organised sub-cults which differ according to the nature of the spirits involved. The sub-cults identified in Johannesburg during the present study were the Mdawu cult and the Nguni cult.

No previous investigations of these cults in urban areas have been made, consequently information provided by informants for the present study (presented in Appendix C)provides new insights into this important aspect of the izangoma cult.

Having placed indigenous healing in the context of the indigenous world view and belief system it is important, for the present study, to see how this world view has been affected by urbanisation.

Research has shown that traditional beliefs, customs and rituals, particularly those associated with the ancestors, have persisted in cities (BEMBO, 1976; Hellman, 1967; Pauw, 1974; Sundkler, 1961). Urbanisation and the insecurity created by the unsettling of black society, the destruction of traditional family and social systems, legislation like the Pass laws and laws forbidding the performance of many traditional rites, may even have increased the black persons' need for the security of their own tradition.

The influence of traditional beliefs in cities is evidenced in reports of increased fears of witchcraft in cities (Cheetham, 1975; Hammond-Tooke, 1975b; Mitchell, 1965). The strength of traditional beliefs is also evidenced by the fact that many studies have shown that indigenous healers are regularly consulted by most urban black people (Boshier and Costello, 1975), including Christians (Mönnig, 1967), medical doctors and well

educated people (BEMBO, 1976; Möller, 1978; Parrinder, 1963). Even though traditional beliefs still prevail in the urban context little attention has been paid to the urban healer. To date most studies have concentrated on rural healers.

Generally, healers are classified into two broad categories - the izangoma (plural of sangoma) and the izinyanga (plural of inyanga) (in urban areas this category includes 'herbalists'). There is, however, little agreement in the literature as to the exact nature of the difference between the two categories. Some researchers believe the difference to lie in training (Byrant, 1966; The Collector, 1911; Elliott, 1970; Hammond-Tooke, 1962), others see the difference to be in the nature of healers' calling (Boshier and Costello, 1975; Krige, 1950), in their divinatory ability (Ngubane, 1977; Robbertze, 1978), or in their knowledge and use of medicines (Cheetham, and Cheetham, 1976).

Boshier and Costello (1975), for example, gave the following definitions:

> "The inyanga inherits his profession... his main function is divination...healing may or may not be (practiced)...The sangoma is called to the profession rather than inheriting it...this calling comes from spiritual realms and is obligatory" (p.2).

Hammond-Tooke (1962) by contrast claimed that izinyanga do not divine but work only with medicine. Another distinction was made by Cheetham and Cheetham (1976) who saw the sangoma as essentially a diagnostician and therapist and the inyanga as chiefly working with herbs and often involved in sorcery. Even using psychometric tests to investigate izangoma and izinyanga, Kruger (1977) could find no significant differences between the two categories of healers.

Conceivably the roles of izinyanga and izangoma differ to the same extent that the role of the clinical psychologist and psychotechnician differ. It is equally possible that there is only one broad category of healer and that the two cults are not mutually exclusive.

There is also some confusion in the literature about the personality characteristics of male and female healers. It has been suggested that while female healers are well integrated, intelligent and friendly, males are moody, possibly homosexual, or even psychopathic (Hammond-Tooke, 1962; Lee, 1969; Ngubane, 1977). Kruger (1977), by contrast, found there to be no significant difference between male and female healers who were all "in good contact with everyday reality" (p.1). Others, too, have reported that both male and female healers are not deviants, homosexuals, or maladjusted but rather are well-adjusted people with self-confidence and high moral standards (Beattie and Middelton, 1969; Bührmann, 1977b; Schweitzer, 1978).

Several reasons account for the confusion that exists about izangoma and izinyanga and about male and female healers. The first is the general lack of knowledge about healers due to insufficient research in this area. Secondly, urbanization has caused a blurring of the distinction between healers of different sexes and ethnic groups, as well as mixing Western and indigenous beliefs about healing. Thirdly, variations in the training and abilities of izangoma and izinyanga are so wide that it is difficult to make generalisations about the two groups. It also appears that there has been a broadening of the healers' role in urban society. Izinyanga, for example, seem to have changed from being specialists who use one form of cure (Credo Mutwa, personal communication), to being general practitioners with a broad knowledge of the cures of many ethnic groups.

To sum up, there is an urgent need to clarify the distinction between categories of healers as well as to specify their roles and abilities. Indeed Laubscher (1937) suggested that it is only by understanding the different categories of healers that it will be possible to understand the role healers play in the indigenous cultures.

The purpose of the present study, therefore, was fourfold. It aimed, firstly, to investigate the differences between izangoma and izinyanga in terms of their biographical data, pre-training experiences, training procedures and divination; secondly, to investigate differences between male and female healers irrespective of their indigenous healing category; thirdly, to investigate the nature of the calling, training and practice of healers in urban areas; and forthly to examine the work of healers within the context of newer conceptions in psychology.

II. METHODOLOGY

Research Approach used in the Present Study

In conducting the research for the present study the following were kept in mind:

(a) Western science is based on a mechanistic world view, which presupposes a set of philosophical assumptions about the nature of reality that is culture-bound and cannot be applied to a culture with contradictory assumptions. Western science has ignored that what is "real" is what each culture makes real, and that "when a myth is shared by a large number of people it acquires not only as great a power as 'objectivity', but becomes reality in itself" (Newman, 1977, p.59).

(b) Western science condemns as magical many of the indigenous healers' achievements and beliefs because it has no grounds for understanding them. It rejects, for example, the indigenous belief that physical death is not the end of consciousness, that a person who spontaneously enters altered states of consciousness (ASC) is not mentally ill, and that the dead can convey messages to the living (Tart, 1975).

The discrepancy between Western and non-Western world views, and the conflict as to which research approach should be used in an investigation of non-Western cultures, has lead to the Relativist/Universalist controversy.

The Universalist position holds that there are universal, non-evaluative norms of mental health and abnormality which can be applied to all societies. Until recently this position was used in most investigations of indigenous healing. Such investigations created the situation in which people who were important and influential leaders in indigenous societies were described as neurotic, psychotic, hysterical and schizophrenic

according to Western criteria (Firth, 1969; Hammond-Tooke, 1962; Laubscher, 1937; Lee, 1969; Sampson, 1969). A weakness of the Universalist position is that it attempts to study people whilst at the same time ignoring their cultural and spiritual environments.

The Culture Relativist position, by contrast, holds that each culture is important in its own right and that there are no universal norms of mental health. This approach believes that a cultural system can only be understood by examining it within its own context and framework. Holdstock (1977) wrote that "it is only from a person-centred approach that the fundamental differences in values, beliefs and ways of life of the many different ethnic groups in South Africa can be understood and appreciated" (p.48).

To conclude then, Western research methods, which contravene Relativist principles, were regarded as unsuitable for investigating indigenous healers for they impose a Western frame of reference on a non-Western people. Instead systematic and phenomenological methods, which try to explicate meaning instead of trying to quantify and measure, and which have been found to be better than scientific methods in researching indigenous healers (Bührmann 1977; Mqotsi, 1957; Schweitzer, 1977), were used. This approach was based on the principles of accepting the separate realities of people individually, in groups, and within their cultures.

Informants

The greatest black population in South Africa is concentrated in and around Johannesburg. Information for the present study came from observation of, and discussion with, indigenous healers drawn from this population. Forty-five healers (10 from Soweto and 35 from the suburbs)

were given hour-long interviews designed to provide quantifiable information.

Healers were selected for interviews on the basis of (a) recommendations made by a sangoma who served as assistant and intermediary for the author, (b) recommendations of healers already interviewed, and (c) contacts made at various ceremonies and rituals in and around Johannesburg.

Healers were classified into four categories on the basis of their sex and their answer to the question: "Do you call yourself a sangoma or an inyanga (or appropriate language equivalent)?" The age and sex distributions of the healers are shown in Tables 1 and 2.

Table 1

Sex Distribution of the Healers

	Izangoma	Izinyanga	Total
Males	12	12	24
Females	19	2	21
Total	31	14	45

Table 2

Age Distribution of the Healers

	Izangoma			Izinyanga			TOTAL
	F	M	T	F	M	T	
under 35	0	3	3	1	1	2	5
over 35	19	9	28	1	11	12	40
Total	19	12	31	2	12	14	45
$\bar{X}$ age	44	37	41	35	50	42	41
S.D.	7	7	7	7	55	11	8

Care was taken not to select related groups of healers, or healers from specific categories and ethnic groups, as has occurred in studies of rural healers (Mayer, 1963; Mqotsi, 1957; Schweitzer, 1977). Although this variation did not control for ethnographic factors, it was necessitated by the heterogeneous nature of the black population of Johannesburg. It was also felt that the results would be more generalizable if a wider sample were taken. The ethnic group distribution of the sample of healers is presented in Table 3.

Table 3

Ethnic Distribution of the Healers

Ethnic Group	Izangoma			Izinyanga			TOTAL
	F	M	T	F	M	T	
Nguni	9	4	13	0	3	3	16
Sotho	8	2	10	1	5	6	16
Other	2	6	8	1	4	5	13
Total	19	12	31	2	12	14	45

The religious affiliations, educational levels, length and nature of practice of the healers are described in Tables 4 to 6.

Table 4

Religious Affiliations

Church	Izangoma			Izinyanga			TOTAL
	F	M	T	F	M	T	
Separatist	12	1	13	0	1	1	14
Conventional Western	2	3	5	1	2	3	8
None	5	8	13	1	7	8	21
Total	19	12	31	2	*10	12	43

* Two izinyanga refused to speak of religion

Table 5

Education Level

Level of Education	Izangoma			Izinyanga			TOTAL
	F	M	T	F	M	T	
No school	2	1	3	0	3	3	6
Grades & Std. 1	5	2	7	0	4	4	11
Stds. 2 - 4	5	3	8	0	2	2	10
Stds. 5 - 8	7	6	13	2	3	5	18
Total	19	12	31	2	12	14	45

While healers were not included in the sample unless they had completed their training, not all had certificates from an official Herbalist Association, and they all differed in the length and nature of their training (see Table 6).

Table 6

Other Aspects of Healers' Practices

	Izangoma			Izinyanga			
	F	M	T	F	M	T	TOTAL
$\bar{X}$ length of practice (years)	8,5	6,6	8	1	15	8	9,4
Full-time healers	2	1	3	0	1	1	4
Certificate	14	12	26	0	7	7	33

Materials

A portable tape recorder was used to record most of the ceremonies, discussions and interviews through which information for the study was collected. When the situation was such that the tape recorder could not be used, the interviews were transcribed directly.

Formal interviews were composed of 30 questions based on the literature on indigenous healing in South Africa (See Appendix G). The questions covered five main areas of the healers' lives and work:- biographical data, the nature of pre-training symptoms, training procedures, divination practices and the nature of the guiding ancestral shades. As in previous studies (Cawte, 1972; Cheetham and Cheetham, 1976;

Kiloh, 1975) questions often had to be modified to accommodate unexpected answers and circumstances. Often questions were re-phrased or examples and illustrations were given in order to explain the meaning of a question. Furthermore, whenever appropriate, non-structured questions relating to other aspects of the healers' lives and work were included in the interviews.

Procedure

Burger (1969) recommended that in investigating a non-Western community an intermediary who is respected by the community should help bridge the gap between researcher and informants. In the present study a female sangoma (E.P.),who had been in the employ of the author's family for five years, served as an intermediary. E.P. helped to gain the author the acceptance of several healers who, in turn, gained the author the acceptance of other healers. In addition, E.P.'s knowledge and abilities as a healer enabled her to give the author meaningful and accurate insights into the subject under investigation.

Healers were interviewed alone or with friends depending on the situation in which they were most at ease. As most of the healers working in the suburbs were in domestic service and had considerable contact with Europeans they could all understand and speak English. Consequently, interviews were conducted by the author in English. However, to ensure that misunderstandings did not occur, a Xhosa woman (Rosie K.) fully conversant in English, Sotho, Xhosa and Zulu, and who was a trained sangoma, assisted with the interviews and interpreted when necessary.

Interviews were conducted in a place chosen by the healers themselves (generally their own living quarters), and at a time set by

themselves (usually during the lunch break or on a day off). Thus it was hoped to avoid anxiety and stress caused by an unfamiliar environment or by time pressures.

Interviewing techniques recommended by Burger (1969) and by Kahn and Cannell (1957) were combined with a person-centred approach in which the interviewer showed warmth and responsiveness, and a genuine interest in, and total acceptance of, the informant. Before each interview the author explained that she was a student at the Unversity of the Witwatersrand and wanted to learn more about izangoma and izinyanga in order to write a thesis for her Masters degree. When necessary this was further explained by Rosie K..

The interviews were generally started with the following open ended question: "I want to learn more about what it means to be a sangoma/inyanga. I think it is time that White people knew more about the Black people's medicine and the way they cure their patients. Is there anything you can tell me?" This question was posed with the view to eliciting as much spontaneous information as could be forthcoming from each informant. Initially, the author did not ask many direct questions but rather listened to the healer with interest, often repeating or re-phrasing the last statement to encourage the healer further. Only when the healer was at his/her ease and talking freely was the emphasis shifted to a more direct interview situation.

The validity and reliability of the interviews were evaluated in several ways:-

(1) Six months after the initial interview a randomly selected sample of twenty healers were contacted by telephone and asked to help the author check certain answers about which she was unsure. These answers were compared to the original answers.

(2) During the interview answers were cross-validated with such overt indicators as taking snuff, divination, possession of a certificate, wearing beads and other such behaviours.

(3) Healers were asked the same question twice in differing forms during the same interview and answers were cross-checked.

(4) Answers relating to non-healers (i.e. clients, patients, family, thwasas) were checked with as many of these people as possible.

III. RESULTS

1. Biographical Data

Quantitative Analysis

The biographical data presented in Tables 7 to 12 reveal that the only significant difference between healers was that more izangoma than izinyanga belonged to Separatist churches ($X^2(1) = 3,9$; $p < 0,05$). There were no significant differences[1] between inzangoma and izinyanga, or between male and female healers with respect to: chronological age, pre-training age, education, ethnic group or marital status. A separate analysis of each of these aspects is presented below.

Inferences concerning female izinyanga hold inconclusive but important implications about the small and relatively recent population of urban female izinyanga.

Age. The average chronological ages of the izangoma and izinyanga were 41 and 48 years respectively (Table 7). Healers were older than the majority of the black population of Johannesburg. While 68 percent of the black population were under 35, only 11 percent of the healers were. (All population figures were taken from the 1975 population census).

Table 8 shows the ages at which the healers started their training (pre-training ages). The izangoma and izinyanga had similar chronological and pre-training chronological age distributions (Tables 7 & 8). With respect to sex however, the age distributions of the two groups showed opposite trends. Male izangoma were, on average, 13 years younger than male izinyanga and also tended to start training at a younger age. Female izangoma, by contrast, were 9 years older than female izinyanga. None of these age trends were significantly different however.

[1] All results in the study were tested at the 0,05 level of significance.

Table 7

Age Distribution of Healers

	Frequency							Percentage of Sexes							
	Izangoma			Izinyanga				Izangoma			Izinyanga				
	F	M	T	F	M	T	TOTAL	F	M	T	F	M	T	TOTAL	GENERAL POPULATION
Under 35	0	3	3	1	1	2	5	0	25	10	50	8	14	11	68
Over 35	19	9	28	1	11	12	40	100	75	90	50	92	86	89	32
Total	19	12	31	2	12	14	45	100	100	100	100	100	100	100	100
$\bar{X}$ Ages	44	37	41	35	50	48	43								
SD	7	7	7	7	5,5	11	8								

Table 8

Pre-Training Ages of Healers

	Frequency							Percentage of Sexes						
	Izangoma			Izinyanga				Izangoma			Izinyanga			
	F	M	T	F	M	T	TOTAL	F	M	T	F	M	T	TOTAL
Under 35	9	9	18	1	4	5	23	47	75	58	50	33	36	51
Over 35	10	3	13	1	8	9	22	53	25	42	50	67	64	49
Total	19	12	31	2	12	14	45	100	100	100	100	100	100	100
$\bar{X}$ Ages	34	30	32	33	37	36	33							
SD	7	8	8	1	10	10	9							

Education

Table 9

Education levels attained by the Healers

	Frequency							Percentage of Sexes						
	Izangoma			Izinyanga				Izangoma			Izinyanga			
	F	M	T	F	M	T	TOTAL	F	M	T	F	M	T	TOTAL
No School	2	1	3	0	3	3	6	11	8	10	0	25	21	13
Grades & Std.1	5	2	7	0	4	4	11	25	17	22	0	33	29	25
Stds. 2 - 4	5	3	8	0	2	2	10	27	25	26	0	17	14	22
Stds. 5 - 8	7	6	13	2	3	5	18	37	50	42	100	25	36	40
Total	19	12	31	2	12	14	45	100	100	100	100	100	100	100

Table 9 reveals that generally the healers had only received a few years of Western education. Thirteen percent had no schooling and 60 percent did not reach Standard 5. Although the izangoma (whose median education level was standards 2 to 4) were generally better educated than the izinyanga (whose median educational level was standards 1 to 2) differences were not significant ($\underline{X}^2(1) = 2,9$; $\underline{p} > 0,05$). Differences between males and females were also insignificant in both the izangoma ($\underline{U} = 216$; $\underline{p} > 0,05$) and izinyanga ($\underline{U} = 25$; $\underline{p} > 0,05$) groups.

Ethnic Group

There was a higher proportion of both Shangaan (20 percent) and Sotho (22 percent) healers in the sample than was expected from the

population figures. The incidence of Zulu (25 percent), Xhosa (11 percent) and Tswana (13 percent) healers, by contrast correspondended more closely with that of the total population (see Table 10).

Several interesting trends emerged within the different ethnic groups. Firstly, all the Xhosa healers were izangoma, and 80 percent of Xhosa izangoma were female. Secondly, over 80 percent of the Sotho izangoma were female, and 75 percent of the Sotho izinyanga were male. Thirdly, amongst Shangaan healers there was a higher ratio of males to females (7:2) than occurred in the general population (4:2).

Table 10

Ethnic Group Distribution of the Healers

	Frequency							Percentage of Sexes									
	Izangoma			Izinyanga				Izangoma			Izinyanga				General Populatio		
	F	M	T	F	M	T	TOTAL	F	M	T	F	M	T	TOTAL	F	M	T
Xhosa	4	1	5	0	0	0	5	21	8	16	0	0	0	11	5	5	1
Zulu	5	3	8	0	3	3	11	26	25	26	0	25	21	25	15	15	3
Shan - gaan	1	4	5	1	3	4	9	5	33	16	50	25	29	20	4	2	6
Tswana	3	1	4	0	2	2	6	16	8	13	0	17	14	13	8	10	18
Sotho	5	1	6	1	3	4	10	26	8	19	50	25	29	22	6	4	10
Other	1	2	3	0	1	1	4	5	18	10	0	8	7	9	62	64	26
Total	19	12	31	2	12	14	45	100	100	100	100	100	100	100	100	100	100

Church Affiliations

A third of the healers, and a third of the black population of Johannesburg belonged to Separatist Churches. However, while most of the healers were Apostolic (54 percent) or Zionist (31 percent) few of the black population were (Table 11).

Significantly, more izangoma than izinyanga belonged to Separatist churches ($\chi^2(1)=3,9$; $p<0,05$). In fact, 93 percent of the Separatist healers were izangoma, 92 percent of whom were female. Of these izangoma, 67 percent were also profita.

While 47 percent of the total population belonged to Orthodox Churches, only 19 percent of the healers did. The healers belonged, in equal proportion, to either the Roman Catholic or Lutheran Churches. None, however, belonged to the Methodist Church - the most popular church amongst Johannesburg's black population.

Five percent of Johannesburg's population as opposed to 49 percent of the healers had no religious affiliations. Most of these healers were male (71 percent).

Table 11

Church Affiliations

	Frequency							Percentage of Sexes							Total Population		
	Izangoma			Izinyanga			TOTAL	Izangoma			Izinyanga			TOTAL			
	F	M	T	F	M	T		F	M	T	F	M	T		F	M	T
Apostil Profita	4	1		0	0			2	8		0	0					
			7			0	7			23			0	16		0,4	
Member	2	0		0	0			11	0		0	0					
ZCC Profita	3	0		0	0			17	0		0	0					
			4			0	4			13			0	9		0	
Member	1	0		0	0			5	0		0	0					
Other Profita	1	0		0	0			5	0		0	0					
			2			1	3			6			8	7		33,6	
Member	1	0		0	1			5	0		0	10					
Total number of separatists	12	1	13	0	1	1	14	64	8	42	0	10	8	37		34	
Roman Catholic	1	3	4	0	0	0	4	5	25	0	0	0	0	9		10	
Lutheran	1	0	1	1	2	3	4	5	0	3	50	20	25	9		9	
Total no. of Western church members	2	3	5	1	2	3	8	10	28	16	50	20	25	19		47	
No Church	5	8	13	1	7	8	21	25	67	42	50	70	67	49		5	
Total	19	12	31	2	*10	12	43	100	100	100	100	100	100	100		100	

* Two izinyanga refused to answer any question regarding religion.

Other Aspects of Biographical Data

Seventyone percent of the healers were married(Table 12). Differences between the two groups were not significant (X^2 (1)=1,5; $p > 0,05$). Although marriage was more common amongst male than female healers, differences were again not significant (X^2 (1)= 2,66, $p > 0,05$).

Sixtyfour percent of the healers had certificates from an official Herbalist Association. Twentyone percent more izangoma than izinyanga, and proportionally more males than females, had such certificates.

The healers had practiced for an average of nine years, although only nine percent had done so on a full-time basis. While there was little difference between the male and female izangoma in the length of their practice, the izinyanga males had practiced 14 years longer than the females.

Table 12

Other Aspects of Biographical Data

	Frequency							Percentage of Sexes						
	Izangoma			Izinyanga				Izangoma			Izinyanga			TOTAL
	F	M	T	F	M	T	TOTAL	F	M	T	F	M	T	
Married	11	10	21	0	11	11	32	58	83	68	0	92	79	71
Certificate	14	12	26	0	7	7	33	74	100	84	0	58	50	58
Full-time Practice	2	1	3	0	1	1	4	11	8	10	0	8	7	9
$\bar{X}$ length of practice in years	8,5	6,6	8	1	15	30	$\bar{X}$=9							

2. Pre-training Symptoms

Quantitative Analysis

One hundred percent of izangoma and 50 percent of izinyanga suffered from pre-training symptoms ($\chi^2(1) = 14,7$; $p < 0,05$). Differences with respect to the actual nature of these symptoms were not, however, significant (Table 13).

Headaches, dizziness and fainting fits, the commonest symptoms, were reported by 44 percent of the healers. Also common were general body pains (29 percent), pains centralized in the shoulders (29 percent), a loss of appetite (27 percent), and a loss of eyesight (20 percent). Twentynine percent of the healers described their pre-training symptoms as a form of 'madness'. Generally this involved feelings of disorientation, loss of memory and depression. More specific feelings of antisociability were suffered by 20 percent of the healers. A significantly high proportion of the healers experienced dreams during their time of calling (96 percent), and 89 percent of healers reported that they had been different to their contemporaries as children. It was also interesting that 29 percent of the healers unsuccessfully sought treatment in a Western hospital before accepting the call of the ancestors.

Table 13

Pre-Training Symptoms

	Frequency							Percentage of Sexes						
	Izangoma			Izinyanga				Izangoma			Izinyanga			
SYMPTOMS	F	M	T	F	M	T	TOTAL	F	M	T	F	M	T	TOTAL
Had Thwasa	19	12	31	1	6	7	38	100	100	100	50	50	50	84
Headaches Fainting Dizziness	9	6	15	1	4	5	20	47	50	48	50	33	35	44
Pains in the body	5	5	10	1	2	3	13	26	42	32	50	17	21	29
Pains in the shoulders	8	3	11	0	2	2	13	42	25	36	0	17	14	29
Loss of Appetite	2	6	8	1	3	4	12	11	50	26	50	25	29	27
Loss of Sight	6	2	8	0	1	1	9	32	17	26	0	8	7	20
Anti-sociable	4	3	7	1	1	2	9	21	25	23	50	8	14	20
Madness	5	5	10	1	2	3	13	26	41	32	50	17	21	29
Other	7	4	11	0	2	2	13	37	33	35	0	17	14	29
Dreams	18	12	30	2	11	13	43	94	100	97	100	92	93	96
Different as a child	19	12	31	0	9	9	40	100	100	100	0	75	64	89
Went to Hospital	8	4	12	0	1	1	13	42	33	39	0	1	8	29

Qualitative Analysis

Traditionally, the pre-training symptoms experienced by those who become izangoma are known as 'thwasa' symptoms, for they call the person to 'thwasa' or train as a sangoma. Many urban izinyanga also referred to their pre-training symptoms as 'thwasa' symptoms.

An informer described thwasa as "a gift from the ancestors. Sometimes it happens early, sometimes late. It is all according to the ancestors." The conceptualization of thwasa as a 'gift' is important as it indicates that healers see themselves as having been chosen by the ancestors to receive something special from them.

Both izangoma and izinyanga reported that as children they were different to their contemporaries, being more sickly and prone to fainting, strange experiences, visions and dreams. Sam D. reported:

> "As a child I often had headaches. Many times I missed school I was so sick. My arms felt as though I had just been holding something heavy and I felt tired - as though I had run many miles. Often my feet felt as though they were burning."

The childhood dreams healers reported were stereotyped and involved rivers, mountains and the ancestors. Many reports of childhood experiences involved precognitions of the future. Shiela G. described:

> "I was nine years old when one day I started to scream. No one could hold me I was so strong. Then I collapsed and I saw my dead grandmother. She gave me three bones - one cowrie shell and two knuckle bones and said 'this is your gift from me'."

At ten years Mdungazi K. saw a hand in the air above him offering him food. After he had eaten the hand disappeared. Mdungazi saw this vision to mean that his ancestors were taking care of him just as later he would become their custodian. As children, eight healers remembered being told by diviners that they would be called by their ancestors to become healers.

Later symptoms reported by the healers resembled those ancient and universal symptoms experienced by traditional healers of other cultures, and included a love of solitude, a desire to roam in unfrequented places, visions, spontaneous song making and involuntary movement into ASC. One healer described her experience of the thwasa symptoms in an urban environment as follows:

> " Before I went to thwasa I went mental. I roamed around the streets not knowing where I was going. Sometimes I would find myself walking in a strange suburb without my shoes or purse - I did not know how I got there or why I was there."

The commonest symptom experienced by urban healers was ithongo or dreams with messages and instructions from the ancestors to go to certain places, acquire specific things and perform certain acts. Some dreams even revealed the teacher and place where the person was to train. For example, Lizzy S. described the following dream:

> " I was told in a dream to go and train at Bushbuck Ridge. I was shown exactly what I would find when I got there - a building, like a school, and past that some huts. I was told to go through the gate and that I would see some white goats and chickens and a child who would lead me to my teacher.
>
> It all happened just as I was told in my dream. When I arrived my teacher said that she was waiting for me as she had been told in a dream that I was coming."

Typical ithongo involved snakes, mountains, rivers, medicine and divination. Some dreams reported by urban healers are cited below:

> " At this time (thwasa) my grandmother came to me and showed me the bones - the knuckles and the ivory - and told me that I would find these things."
>
> " I would dream of a big mountain with rivers and a forest. I was on top of the mountain looking for medicine."
>
> " I dreamed that I went into a river and a snake wound around my body and pulled me under the water. We went under the water to a dry place, with green grass, where the old people live."

Prophetic dreams about death, sickness or pregnancy were also common, although many were of an untraditional nature as in the following:

> "I saw a bomb in the Carlton - it looked like a big flash of lightning. The people were afraid and laid down. The next day a bomb exploded in the Carlton just as I dreamed it would."

Manifestation of the calling on a spiritual level through dreams was accompanied by physical and behavioural signs, several of which were experienced by John I.:

> "When my aunt, who was a sangoma, died I suddenly became very sick, my bones were painful, I did not want to see white people and I could not eat. I became so thin that I finally had to leave my job."

Healers reported that the behavioural symptoms are mainly sent to those who are reluctant to adopt the life of a healer. Often these symptoms were related to a symbolisation of life and death. As with John I., for example, many thwasas rejected all food thus symbolising a rejection of their previous lifestyles. Other commonly reported behaviours (excessive sneezing, yawning, belching, hiccuping or otherwise sharply taking in or expelling moya, breath or spirit) were also symbolic, for they identified the thwasas with their spirits whose presence was shown by the sounds accompanying these behaviours.

Many healers also experienced a temporary loss of eyesight. Ethel P. described:

> "My thwasa started in 1968 ... one morning I heard a loud noise and felt as though something hit me across the eyes and went into my eyes. From then until 1969 I suffered from sore eyes ... I went to hospital but they did not help me ... eventually I could not see at all and I had to leave my job ... my eyesight returned the day I went to thwasa."

During their blindness most informants described feelings of helplessness

and alienation from all they had previously known or believed to be important. At this time they were able to accept the ancestor's call. One healer described her blindness as a time when she felt "what it was like to be a spirit."

These results indicate (a) that urban healers still experience traditional thwasa symptoms and (b) that although symptoms are more common amongst izangoma than izinyanga the nature of the symptoms are similar.

3. Training

Quantitative Analysis

(i) Training received by informants. The following significant differences in the training of the healers were revealed in Table 14.

a) Ritual, song and dance were important for all izangoma and no izinyanga ($\underline{X}^2$ (1)=40,4; $\underline{p} < 0,05$).

b) Izangoma generally trained in larger groups than izinyanga, and significantly more izinyanga than izangoma trained alone ($\underline{X}^2$ (1)= 14,3; $\underline{p} < 0,05$).

c) More izinyanga than izangoma received no official training ($\underline{X}^2$ (1) = 11,7; $\underline{p} < 0,05$);

The training of izangoma and izinyanga did not, however, differ significantly with respect to the following:

d) the proportion who had an urban training ($\underline{X}^2$ (1) = 11,7; $\underline{p} > 0,05$);

e) the proportion who had a part-time training ($\underline{X}^2$ (1) = 13,5; $\underline{p} > 0,05$);

f) the length of training, which was on average 10 months, (izangoma had approximately two months longer training than izinyanga).

g) cost of training (although izangoma paid R41 more than izinyanga). Several interesting differences between male and female healers also emerged in Table 14.

h) More male than female healers trained on a full-time basis ($\underline{X}^2$ (1) = 11,7; $\underline{p} > 0,05$);

i) Female izinyanga paid R20 more than female izangoma for their training.

Table 14

Training Received by the Healers

	Frequency							Percentage of Sexes						
	Izangoma			Izinyanga				Izangoma			Izinyanga			
	F	M	T	F	M	T	TOTAL	F	M	T	T	M	T	TOTAL
Urban Training	12	1	13	2	2	4	17	63	8	42	0	17	29	38
Rural Training	7	11	18	0	7	7	25	37	92	58	0	58	50	56
No Training	0	0	0	0	3	3	3	0	0	0	0	25	21	7
Full-time Training	9	12	21	0	6	6	27	47	100	68	0	50	71	60
Trained Alone	0	1	1	0	7	8	9	0	8	3	50	58	57	20
Ritual, Song & Dance	19	12	31	0	0	0	31	100	100	100	0	0	0	69
$\bar{X}$ length (months)	12	10	11	9	9	9	10							
$\bar{X}$ cost (Rand)	160	225	200	200	180	139	159							
$\bar{X}$ No.of co Initiates	6	6	6	1	4	3	5							

(ii) Training administered by informants.

Table 15

Trends in Training Given by the Healers

	Frequency							Percentage of Sexes						
	Izangoma			Izinyanga				Izangoma			Izinyanga			
	F	M	T	F	M	T	TOTAL	F	M	T	F	M	T	TOTAL
Frequency of Teachers	5	2	7	0	5	5	12	26	17	0	0	42	0	27
Frequency of Full-time Teachers	1	0	1	0	1	1	2	5	0	3	0	8	7	2
$\bar{X}$ Charge in Rand	160	162	161	0	86	86	123							
$\bar{X}$ length of Training in months	10	13	12	0	7	7	9,5							

Twentyseven percent of the healers had trained their own initiates (Table 15). A comparison of Tables 14 and 15 shows that since these healers underwent training, aspects of training have changed. While 60 percent of the healers received full-time training (Table 14) only 17 percent of the healers who had had initiates gave full-time training (Table 15). Healers who gave part-time training did not, however, lengthen the training period. By contrast all but the male izangoma gave a shorter training than they received. Training given by izinyanga was, on average, five months shorter than that given by izangoma.

The mean charge for training levied by the teachers sampled was R123. Amongst male healers this was a mean of R70 less than they had paid for

training. Only the female healers charged the same as they themselves had been charged (R160).

Qualitative Analysis

The main differences between healers arose because izinyanga, unlike izangoma, do not have to answer the call of their ancestors by initiation into an arduous and ritualized possession cult. While most izinyanga did have an official apprenticeship this was not essential, and some learned their skills purely through dreams, or were taught during childhood by a relative and simply inherited the profession. Sam D., for example, reported that as a child he used to help his grandfather with the gathering and preparing of herbs. Later, when his grandfather's eyesight weakened through old age Sam would describe to him how the bones had fallen. In his teens Sam left the home of his grandfather to find work in Johannesburg. Only some ten years later was Sam called, through dreams and ill health, to take up his grandfather's work as an inyanga. Frans D. became an inyanga in a very different way. He described:

> "As a child I was often sick. When I was 19 I started to have strange dreams about my ancestors, divination and medicine. I often dreamed I must go to a certain place to find herbs and I was shown how to prepare them. No sooner had I obeyed my dream than a person who needed the medicine I had prepared would arrive. After many years of such dreams my grandfather came to me one night and told me that when I woke up I must walk until I found an open place far away from people. I did as he said. Suddenly I felt my leg shaking and pulling. I dug there and found a knuckle bone. Over the next months I found all my bones in this way. I learned to understand my bones through my dreams. I also learned about medicine in my dreams."

In contrast to Sam D. and Frans D., Diadla G. was, until the time of his calling at 32 years of age, unaware that any of his ancestors had been izinyanga and had had no indication of his extra-sensory powers. He reported:

> "My becoming an inyanga all started with dreams .... I was told in a dream to go to Natal to train under an inyanga there. I had many dreams and became very sick. Eventually I went to this inyanga I had dreamed about, he took me out into the mountains and taught me about medicines. I stayed with him about three months."

In contrast to izinyanga, all inzangoma underwent an official training period. Financial and practical difficulties, however, prevented some from undergoing a traditional training and forced them to train on a part-time basis over many years. Also, unlike izinyanga, inzangoma had a community-orientated training in which much stress was laid on ritual and dance.

In urban areas dance was accompanied by rythmic song, hand clapping and music, all of which help the dancer to attain ASC. In this ASC the ancestors communicate with the dancer and divinatory skills are heightened. Despite the limitations of urban life much of the ritual that traditionally accompanied dance has survived. Vital to this ritual is the dancer's heavy, beaded, ceremonial apparel. This garb not only has symbolic significance but also physically weighs the dancer down and, together with the sound from the dancer's whistle and leg rattles, places the dancer firmly at the centre of his/her world.

Ritual was also central to the community orientation of urban training. Sacrificial rituals were performed to mark the end of each successive stage of a thwasa's development for they establish contact with the shades in a very concrete way. Urban healers reported that behind the sacrificial ritual is the belief that, through the death of the sacrificial animal, life is given to the ancestors. This is symbolized during the sacrifice by the thwasa's act of ritually drinking and then vomiting up the animal's blood. Through this act, too, thwasas symbolically

'sacrifice' their identities, ambitions and goals in order to take up the life of a sangoma - the mouthpiece of the shades. Healers described: "When you become a sangoma you cease to be an individual. You become many people in one." "When you become a sangoma you become the house of your ancestors."

Another important part of the sacrifice is the animal's gall bladder which is inflated and tied into the thwasa's hair, for moya (air) is believed to strengthen the thwasa with the power of the spirits.

While ritual is also central to the training and work of izinyanga it is far less cult-and community-orientated, for izinyanga have a far less demanding, ritualized and dramatic relationship with their ancestors than izangoma. An informer (Lucy G.) explained that this is symbolized by the fact that izinyanga traditionally sacrifice a sheep rather than a goat - the sheep being a quieter and more docile animal. Izinyanga' sacrifices are also very much more of a family event than those of izangoma and are performed primarily to symbolize and regenerate the bond between family and ancestors.

While izangoma training differed from that of izinyanga with respect to its more dramatic cult-orientated elements, there were also certain very strong similarities in the two forms of training.

Instruction in divination was generally included in both forms of training - although it was not essential to either. Dreams, however, played a vital role in the training of all healers. An informer said of thwasa: "To thwasa is to dream." Without dreams there can be no relationship between thwasa and the shades, and no progress can be made in training. Usually dreams are stereotyped and resemble those experienced during the time of calling (see p.28). Ironically, in urban areas where

competition and jealousy have destroyed the traditional supportive atmosphere of certain thwasa communities, dreams can be used negatively, as the following report shows:

> "The other thwasas who were jealous of me put knives under their pillows to stop me from dreaming. Instead of giving me medicine to make me dream I was given plain water. I did not dream and I wondered why. Then I put a knife under my pillow. That night I dreamed of three cows, two black and one red. The red one pushed me out of the yard of the house with his horns and told me that I would not get anything there. The next day I told my teacher of my dream and I left her house " (Shiela G.).

In this dream evil and transition are symbolized by black and red (the significance of this is described in Appendix C), while the ancestors are symbolized by cows. The report also shows how, even in urban areas, dreams are not interpreted but are acted upon directly.

Urban healers reported several techniques used to facilitate dream recall. Izangoma thwasas sleep in the same room as their teachers and wake during the night to relate and discuss their dreams. Healers beat a mixture of ubulawu[2] and water to a froth which they eat to increase the vividness and frequency of dreams; and often foods like pork, eggs, mutton and fish, which are believed to have an inhibiting effect on dreaming, are avoided.

The use of herbal medicines for cleansing and purifying, for heightening sensitivity towards the shades, and for increasing dreaming, was also important in the training of all healers. These medicines could be drunk, smoked or inhaled, or used for washing and steaming the body. Both izangoma and izinyanga stressed the importance of learning how to find and use indigenous herbs. Izangoma also had to learn the ritual to propitiate the ancestors whom they believe control the power inherent in herbs. Most urban healers were found to obtain their herbs

---

[2] An indigenous herb.

from herbalist of 'muti' shops.

The length of training varies, as it depends on the shades, the teacher, and the nature of training being received. An informer claimed that "because the oral tradition is so great it needs many years for an initiate to absorb it all." Findings indicated, however, that urban training placed little emphasis on the oral tradition and was usually under a year.

Following training, both izangoma and izinyanga continued to pay tribute to their ancestors through sacrificial ceremonies held at intervals throughout their lives. Izangoma tended to retain close contact with their teachers and co-initiates and to include them in their ceremonies. Thus, it appears, urban izangoma are supported throughout their lives by relationships with ex-members of the healing community and by intra-psychic relationships with the shades.

In summary, results indicate that izangoma and izinyanga training are similar with respect to the role played by (a) dreams, (b) divination and (c) medicine, but differ with respect to the role played by (a) drama, ritual and cult activity and (b) the healing community.

Furthermore, indications were (a) that the traditional male orientation of the izinyanga profession may be changing in urban areas, (b) that there is a trend towards urban training on a part-time basis amongst both izangoma and izinyanga, and (c) that the trend is towards shorter, more condensed training in urban areas.

5. Divination

Quantitative Analysis

As Table 16 indicates there were no significant differences between healers with respect to (a) divination with the bones and (b) the prescription and selling of medicines. Significant differences did however emerge in the following areas:

(a) More izangoma than izinyanga divined during dance ($\underline{X}^2(1) = 40,4$; $\underline{p} < 0,05$).

(b) Significantly more izangoma than izinyanga divined both mentally and with the bones ($\underline{X}^2(1) = 11,7$; $\underline{p} < 0,05$).

(c) The least and most popular healers were female izinyanga and male izangoma respectively.

(d) Izangoma had a mean of 14 clients a week more than izinyanga, even although they charged 50 cents more per divination.

There were no significant differences with regard to sex although 17 percent more females than males divined with the bones ($\underline{X}^2(1) = 11,7$; $\underline{p} > 0,05$), and more male than female healers used mental divination.

Table 16

Divination and Related Aspects of the Healers' Work

	Frequency							Percentage of Sexes						
	Izangoma			Izinyanga				Izangoma			Izinyanga			
	F	M	T	F	M	T	TOTAL	F	M	T	F	M	T	TOTAL
Bones	14	12	26	1	10	11	37	74	100	79	50	83	79	82
Head	18	10	28	1	4	5	33	95	83	90	50	33	36	73
Head & Bones	13	10	23	0	2	2	25	64	83	74	0	17	14	55
Other	2	3	5	0	1	1	6	5	25	16	0	8	7	13
Dance	19	12	31	0	0	0	31	100	100	100	0	0	0	68
Dreams	19	12	31	1	9	10	41	100	100	100	50	75	71	91
Medicine	19	12	31	1	11	12	43	100	100	100	50	92	86	95
Snuff	19	12	31	2	12	14	45	100	100	100	100	100	100	100
Total	19	12	31	2	12	14	45							
$\bar{X}$ No. of Clients/ Week	31	31	26	3	20	12	19							
$\bar{X}$ Charge/ Divination (rand	2.50	2.50	2.50	2.00	2.00	3.00	2.75							

Qualitative Analysis

In urban areas divination is used to answer any question, explain any situation, indicate the cause, nature and cure of sickness, the whereabouts of lost property, and the advisability of making any decision.

It can also look into the past, present or future and explain physical, emotional and spiritual well-being.

Most urban sets have four ivory bones representing an old man and old woman, and a young man and young woman. Generally, sets also include sea shells and animal bones chosen in terms of what they are to represent. Thus a bone from a reed buck which wanders at night may represent evil spirits which also wander at night. In urban sets evil and witchcraft are often represented by a round stone - the traditional device used by the tokoloshe (a Zulu familiar) to make himself invisible. One bone may have several meanings. The bone of an antbear, for example, can represent the ancestors (who, like the antbear, dwell in the earth), death (because it digs graves), and the diviner him or herself (who, like the antbear, also digs for roots and herbs) (Rosie K. personal communication). Seashells may represent Europeans (who came from over the sea), and Mdawu shades[3] (who live in the water).

Many urban healers have added to their sets objects to represent aspects of urban living. One diviner used a brass curtain ring to represent a telephone or wedding ring. Others used a variety of stones to represent motor cars. Urbanization has also necessitated the replacement of traditional bones that are no longer available. Wild animals' bones are replaced by bones of sacrificial animals. Ivory bones, with their circle-dot symbol, are often replaced by, or combined with, dominoes.

Just as urban divination sets have been adapted to meet the changed circumstances of urban living, so the actual nature of divination in urban areas has also changed. Furthermore, divination differs greatly among

---

[3] The shades are all spirits which affect the living irrespective of descent line (See Appendix C for a detailed explanation).

urban healers and one bone may have opposite meanings to different diviners. In Johannesburg two broad approaches to divination were identified during the present study - a Systems approach and a Gestalt approach.

In the former the set is divided into small groups of families each of which has bones representing an old man and a young man, an old woman and a young woman. These bones can either fall with the pattern facing up (which bodes well) or with the pattern hidden (which bodes ill). Thus sixteen different combinations of the four bones are possible within each family. The bones of other families are carved from the hoof of an animal and so can fall on one of four sides. .This increases the number of combinations of the four bones in one family to 256. When interpreting the bones each family is considered separately and then the relationship between the families is examined.

The second approach follows basic Gestalt principles, for the bones are not divided into separate families but are interpreted as one meaningful whole. Within the context of the whole the meaning of the individual bones and smaller combinations are interpreted. Of great importance are the spaces betweenthe bones and the direction in which the bones face.

Whether a Systems or Gestalt approach is used to interpret the bones the accuracy of the divination depends on the power and ability of the diviner.

While the bones are the most common form of divination amongst healers, many other forms have also been evolved to meet the different needs of the urban population. Diviners initially develop their psychic powers by learning to divine with any objects - stick, nails, bottle caps,

pebbles, beads, by observing birds in flight, fishes swimming, the movement of insects, or even the pattern made by spilt grain. The actual object used to divine is not important for it merely provides a focus for concentration and a means of raising psychic power (Mutwa, personal communication). Once the art of divination is learned the divination tool which a healer is to use is usually revealed in a dream.

Just as psychologists use a variety of psychometric tests, so urban healers have a variety of divination techniques. These include whistling calabashes, a range of balancing horns (usually used in gatherings to point out a culprit of witchcraft or theft), crystal balls, and a concertina-like arrangement of sticks. Another divination tool, an irregularly shaped rock, has parallels with the Rorschach Inkblot Test, for diagnosis is based on the shapes the client sees in the rock. During divination healers also assess their clients' appearance, behaviour, response to divination, and understanding of their problems (personal communication). The parallel with the traditional Western psychiatric examination is striking.

Urban healers also use what they call 'mental divination' or 'divination with the head'. These divinatory skills are developed through a series of graded tests in the following way.

First, thwasas perform a special divination dance to call their shades to reveal to them the whereabouts of a hidden object. Initially thwasas are helped by their teachers who indicate, by the volume of their response to each guess, when the thwasas are correct in their divinations. Gradually the teacher's responses become fewer until the thwasas can divine the object and hiding place without any help. Ultimately thwasas must be able to describe an image held in the teacher's mind.

In another form of divination consultants chant siyavuma 'we agree) to every statement made by the diviner. This form is seldom used in urban areas however. More common is divination based on body sensations which are attributed to the shades. The following example of this form of divination was reported by the employer of an inyanga:

> " Our two cows disappeared from our smallholding (outside Johannesburg). Everyone on the farm went in search of them. Frans D. our gardener (also an inyanga), however, just sat with his head in his hands. He said he was listening to his ancestors. About twenty minutes later he ran off and two hours later returned with the cows. He said his ancestors had shown him which way to go. Whenever he went in the wrong direction his heartbeat increased and returned to normal when he was again on the correct path. In this way, he said, he was lead to our cows."

A final and very important form of divination, particularly in urban areas, is that which occurs during ASC attained through ritual and dance. Specific divination dances are performed for different purposes and occasions. The ukuhlela, a Mdawu group dance, evokes very powerful divinations. This dance occurs as follows in urban areas:

The dancers wearing the ritual Mdawu clothing (Appendix C) crawl to mats and sit in a row. Their crossed legs are covered with lengths of beaded black material, and they shake their bodies rythmically to chanting and drumbeats. They then straighten their legs and jump forwards, then backwards, in a sitting position. As they sink into a trance they move to a kneeling position and continue their rythmic movements. If the Mdawu spirits are evoked it is essential for the dancers to be covered with a white sheet to symbolize the state of purity necessary for an invocation of the Mdawu shades, and to protect the dancers from the strength of their shades' power. At this time the dancers make very powerful divinations. An Mdawu dance of this kind can only be performed at the end of a ceremony for the Mdawu spirits, being the

most powerful spirits, cannot be followed by other spirits.

There are also less powerful Mdawu divination dances. These start with a greeting in which the dancers identify themselves and their guiding shades. Those present chorus siyavuma (we agree) in acknowledgement of each statement. After the greeting follows a very vigorous dance, with stamping, jumping and gross arm and body movement. At the climax of the dance, the dancers enter ASC during which they divine.

In contrast to the vigorous Mdawu dance the Nguni dance, which also leads to divination, is a quiet dance characterised by a ripple, shaking movement of the body. Often Nguni dancers dance for hours on their knees on the hard African soil without becoming fatigued or incurring any injury.

Different forms of divination have evolved to meet the different requirements of South Africa's indigenous population. Certainly far from disappearing as a consequence of urbanization and acculturization, divination seems to have increased in popularity and appears to fulfil an important need in the black urban population.

6. The Ancestors

Quantitative Analysis

Table 17

Lineage of the Healers' Guiding Shades

Ethnic Group	SHADES											
	PATRILINEAL					MATRILINEAL					OTHER	Total
	Generation					Generation						
	1st	2nd	3rd	Remote	Total	1st	2nd	3rd	Remote	Total		
Xhosa	1	0	1	0	2	4	2	1	0	7	0	9
Zulu	5	5	3	2	15	4	6	0	1	11	4	30
Shangaan	3	11	2	6	22	2	6	0	5	13	1	36
Sotho	1	11	2	1	15	0	13	3	0	16	0	31
Tswana	1	5	0	0	6	3	2	1	1	7	1	14
Swazi	2	0	0	0	2	0	0	0	1	1	0	3
Ndebele	0	1	2	0	3	1	2	1	0	4	0	7
Total	13	33	10	9	65	14	31	6	8	59	6	130

Thirteen of the healers were unable, or unwilling, to identify their guiding shades. As this made male/female and izangoma/izinyanga comparisons difficult, data concerning the lineage of the shades were tabulated in terms of the healers' ethnic groups (Table 17).

Healers had a mean of 4 guiding shades each. Fifty percent of these shades were patrilineal, 45 percent were matrilineal, and five percent were unrelated to the healers. Of the patrilineal ancestors 20 percent were first generation, 51 percent were second generation, 15 percent were third generation and 14 percent were remotely related. The distribution of matrilineal ancestors reflected a similar pattern - 24 percent being first generation, 53 percent second generation, 10 percent third generation and 13 percent remotely related.

There were no significant inter-tribal differences between healers with respect to patrilineal or matrilineal ancestors. The Xhosas were the only healers who deviated from the general pattern. They showed a greater tendency towards matrilineal ancestors.

Qualitative Analysis

Healers who could not identify their guiding shades explained that this was because their knowledge of their shades was intuitive rather than concrete. For example, Rosie K. said "The shades are like the wind you cannot see them or touch them, you just feel in your heart what you must do."

Other healers did not wish to discuss their ancestors for they felt that this would be showing them a lack of respect. Most healers, however, were able to identify, in great detail, the specific shades who guided them in their work.

IV. DISCUSSION

Biographical Data

Sex. Findings indicated that two new categories of healers have emerged in urban areas. Previously 90 percent of izangoma were female and all izinyanga were male (Boshier and Costello, 1975; Lee, 1969; Mönnig, 1967), whereas in the present study almost one-third of the izangoma sampled were male and one-seventh of the izinyanga sampled were female. This suggests that the scope of indigenous healing is broadening at the present time - possibly as a consequence of an increased demand for indigenous forms of healing in urban areas.

The present study contradicted suggestions that male and female healers differ with respect to personality characteristics (Hammond-Tooke, 1962; Lee, 1969; Ngubane, 1977). Hammond-Tooke (1962), for example, theorized on the basis of his observations of a "few" healers, that male izangoma are effeminate, hysterial, neurotic type people, whilst females are friendly and well-adjusted. The present study, by contrast, lent support to findings that both male and female healers are in good contact with reality (Kruger, 1977) and are well-adjusted, healthy people (Beattie and Middleton, 1969; Buhrmann, 1977b; Schweitzer, 1977). Healers were found to be interested, friendly and helpful people who were generally aware of the need for Western doctors to know more about indigenous healing. Urban black people, generally, were found to regard healers as influential leaders, while white people who had had considerable contact with healers, regarded them as sensitive, involved and responsible people (personal communication with employers of

healers, and such researchers as Boshier, Holdstock, and Schweitzer).

Age. Informants related the finding that izangoma were generally younger and less experienced than izinyanga to two factors. The first is that izinyanga tend to remain in urban areas while izangoma tend to move to rural areas where their ritualized, dramatic cult activity is not restricted and where initiates can more easily be trained. The second is that izangoma often lose their extrasensory powers following training. Of interest is that Lee (1969) and Ngubane (1977) reported a similar loss to be characteristic of izizwe and amamdiki possession. The process involved here has parallels with Western psychotherapy - for once the 'sick' person accepts and integrates repressed, unconscious conflicts and problems (in the thwasa that part of themselves symbolized by their ancestors) the sickness disappears.

The theory that the onset of thwasa is caused by physiological changes of puberty or menopause (Hammond-Tooke, 1962; Lee, 1969; Mutwa, personal communication) were not supported by the present study which found the mean pre-training age of initiates to be 35 years. More probable is that thwasa is precipitated by an existential crisis.

Education. Findings support reports of a low correlation between Western education and traditional beliefs amongst black people (BEMBO, 1976; Miller, 1974) as most healers were poorly educated. This is inconsistent with the fact that healers are generally intelligent people (Beattie and Middleton, 1969; personal communication with urban healers). Significantly, however, like rural healers (Mqotsi, 1957) urban healers reported that they were deliberately kept from

attending school by their ancestors. This can be explained in terms of recent brain research. Western education has been shown to develop the left cerebral hemisphere which controls rational, sequential thought (Luria, 1973) at the expense of the right cerebral hemisphere which controls non-linear, irrational thought and is the centre of psychic abilities (Bogen, 1967; Ornstein, 1972). Consequently the healers avoidance of Western education is understandable.

Religion. The finding that many healers belonged to a Christian church is consistent with reports (a) that there is a high degree of church membership amongst the black population of Johannesburg (Möller, 1978), and (b) that healers are by nature a very religious group (Boshier and Costello, 1975). Church membership amongst healers appears, however, to be a recent phenomenon. This was suggested by two factors. Firstly, informers reported that previously healers did not belong to churches and that they have only recently come to believe that "alone the ancestors know nothing, for only God can give them power" (Rosie K). Secondly, the present study contradicted the findings of previous studies that (a) izangoma cannot become profita (Sundler, 1961), and (b) that Separatist churches ban healers who they regard as "commercial, anarchic and malevolent because they use their power for personal gain" (Kiernan, 1976 p.169).

Findings that more izangoma than izinyanga were religious and that izinyanga preferred Orthodox to Separatist churches is probably a result of the individual rather than cult orientation of the izinyanga profession.

Healers who did not belong to a church attributed this to:-

a) their ancestors whom they believed did not want them to attend church,

b) practical reasons including work, transport, and children,

c) time pressures due to the fact that Sundays were their busiest days,

d) a disinterest in organized religion.

Ethnic Group. One healer remarked about her ethnic group affiliation "I am Zulu, but I have many tribes in my body." This statement reflects a general attitude amongst urban healers, for the present study found that urban healers of different ethnic groups do not differ greatly in the nature of their work and treat people of all ethnic groups. This similarity is probably related to the finding that a person can be called and possessed by ancestors of several different ethnic groups and it appears to be a consequence of inter-tribal marriage in urban areas.

Of interest, however, was the finding that Shangaans were more susceptible to spirit possession than other ethnic groups and that Sotho peoples were more prone to the izinyanga than izangoma calling. Surprisingly only findings related to Sotho and Xhosa izangoma supported reports that the majority of izangoma are female (Byrant, 1971; Lee, 1969).

Marital Status. It has been suggested that women develop thwasa symptoms subconsciously as a way of asserting themselves in unsatisfactory marital relationships (Lewis, 1970). Most female informants in the present study, however, were living apart from their husbands and appeared to derive few secondary gains from being healers.

Indeed, many female izangoma strongly resisted their calling because it demanded such a total change in life style and meant that their lives would be devoted to meeting the needs of their ancestors and clients.

No support was found for the theory that male izangoma are homosexually inclined (Hammond-Tooke, 1962; Lee, 1969). This theory, however, was based on observation of a "few" male izangoma who were diagnosed homosexual because of their clothing and high pitched voices. The present study found that in the context of indigenous healing 'homosexual' behaviour is entirely normal - female garb is worn by males purely to respect and facilitate contact with their ancestors, and high voices are directly attributable to possession by a female shade. Furthermore, over 80 percent of male healers were married.

An interesting finding which directly related marital status to the shades was that several informants, including all those who were married to fellow healers, reported that their marriages were arranged by ancestors. Generally reports of these "arranged marriages" were stereotyped and involved detailed dreams in which the person saw the one he/she was to marry and was told where to go to meet this person. In one instance the ancestor who had caused the death of a woman's husband because she resisted her calling, sent her another husband following her training.

Pre-Training Symptoms

Two major findings concerning pre-training symptoms emerged in the present study. First, findings contradicted reports that izangoma

and izinyanga have different kinds of pre-training experiences (Boshier and Costello, 1975; Krige, 1950). It was, however, found that fewer izinyanga suffered from pre-training symptoms which, although similar, were often more intense for izangoma than izinyanga.

The second important finding was that urban healers have symptoms similar to those documented for rural healers (Berglund, 1972; Byrant, 1911; Köhler, 1950; Laubscher, 1937, 1975). It is interesting, however, that with the greater availiability of Western medicine, many healers reported that they intially favoured this in seeking a cure for their thwasa symptoms. Without exception, however, Western medicine either failed entirely to provide a cure, or the symptoms returned immediately the healer left hospital. It was also interesting that, whilst dreams of urban healers were symbolically similar to those documented for rural healers (Callaway, 1884; Lee, 1969; Mqotsi, 1957), they generally involved aspects of urban living. For example, precognitive dreams of urban healers involved precognitions of police raids, terrorist activity, telephone calls, letters and even telegrams, rather than the traditional subjects of pregnancy, sickness and death.

Findings concerning childhood symptoms were similar to those reported by Mqotsi (1957) and Ngubane (1977) and supported the view that "thwasa is inborn and cannot be developed" (Laubscher, 1937, p.136). Interestingly, healers who did not experience childhood thwasa symptoms explained this as being due to the ancestors. One said "sometimes thwasa happens early, sometimes late - it is all according to the will of the ancestors." This view would suggest

that thwasa is not "inborn" but can be imposed by an external force at any time.

Significant findings were associated with reports of specific symptoms. Loss of eyesight (also reported by Schweitzer, 1977) was reported by healers who most strongly resisted their calling. Loss of appetite occurred more commonly among men and so contradicted Lee's suggestion (1969) that thwasa can be attributed to anorexia nervosa - a disorder mainly confined to women. Reports of 'madness' and 'antisociability' which were reported by many healers seemed to support theories that the condition of thwasa is a state of psychosis or neurosis (Firth, 1967; Laubscher, 1937, 1975; Lee, 1969; Sampson, 1969). Healers reported as 'mad', their loss of a sense of personal identity and purpose in life - feelings which Cheetham (1975) reported to be a normal and expected consequence of rapid acculturization and urbanization. The rapid disappearance of symptoms of 'madness' at the start of training is also inconsistent with a psychosis or neurosis. Furthermore, several thwasas who were in full-time employment during their training, reported that their employers were unaware of their activities as initiates, or later as healers - another contra-indication of psychosis or neurosis. Looked at from another perspective, the fact that the 'sick' person in his/her turn becomes a healer is vitally important for, as Holdstock (1979) emphasised, therapy is most effective when there is the greatest cultural and personal similarity between healer and healed.

While thwasa symptoms have generally remained invariant in form, they were found to have more serious consequences in urban than in rural areas. They frequently lead to a loss of employment and

consequently of the legal right to reside in Johannesburg. Informants were thus left without accommodation or money and thereby literally and symbolically became as dependent on their families for an existence, as their ancestors were dependent on them. The thwasa symptoms were found to have symbolic significance in other respects too. During their time of calling, for example, three female informants reported that their ancestors deprived them of their roles as wives and mothers (by causing the deaths of their husbands or children) in order to force them to take up their roles as healers.

In essence then, the present study found that izangoma and izinyanga have similar pre-training experiences, which differ only with regard to intensity and incidence, and which closely resemble symptoms reported for rural healers.

Training

The present study supports reports that the main difference between izangoma and izinyanga lies in the nature of their training (Byrant, 1960; The Collector, 1911; Elliott, 1970; Hammond-Tooke, 1962). Training was found to differ with regard to (a) the role of ritual, song, dance, and the healing community, and (b) the importance of cult clothing and paraphernalia.

For both izangoma and izinyanga, however, it was found that urban training differs dramatically from the traditional training documented in the literature (Byrant, 1966; Elliott, 1970; Köhler, 1950). Traditionally, izangoma had to undertake training within a supportive

healing community, isolated from society. Many informants stressed that it was because this healing community was so important that they did not train in an urban area. Their phenomenological reports support findings that the value of the healing community lies in its ability to reduce stress by its structure, its emphasis on humility and respect, its isolation of the initiate from all outside influences, and its stress on sexual abstinence and a strict diet (Turner, 1975).

There were indications in the present study, however, that these controls are breaking down, and that the whole nature of the healing community is changing in urban areas. The change in both izinyanga' and izangoma' training may be related to political and economic factors which force many healers to train on a part-time basis. Black people who seek training in homelands outside South Africa may be refused re-entry permits or passes to return to work in city areas.

At their time of calling many people are the sole supporters of large families and cannot afford to give up their work. There are also high costs involved in becoming a healer. Training and ceremonies cost over R400 and paraphernalia can cost over R150. Changes in training may also be related to the very lucrative nature of the healing profession. One informant described:

> "When I was young the izangoma were good and powerful and could cure any sickness ... today the usual answer a sangoma gives those who consult him is that their sickness is due to thwasa. He tells them that he is the one chosen to be their teacher. But he only wants their money and to have people to work in his house. That is why so many people only finish half their training - for the teacher is not interested in the progress of the thwasa."

Other informants reported that teachers in urban areas often undercut each other in order to attract initiates. There were also reports of

jealousy and dislike amongst co-initiates in urban healing communities (see p. 36). Several informants were so poorly trained that they re-experienced the thwasa symptoms and had to undergo a second training.

The present study, therefore, supported reports that there are many charletans in Johannesburg who are poorly trained or who are not even called by their ancestors but become healers purely for economic gain (Beattie and Middleton, 1969; Boshier and Costello, 1975; Sundkler, 1941; Wilson, 1967). It is, therefore, essential that in any research on urban healers careful checks are provided to eliminate charletans from the sample.

Generally, healers condemned urban training, and particularly part-time training, in very strong terms. One said "I can't train anyone in Johannesburg because the ancestors do not like lights. Those who are trained in Johannesburg will probably get the thwasa sickness again, and will have to go to a rural area for their training." Another said "training in the city is bad because it is too busy and there is too much coming and going. When you train you must be quiet and not be disturbed." A third said "The old people didn't speak English and many did not know about the city, so they can't send dreams to thwasas in the city." Rosie K. explained "The ancestors try to make you like they were, if they were never in cities you will be unable to train in a city and you will get sick and learn nothing if you try. But if your ancestors used to live in a city then you will be able to train in a city."

Although the traditional nature of the training of healers has changed in urban areas dance, dreams, ritual and medicines are still as

vital to urban healers as they are reported to be for rural healers.

Dance. Findings of the present study support reports that izangoma use dance, rythmic song and music to enter ASC and to enhance divinatory ability (Laubscher, 1937). Significantly recent Western research has shown (a) that rythmic, low frequency sounds can provoke seizures and movement into ASC in certain people (Tempest, 1971; Watson, 1973), and (b) that psychic ability increases during ASC (Ryzl, 1966; Tart, 1976).

Izangoma enter ASC at the height of the dance. Anthropologists have tended to ignore the dramatic aspect of dance and have emphasized its instrumental rather than expressive aspects. The present study supports suggestions that this is a misinterpretation of the true value of dance, which lies not in the question of whether there is actual possession or not, but in the healing qualities of the dance (Beattie and Middleton, 1969).

Recently many psychologists have recognized the therapeutic importance of dance and body consciousness in dealing with life's tensions and problems (Holdstock, 1979; Luce, 1970, 1972; Van der Hooft, 1978). Certainly techniques like biofeedback, yoga, polarity therapy, Rolfing, T'ai Chi Chuan, massage, and bioenergetics are gaining increasing use in the West.

Feder and Feder (1977) have shown that body movement is a basic and primitive way of coping with stress. It has been suggested that dance eases mental tension by relieving physical tension (Mishlove, 1975). Others have shown that rythmicity and movement lead to relaxation by increasing the activity of the non-verbal right cerebral hemisphere (Ornstein, 1972). Dance movements have also

been found to facilitate the emergence of unconscious impulses, memories and emotions (Feder and Feder, 1977). This provides a scientific basis to the izangoma practice of confessing dreams during a special dance that they believe returns forgotten dreams to memory.

As there is today such an awareness of the importance of dance and body movement to the therapeutic process, South Africa's healers provide a unique opportunity for further research in this area.

Dreams. Like dance, dreams were found to be as important to urban healers as they are reported to be for rural healers (Berglund, 1976; Bührmann, 1977a, 1977b; Schweitzer, 1977).

Western psychology has shown that dreams can play a therapeutic role in the healing process. Freud (1913) was the first psychologist to link dreams with the unconscious and to suggest that they can be used to resolve intra-psychic conflicts. Jung (1963) later suggested that dreams reflect elements in the collective unconscious which contains residues of ancestral life or archetypes (for further detail see Appendix D). More recently, contemporary psychotherapy has shown that an awareness of dreams facilitates the transformation of potentially negative psychic forces, such as aggression, into more creative ones (Schweitzer, 1977a). Today many psychologists acknowledge that dreams are vital to a holistic and healthy life (Green, 1968; Hadfield, 1954; Perls et al.,1973).

The study showed, therefore, that dreams are as important today in urban areas as they have always been in rural areas, and furthermore, that there are sound psychological bases to the use healers make of

dreams. There is an urgent need for further research in this area. Certainly the content of the dreams of both healer and client, as well as the way in which dreams are being used and analyzed during treatment, need to be explored (Holdstock, 1979).

Medicine and Ritual. The present study supports findings that despite urbanization symbolism and ritual have retained much of their traditional meaning and value in urban areas (Hammond-Tooke, 1970; Krige, 1974; Pauw, 1974; West, 1975).

It was interesting to find that initiates who trained on a part-time basis in Johannesburg wore their traditional red loin cloths and white T-shirts under their work uniforms. Those who had passed through certain sacrificial rituals would also wear pieces of the animal's hide under their uniforms, and the gall bladder in their hair under head scarves.

The study supports findings that urban healers generally felt that the ancestors understand how things are in the city and sanction conformity with urban requirements and submission to European law (Mayer, 1963). Thus rituals adapted for use in cities are acceptable to the shades. Healers reported that sacrificial and other rituals are every day occurrences in Johannesburg and its surrounding townships.

Significantly, however, even in urban areas the last ritual in izangoma training - the home coming ceremony - generally must be carried out in a rural area, usually at the healer's birthplace. [illegible] this, however, is changing in urban areas where several generations of a healer's family may have been born in the city.

Like ritual, medicine has continued to play an important role in the lives of urban healers. This was seen, for example, in the symbolic use informants made of medicines. For instance, black medicines were generally used at the start of training to drive the initiate out of the darkness of their previous lives, then white medicines were taken to help the initiate attain a state of purity.

It was of interest in the present study that, in their use of certain medicinal herbs, such as those used to attain ASC, healers anticipated the controversial Western techniques of narcoanalysis and narcosynthesis. These techniques resulted from the growing need to intensify and shorten the therapeutic process, and involve the use of certain chemical agents, such as barbiturates and amphetamines, as adjuncts to psychotherapy. The value of the drugs lies in their ability to bring unconscious processes, feelings and thoughts to awareness. Recent research in the area has yielded "promising results" (Naranjo, 1975, p.175). South Africa offers a valuable area for further investigations into the therapeutic use of drugs which induce ASC.

Significantly, certain healing rituals also resemble some psychotherapeutic techniques like, for example, Gestalt techniques which are used to enact and resolve unfinished issues between the living and dead and to enact a desired state of affairs in order to bring it about.

In summary then, the greatest difference both between izangoma and izinyanga, and between urban and rural healers, lies in training. Significantly, however, the essential components of training, namely dreams, ritual and dance, are still vital in urban areas. Important, too, is that the therapeutic value of these components has been

recognized and validated in the context of Western psychology.

The Practice of Urban Healers

The finding that healers saw a mean of 19 clients a week was only an indication of general trends. This is because no independent checks were made on healers' estimations of their clients, several healers could not estimate their clientelles, and there was a high standard deviation amongst healers.

Indications were, however, that consultants were concerned not with the category of healer they consulted, but with the effectiveness of the treatment they received (personal communication). Interestingly, although izangoma are traditionally female (Hammond-Tooke, 1961; Lee, 1969) male izangoma had the majority of clients. Possibly this is related to the finding that more male than female izangoma had certificates from an official Herbalist Association.

Generally, the study supports findings that indigenous healers play a vital role in urban areas (Boshier and Costello, 1975; Cheetham, 1976; Holdstock, 1976, 1979). The study relates this to the fact that healers are the carriers of African history, customs and beliefs, and help maintain the traditional world-view, morals, and values of the black people (Bührmann, 1977b). Furthermore, they are the channels through which the ancestors are able to gain immortality (Cheetham, personal communication). Healers are so influential in urban areas, however, only because they have the faith and trust of the urban black people. It was found that the work of the urban healer is multifold and includes (a) providing protection against sorcery, witchcraft, illness, and misfortune of all kinds,

(b) aiding those suffering from various illnesses and states of possession, (c) interpreting the messages of the shades sent in dreams and visions to their clients and (d) performing feats of divination. As divination has been given much attention by investigators of rural healers it will be dealt with in detail.

Divination. Divination amongst urban healers differs from that reported for rural healers in several respects. Findings contradicted reports that izinyanga and izangoma can be differentiated on the basis of divinatory ability (Ngubane, 1977; Robbertze, 1978). More specifically, no support was found for reports that izinyanga do not divine (Krige, 1950; Hammond-Tooke, 1962); that Nguni healers use only mental divination (Reynolds, 1967; Schweitzer, 1977); or that mental divination is only used by izangoma (Krige, 1974; Ngubane, 1977). It was, however, found that mental divination used by izinyanga differs from that of izangoma which involves spirit possession, dance and ritual. By contrast izinyanga base divination on messages they receive from their own bodies, as the following two accounts illustrate: "When people come to me I can feel their pain. If they have a headache, I feel a pain in my head." "When someone is coming to see me my heart tells me, it beats loudly in my chest so that I know I must get my medicines ready."

Urban healers were found to use divination in ways similar to those reported for rural healers (Mönnig, 1967). The trend in divination, however, seems to be away from the group orientated form described by Byrant (1911) and Lee (1969), towards a more individually orientated form. This is probably related to the breaking down of the extended family system in urban areas.

As divination is so important to the training and practice of urban healers, it will be evaluated in some detail. A common criticism of divination was given by Junod (1962) who said that divination kills any serious attempt at the use of reason or experience in practical life. He suggested that many healers do not bother to gain a deep knowledge of medicinal herbs but rely on divination to indicate which herbs to prescribe. He concluded that the bones annihilate moral conscience for they tend to reveal that all misfortune is due to sorcery or the wrath of the ancestors, and that medicine or sacrifice can counter it.

The present study found these criticisms to be invalid. According to South African law healers must have a certificate, attained by passing certain tests of divinatory ability, before they may practice. Furthermore, healers use their bones not to prescribe medicine but to help in the diagnosis of illness. In addition, clients only have to pay for treatment after they are cured (Boshier, 1974). Some clients even wait until they dream that they must pay for their cure before doing so (personal communication). In this way ineffective medicine and cures prescribed upon a cast of the bones would not be paid for. Another aspect of divination which is often ignored is the growing awareness that certain people do have psychic abilities beyond the understanding or explanation of science (pp. 117 - 121). Possibly South Africa's diviners are guided by some extrasensory power which does enable them to make accurate divinations.

Certainly, as discussed earlier, there are many charletans practicing in Johannesburg, and Junod's (1962) arguments against

divination are valid in reference to their use of divination. It would be unfortunate, however, if the abilities of genuine diviners were dismissed along with inabilities of the charletans.

The Ancestors

The ancestors are central to the calling, training and practice of all healers and have been given much attention in the literature. The present study found the ancestors to be just as vital today, in urban areas, as they have always been throughout history. Interestingly, however, certain new trends associated with the ancestors appear to have emerged in urban areas, and there were indications of a great need for future research.

Traditionally, paternal ancestors are more important than maternal ancestors in the patrilineal, patriarchal Xhosa, Zulu, Tswana, Sotho and Shangaan ethnic groups (Elliott, 1970; Hunter, 1936; Mqotsi, 1957). For the sample of urban healers, however, patriarchal were only slightly more important than matriarchal ancestors. This supports suggestions that adaptation to urban social structures, as well as social problems like illegitimacy, have broken down strong patrilineal ancestor ties and strengthened the belief in the influence of non-patrilineal kin (Pauw, 1974). Furthermore, possession patterns amongst urban healers did not correspond with the patterns (cited below) that have been reported to operate amongst rural healers:

> "A man may be ithongo (spirit) to his own or his brother's children, but not to a sister's children, and to his grandchildren through his sons but not his daughters. A woman may be ithongo to her own children, her sons' children and her brothers' children. Neither man nor woman can influence their sisters' children who belong to different clans from themselves" (Hunter, 1963, p. 231).

Generally, the important ithongo amongst urban healers were, firstly, maternal and paternal grandparents and, secondly, maternal and paternal parents. Only for Xhosa healers were first generation ithongo more important than second generation ithongo. Reports that ithongo of three generations could have no jurisdiction over the living (Ngubane, 1977) were also contradicted by the present study. Furthermore, only one healer supported the report that married women are influenced by their husbands' shades (Elliott, 1970).

In essence, findings showed that ancestor beliefs have continued to have a major influence in urban areas. Beliefs have, however, been adapted to the urban economic, social and technological milieu and to urban ideals of material and educational advancement. This adaptation has involved a weakening of patrilineal and a strengthening of matrilineal ancestor ties.

Again, the study indicates a need for further research, for insight into indigenous beliefs about the ancestors would lead to a greater understanding of the spiritual dimension of the lives of black South Africans generally. Such an understanding is essential not only in terms of the health needs of the black population but also in terms of the political and economic atmosphere of the present time in South Africa.

V. CONCLUSION

The present study found that the main difference between urban izangoma and izinyanga lies in their training and in their modes of communication with their ancestors. There were few differences between the two categories of healers with regard to their calling and practice. There were also found to be few differences between male and female healers.

Important differences between the findings of the present study and findings of previous studies on rural healers emerged. Generally with urbanization there has been a trend towards shorter training on a part-time basis and an emergence of two new categories of healer - female izinyanga and male izangoma.

The study found that healers are as important today as they have always been, and suggested that urban healers help indigenous people to cope with the change from a traditional to a Western life-style by interpreting problems and providing solutions within indigenous norms and beliefs.

Finally, the study showed that validity has been lent to the training and practice of healers by several Western sources including humanistic and transpersonal psychology and the personality theory of C.G. Jung; developments in brain and sleep research; research in the field of parapsychology; and findings and work of such bodies as the WHO.

It was concluded that there is an urgent need for the Health Service of South Africa to recognize the role and value of indigenous healers, and for further investigation to be made into the applied and research aspects of indigenous healing.

VI. REFERENCES

Abdi, Y.O. The problems and prospects of psychology in Africa. International Journal of Psychology, 1975, 10, 227 - 234.

Alberti, G. Psychopathology and parapsychology: some possible contacts. In B.B. Wolman (Ed.), Handbook of Parapsychology. New York: Van Nostrand Reinhard Company, 1977.

Ampofo, O. Traditional medicine: some examples of its use. World Health Organization, 1977, 31, 428 - 432.

Bannerman, R.H. Study tour in China. World Health, 1977a, November, 433 - 435.

Bannerman, R.H. World Health Organization's programme in traditional medicine. World Health Organization Chronicle, 1977b, 31, 427 - 428.

Beattie, J. Other Cultures: Aims, Methods and Achievements in Social Anthropology. London: Routledge and Kegan Paul, 1964.

Beattie, J., & Middleton, J. (Eds.). Spirit Mediumship and Society in Africa. London: Routledge and Kegan Paul, 1969.

BEMBO. Black Development in South Africa, Johannesburg: Perscor Printers, 1976.

Bennet, E.A. What Jung Really Said. London: Barne and Rockliff, 1961.

Berglund, A.I. Zulu Ideas and Symbolism. Unpublished doctoral dissertation, University of Cape Town, 1972.

Berglund, A.I. Heaven - herds: a study in Zulu symbolism. In M.G. Wisson and M. West (Eds.), Religion and Social Change in Southern Africa. Cape Town: David Philip, 1975.

Bergland, A.I. Zulu Thought-patterns and Symbolism. Uppsala and Cape Town Swedish Institute of Missionary Research, and David Philip, 1976.

Bogen, J.E. The other side of the brain. Bulletin of the Los Angeles Societies, July, 1969.

Boshier, A.K. African apprenticeship. In A, Angoff and D. Barth (Eds.), Parapsychology and Anthoropology. New York: Parapsychology Foundation, 1974.

Boshier, A.K., & Costello, D. Witchdoctor. Johannesburg: The Museum of Man and Science, 1975.

Byrant, A.T. Olden Times in Zululand. London: Longmans, 1911.

Byrant, A.T. Zulu Medicine and Medicine Men. Cape Town: C. Struik, 1966.

Burger, H.G. Ethnic Live-in: A Guide for Penetrating and Understanding a Cultural Minority. Missouri: Missouri University Publishers, 1969.

Bührmann, M.V. Xhosa diviners as psychotherapists. Psychotherapia, 1977b, 3, 17 - 20.

Callaway, H. The Religious System of the Amazulu. London: The folk-lore Society, 1884.

Cawte, J.A. Cruel, Poor and Brutal Nations. Hawii: Honolulu University Press, 1972.

Charsley, S.R. Dreams in an independent African church. Africa, 1973, 43, 244 - 257.

Cheetham, R.W.S. Conflicts in a rural African patient treated in an urban setting. Medicine, 1975, 30, 1536 - 1566.

Cheetham, R.W.S., & Cheetham, R.J. Concepts of mental illness amongst the rural Xhosa people in South Africa. Australian and New Zealand Journal of Psychiatry, 1976, 10, 39 - 45

Coxhead, D., & Hiller, S. Dreams: Visions of the Night. London: Thames and Hudson, 1975.

Douglas, J. Extra-Sensory Powers: A Century of Psychical Research. London: Victor Gollancz, 1976.

Douglas, M. (Ed.). Witchcraft Confessions and Accusations. London: Tavistock Publications, 1970.

Duath, J. Traditional Medicine: some examples of its use. World Health Organization Chronicle, 1977, 31, 428 - 431.

Eggan, D. The significance of dreams for anthropological research. American Anthropologist, 1949, 51, 177.

Ehrenwald, J. Psi, psycnotherapy and psychoanalysis. In B.B. Wolman (Ed.), Handbook on Parapsychology. New York: Van Nostrand Reingold Company, 1977a.

Ehrenwald, J. Parapsychology and the healing arts. In B.B. Wolman (Ed.), Handbook of Parapsychology. New York: Van Nostrand Reinhold Company, 1977b.

Elaide, M. Shamanism: Archaic Techniques of Extacy. Princeton, Princeton University Press, 1966.

Elliott, A. The Magic World of the Xhosa. London: Collins, 1970.

Feder, L., & Feder, B. Dance therapy. Psychology Today, 1977, 10, 76 - 82.

Fahler, J., & Osis, K. Checking for awareness of hits in a precognition experiment with hypnotized subjects. Journal of the American Society for Psychical Research, 1966, 60, 340 - 346.

Firth, R. Foreword. In J. Beattie and J. Middleton (Eds.), Spirit Mediumship and Society in Africa. London: Routledge and Kegan Paul, 1969.

Fisher, C. Psychological significance of the dream-sleep cycle. In H.A. Witken & H.B. Lewis (Eds.), Experimental Studies of Dreaming. New York: Random House, 1967.

Fortes, M., & Dierterlen, G. (Eds.), African Systems of Thought. London: Oxford University Press, 1965.

Frankl, V.E. Psychotherapy and Existentialism. New York: Simon & Schuster, 1967.

Freud, S. The Interpretation of Dreams (1913). In A.A. Brill (Ed.), The Basic Writings of Sigmund Freud. New York: Basic Books, 1959.

Gelfand, M. Witchdoctor. London: Harvill Press, 1964.

Giorgis, T.W., & Helms, J.E. Training international students from developing nations as psychologists: A challenge for American psychology. American Psychologist, 1978, 33, 945 - 951.

Gluckman, M. Custom and Conflict in Africa. Oxford: Basil Blackwell, 1970a.

Gluckman, M. The logic of African science and witchcraft. In M. Marwick (Ed.), Witchcraft and Sorcery. Harmondsworth, Middlesex: Penguin, 1970b.

Goodenough, D.R. Some recent studies of dream recall. In H.A. Witkin & H. B. Lewis (Eds.), Experimental Studies of Dreaming. New York: Random House, 1967.

Grad, B., Cadoret, R.J., & Paul, G.I. The influence of an unorthodox method of treatment on wound healing in mice. International Journal of Parapsychology, 1961, 3, 5 - 24.

Green, C. Lucid Dreams. London: Hamish Hamilton, 1968.

Green, E.F., & Green, A.M. Volition as a metaforce in psychophysiological self regulation. In A. Douglas, Extrasensory Powers. London: Victor Gollancz, 1976.

Gussler, J.F. Social change, ecology and spirit possession among the South African Nguni. In E. Bourguignan (Ed.), Religion, Altered States of Consciousness and Social Change. Columbus: Ohio State University Press, 1973.

Hadfield, J.A. Dreams and Nightmares. Harmondsworth: Penguin Books, 1954.

Hammond-Tooke, W.D. Baccha Society. Cape Town: Oxford University Press, 1962.

Hammond-Tooke, W.D. Urbanization and the interpretation of misfortune: a quantitative analysis. Africa, 1970, 40, 25 - 39.

Hammond-Tooke W.D. African worldview and its relevance for psychiatry. Psychologia Africana, 1975, 16, 25 - 32.

Harding, T.W. Traditional healing methods for mental disorders. World Health Organisation Chronicle, 1977, 31, 436 - 440.

Hellman, F. Soweto - Johannesburg's African City. Johannesburg: South African Institute of Race Relations, 1967.

Holdstock, T.L. The Bodily aspects of the person-centred theory of Carl Rogers. Unpublished Paper, 1977.

Holdstock, T.L. Transpersonal psychology in Southern Africa. Unpublished Paper, 1978.

Holdstock, T.L. Indigenous healing in South Africa: A neglected potential. South African Journal of Psychiology, 1979, 9, 118 - 123.

Horton, R. African traditional thought and Western science. Africa, 1967, 37, 50 - 71 & 155 - 187.

Hsu, F.K.L. Prejudice and its intellectual effect in American anthropology: An ethnographic report. American Anthropologist, 1973, 75, 1 - 19.

Hunter, M. Reaction to Conquest. Oxford: Oxford University Press, 1936.

Johnson, H.D. Biometerology - a multidisciplinary science. American Meteorologican Society, 1972, 10, 202 - 209.

Jung, C.G. Memories, Reflections and Dreams. London: Collins and Routledge and Kegan Paul, 1963.

Jung, C.G. Man and his Symbols. London: Aldns Sooks, 1964.

Junod, H.A. The Life of a South African Tribe:II Mental Life. New York: University Books, 1962.

Kahn, R.L., & Cannell, C.F. The Dynamics of Interviewing. New York: John Wiley & Sons, 1957.

Keen, P. Western Medicine and the Witchdoctor. Johannesburg: The Institute for the Study of Man Publications, 1962.

Kiernan, J.P. Prophet and preacher: an essential partnership in the work of Zion. Man, 1976, 11, 356 - 366.

Kiloh, L.G. Psychiatry among Australian Aboriginies. British Journal of Psychiatry, 1975, 1, 126 - 129.

Köhler, M. The izangoma diviners. Ethnological Publications, 1941, 9, 5 - 98.

Kreuger, A.P. Are negative ions good for you ? New Scientist, 1973, July, 98 - 101.

Krige, E.J. A Lovendu prayer - the light it throws on the ancestor cult. African Studies, 1974, 33, 92 - 111.

Krippner, S., Honorton, C., Ullman, M., Masters, R., & Houston, J. A long-distance 'sensory-bombardment'-study of ESP in dreams. Journal of the American Society for Psychical Research, 1971, 65, 55 - 67.

Kruger, T.M.D Xhosa divining and contemporary psychotherapy - a reciprocal perspective. Fort Hare Papers, 1974, 6, 37 - 45.

Kruger, T.M.D. Towards an understanding of the Xhosa diviner. Paper read to Symposium on the Role and Place of the Traditional Medicine Man and "Witchdoctor" in African Health Care, Medical Students Council, Johannesburg, July, 1977.

Kurup, P.N.V. Traditional medicine: some examples of its use. World Health Organization Chronicle, 1977, 31, 428 - 432.

Lachman, P., & Price, M. Current medical attitudes towards indigenous healing. Paper read to conference on Indigenous Healing, University of the Witwatersrand, Johannesburg, May, 1978.

Lambo, T.A. Patterns of psychiatric care in developing African countries. In A. Kiev, Magic, Faith and Healing. New York: The Free Press, 1974.

Laubscher, B.J.F. Sex, Custom and Psychopathology. London: Routledge, 1937.

Laubscher, B.J.F. The Pagan Soul. Cape Town: Howard Timmins, 1975.

Lee, S.G. Social influences in Zulu dreaming. Journal of Social Psychology, 1958, 47, 268 - 283.

Lee, S.G. Spirit possession among the Zulu. In J. Beattie & J. Middleton (Eds.), Spirit Mediumship and Society in Africa. London: Routledge and Kegan Paul, 1969.

Le Roux, A.G. Die psigiatriese betekenis van die toordokter in die bantoekultuur. Proceedings of the Congress of the Psychological Institute of the Republic of South Africa, 1973.

Le Vine, R.A. Dreams and Deeds: Achievement Motivation in Nigeria. Chicargo: University of Chicargo, 1966.

Lewis, I.M. A structural approach to witchcraft and spirit possession. In M. Douglas (Ed.), Witchcraft. Confessions and Accusations. London: Tavistock Publications, 1970.

Lozoya, X. Traditional medicine· some examples of its use. World Health Organization Chronicle, 1977, 31, 428-432.

Luce, G. Biological Rythms in Psychiatry and Medicine. Bethesda, Maryland: National Institute of Mental Health, 1970.

Luce, G. Body Time. New York: Pantheon, 1972.

Luria, A.R. The Working Brain. New York: Penguin Books, 1973.

Lystad, R.A. (Ed.). A Survey of Social Research. New York: Prager, 1968.

Marks, L.E. Synesthesia: the lucky people with mixed up senses. Psychology Today, 1975, 9, 48-49

Marwick, B.A. The Swazi. Cambridge: University Press, 1940.

Marwick, M. (Ed.). Witchcraft and Sorcery. London: Penguin Education, 1970.

May, R. Man's Search for Himself. London: Souvenir Press, 1953.

Mayer, P. Townsmen or Tribesmen. Cape Town: Oxford University Press, 1963.

Mazignski, B. Effect of the presence of man on air ion density in an office. International Journal of Biometerology, 1971, 15, 11-21.

McGurk, F.C. Psychological effects of artificially produced air ions. American Journal of Psychological Medicine, 1959, 38, 136-139.

Meader B.D., & Rogers, C.R. Client-centred therapy. In R. Corsini (Ed.), Current Psychotherapies. Illinois: Peacock Publishers, 1973.

Mishlove, J. The Roots of Consciousness. New York: Random House, 1975.

Mishlove, J. Frontiers of psychic development. Psychic, March, 1976.

Mitchell, J.C. The Meaning of misfortune for urban Africans. In M. Fortes & G. Dierterlen (Eds.), African Systems of Thought. London: Oxford University Press, 1965.

Möller, H.J. The dilemma of the church. In G. Marais & R. van der Kooy (Eds.), South Africa's Urban Blacks: Problems and Challenges. Pretoria: School of Business Leadership, 1978.

Mönnig, H.O. The Pedi. Pretoria: J.L. van Schaik, 1967.

Mqotsi, L. A study of Ukuthwasa. Unpublished Mastoral dissertation, University of the Witwatersrand, 1957.

Myers, F. Human Personality and its Survival of Bodily Death. London: Longmans, Green & Coy. 1903.

Naranjo, C. The Healing Journey: New Approaches to Consciousness. London: Hutchinson & Company, 1975.

Newman, D. The Culture Relativity view. Psychogram, 1977, 3, 58-61.

Ngubane, H. Body and Mind in Zulu Medicine. London: Academic Press, 1977.

O'Leary, K.D., & Wilson, G.T. Behaviour Therapy: Application and Outcome. New Jersey: Prentice Hall, 1975.

Ornstein, R.E. The Psychology of Consciousness. New York: Viking Press, 1972.

Osborn, A.W. The Superphysical. London: Ivor Nicholson & Watson, 1937.

Ostrander, S., & Schroeder, L. Psychic Discoveries Behind the Iron Curtain. New Jersey: Prentice-Hall, 1970.

Parkin, D.J. Palms, Wine and Witnesses: Public Spirit and Private Gain in an African Farming Community. London: Chandler Publishing Company, 1972.

Parrinder, G. Religion in Africa. London: Penguin Books, 1969.

Pauw, B.A. Religion in an African Chiefdom. London: Oxford University Press, 1960.

Pauw, B.A. Ancestor beliefs and rituals among urban Africans. African Studies, 1974, 33, 98-111.

Pauw, B.A. Christianity and Xhosa Tradition. Cape Town: Oxford University Press, 1975.

Playfair, G.L., & Hill, S. The Cycles of Heaven. London: Souvenir Press, 1978.

Robbertze, J.H. The medicine man or traditional healer. Psychotherapeia, 1977, 3, 1-2.

Robbertze, J.H. The traditional "healers". Psychotherapeia, 1978, 4, 1-2.

Rogers, C.R. In retrospect: forty-six years. American Psychologist, 1974, 29, 115-123.

Rogers, C.R. On Personal Power. New York: Delacorte Press, 1977.

Rogo, S. Dreaming the future. Psychic, 1975, September, 17-24.

Ryzl, M. A method of training in E S P. International Journal of Parapsychology, 1966, 8, 501-532.

Sampson, H.F. The White-faced Huts. Johannesburg: Voortrekkerpers, 1969.

Schaperia, I. The Bantu-Speaking Tribes of South Africa. Cape Town: Maslew Miller Ltd., 1937.

Schimlek, F. Medicine versus Witchcraft. Natal: Marionhill Mission Press, 1950.

Schwartz, B.F. Possible telesomatic reactions. Journal of the Medical Society of New Jersey, 1967, 64, 600-603.

Schweitzer, R.D. Categories of Experience amongst the Xhosa: A Psychological Study. Unpublished Mastoral Dissertation, Rhodes University, 1977a.

Schweitzer, R.D. Some suggestions pertaining to mental health services in traditional societies. Psychotherapia, 1977b, 3, 15-17.

Schweitzer, R.D., & Bührmann, M.V. An existential - phenomenological interpretation of thwasa among the Xhosa. Psychotherapeia, 1978, 4, 15-18.

Shack, W.A. Hunger, anxiety and ritual: deprivation and spirit possession among the Gurage of Ehtiopia. Man, 1971, 6, 30-43.

Shaffer, J.E., Schmidt, C.W. Zlotowitz, H.I., & Fisher, R.S. Biorythms and highway crashes. Archives of General Psychiatry, 1978, 35, 41-46.

Smith, J. Paranormal effects on enzyme activity. Journal of Paranormal Psychology, 1968, 32, 281-283.

Sperry, R.W. The great cerebral commisure. Scientific American, 1964, Jan, 42-53.

Stearn, J. Adventures into the Psychic. London: Fredric Muller, 1971.

Stevenson, I. Telepathic impressions: A review of thirtyfive new cases. Proceedings of the American Society for Psychical Research, 1970. 13, 59-62.

Straach, I. Medical aspects of mental healing. International Journal of Parapsychology, 1963, 5, 563-536.

Sundkler, B.G.M. Bantu Prophets of South Africa. London: Oxford University Press, 1961.

Targ, R., & Puthoff, H. Mind - Reach: Scientists look at Psychic Ability. New York: Delacorte Press, 1977.

Tart, C.T. (Ed.). Altered States of Consciousness: A Book of Readings. New York: John Wiley & Sons, 1969.

Tart, C.T. Some assumptions of orthodox Western psychology. In C.T. Tart (Ed.), Transpersonal Psychologies. New York: Harper and Row, 1975.

Tart, C.T. ESP training. Psychic, 1976, April, 21-27.

Tempest, W. Noise makes drivers drunk. London Observer, 1971, November, 16-18.

The Collector, 1911, cited by S.G. Lee, Spirit possession among the Zulu. In J. Beattie & J. Middleton (Eds.), Spirit Mediumship and Society in Africa. London: Routledge and Kegan Paul, 1969.

Turner, V.W. Witchcraft and sorcery: taxonomy versus dynamics. Africa, 1975, 34, 314-325.

Udupu, K.N. Traditional medicine, some examples of its use. World Health Organization Chronicle, 1977, 31, 428-432.

Ullman, M. Parapsychology and psi phenomena. In B.B. Wolman (Ed.), Handbook of Parapsychology. New York: Van Nostrand Reinhold Company, 1977.

Ullman, M., & Krippner, S. Dream studies and telepathy. Parapsychological Monographs, 1970, 12, 55-67.

Van de Castle, R.L. Anthropology and ESP. Psychic, 1974, February, 21-29.

Van der Hooft, A.A. Malopo dance among the Pedi. Paper presented at a Conference on Indigenous Healing held at the University of the Witwatersrand, 1978.

Watson, C. Supernature. London: Hodder & Stoughton Ltd., 1973.

West, M. The shades come to town. In M.G. Whisson & M. West (Eds.), Religion and Social Change in South Africa. Cape Town: David Philips, 1975.

White, J. (Ed.). Frontiers of Consciousness. New York: Julian Press, 1974.

Wilson, G. An African morality. Africa, 1936, 9, 75-99.

Witkin, H.A., & Lewis, H.B. (Eds.). Experimental Studies of Dreaming. New York: Random House, 1967.

Wober, M. Psychology in Africa. London: IAI, 1975.

Wolman, B.B. (Ed.). Handbook of Parapsychology. New York: Van Nostrand Reinhard Company, 1977.

APPENDIX A

Western Medicine and Indigenous Healing

In many traditional societies today, indigenous systems of medicine are used in preference to Western medicine (Bannerman, 1977a, 1977b). Indeed, Western medicine is often treated with distrust and suspicion by indigenous peoples because it is so highly specialised and is usually practiced without reference to indigenous beliefs.

Indigenous healers by contrast usually have their patients' total trust, for they heal purely in the context of indigenous beliefs. Psychologically, too, indigenous healers are at an advantage for they treat not only the illness but the person as a whole - soul as well as body (Boshier and Costello, 1975). Usually, too, they have the support of the whole community in their work with one patient for, in traditional societies, illness is seen as belonging to everybody and thus the responsibility for the illness is shared (Harding, 1977).

Although indigenous healers are often more successful than Western doctors, it is only recently that this has been recognised and documented (Ampofo, 1977; Kurup, 1977; Udupu, 1977). An important source of recognition is the World Health Organisation (WHO) which, in the 1970's, implemented programs to incorporate healers into primary health services. The success of this policy was demonstrated in China where a new indigenous medicine improved the individual's quality of life and achieved total health care coverage in one generation (Bannerman, 1977b). The WHO has also urged for the promotion and development of training and research in indigenous medicine. It specifically stressed the role which indigenous medicine can play in the development of health services in Africa (Bannerman, 1977b).

The greatest medical contribution of indigenous healers has been to the field of mental health. This was seen, for example, in Nigeria (Lambo, 1974), in the Philippeans (Mislove, 1975), and in Malaya where the practice of healers was described as differing from the group therapy practised by Western psychiatrists in its outward appearance only (Dauth, 1977). In South Africa, too, healers have been recognized as having commonalities with certain Western psychologists (Bührmann, 1977; Holdstock, 1977).

The recognition of indigenous healers is part of a new receptiveness in psychology to non-Western approaches to understanding the person and the therapeutic process. This new openness has followed the growing disillusionment with traditional psychological techniques and approaches which have not succeeded in combatting mental health problems.

However, although some psychologists have shown a greater openness to indigenous healers, the primary orientation of psychology is still towards the Western scientific tradition. This orientation has been severely condemned and criticised as being egocentric and lacking respect for the different cultures (Abdi, 1975; Hsu, 1973; Lystad, 1968). It has also been stressed that if psychology is not to become the study of Western people its training programs will have to be internationalised (Giorgis and Helms, 1978). Attention has been focussed on the difference between a truly cross-cultural science of people and a white-centred science of people with cross-cultural trappings (Hsu, 1973).

There is a grave weakness in psychology stemming from the rigid limitations imposed by its Western scientific approach. Thus, while

there is an awareness of the fact that non-Western healers are therapeutically effective, healers are still rejected by most psychologists, and psychology continues in its Western orientation in traditional societies.

Indigenous Healing and Mental Health in South Africa

South Africa is certainly guilty of recognizing only a completely Western orientated health service. The inapplicability of a Western model of psychology for the majority of South Africans, however, is shown by the fact that South Africa has only four registered black psychologists, no registered black psychiatrists and only a score of registered black social workers. There is, however, a black population of over eighteen million people. Their mental health needs are mainly catered for by the indigenous healers.

It is ironical, therefore, that at present in South Africa, the attitude of the medical profession towards indigenous healers is one of total rejection (Lachman and Price, 1978). This attitude is related to several factors. Firstly, medical professionals are generally ignorant about the black culture. Secondly, there is a pervasive Western belief that anything but a scientific approach to healing is dangerous. Thirdly, only the healers' failures are seen in hospitals and clinics while their successes go largely unrecognized.

In 1974 the South African Medical and Dental Council made official their rejection of indigenous healers in a Health Act which forbade any non-registered healer to practice or perform any act pertaining to the medical profession. Registered healers were also forbidden to work medically in collaboration with non-registered healers. The medical attitude towards indigenous healers is supported by the official legal attitude which is also one of condemnation.

The official rejection of indigenous healers is opposed by those who believe that indigenous healing is valid in the indigenous context and will continue receiving support (Boshier and Costello, 1975; Le Roux, 1973). In a recent survey Lachman and Price (1978) found that 80 percent of 308 medical doctors felt that indigenous healers do have an important part to play in the medical team in South Africa - particularly in the field of psychology. Cheetham (1975) found that urbanization has increased psychiatric illness amongst black people. He suggested that this has increased the urgency for indigenous healers to be included in the mental health system. In 1976 the South African Medical Journal opposed the total rejection of healers in its suggestion that medical professionals try to understand the healers' system of operation, accept healers into some fields, like psychology, and help them to recognize which illnesses they cannot cure.

The medical contribution which healers can make in South Africa was discussed at a conference held in 1977 by the Medical Students Council of the University of the Witwatersrand. This was followed, in 1978, by a conference on Indigenous Healing held by members of the Psychology Department of the same university. The economic importance of indigenous healers was stressed at a symposium held by the Cape Town School of Economics in 1978.

Recently many medical and psychological professionals and researchers have stressed that Western people should not assume that they have nothing to learn from an indigenous tradition that has been in use for thousands of years (Boshier and Costello, 1975).

APPENDIX B

The World View of Black South Africans

South Africa's indigenous healers can only be truly understood in the context of their culture and world view. Furthermore, as there are many features common to Western and African thought (Horton, 1967), a study of the African world view provides a greater understanding of society and human behaviour in general (Marwick, 1970).

The African world view is personalized and animistic rather than scientific or mechanical (Beattie and Middleton, 1969; Hammond-Tooke, 1962; Marwick, 1970). In an animistic world all things - living organisms, words, acts, thoughts, deeds - are believed to be charged with a vital force or power (Bührmann, 1977a). This force, which is often personified as gods, spirits, witches or wizards, is believed to have a great influence over people. In this world reality is not only that which is definable in rational terms or acceptable because of proven conclusions (Berglund, 1976). It includes such experiences as dreams, visions, spirit possession, precognition and life after death. The universe, too, is not dichotomized into two distinct and mutually exclusive spheres labelled 'natural' and 'supernatural' as it is for Western people.

Black people live in an undivided world in which ancestor, dream, plant and body all belong together (Kruger, 1974). This contrasts markedly with Western people who, in their need to define and control nature, have become estranged from nature and from their own bodies.

The personalized nature of the black person's world view is also evidenced in the closeness of their interpersonal relationships. One black man, for example, said of his niece "she is my sister's child, that is to say she is my child." Another said of his cousin "she is my

mother's sister's child, so I can say she is my sister." Traditionally, black people live in extended families in closely knit communities.

Many theories have been offered to explain animistic beliefs. One theory is that animistic beliefs were evolved as a means of coping with threatening forces in the world (Beattie and Middleton, 1969; Cheetham and Cheetham, 1976; Hammond-Tooke, 1975b). For, by personifying these forces as human type intelligences - spirits, gods, witches, ancestors - a social relationship could be entered into with them and threatening forces could be averted through ritual, invocation and prayer.

Another theory is that animistic beliefs were evolved as means of upholding a system of control, for the belief in supra-human forces helped to ensure a social continuity and to crush tendencies subversive to the traditional political order and moral values (Schimlek, 1950).

Horton (1967) offered a different theory. He saw industrial societies as being in such a state of flux that such universal components as regularity, predictability and simplicity seem absent. Consequently people seek these universal components in the world of inanimate things. This, Horton suggests, is why they attempt to find explanatory analogies in terms of inanimate objects. By contrast, however, in the indigenous cultures of Africa, people rather than objects represent order, predictability and regularity, and so indigenous people are far more at ease with people than with objects. This Horton sees as explaining why indigenous people seek explanations in terms of people and their relationships.

Whatever the reasons for the black peoples' animistic world view there is a complete system of control behind its beliefs and values.

Indeed, contrary to popular opinion, the goals of explanation and prediction are as powerfully present in the indigenous world view as they are in a Western world view, only these goals are more closely linked to emotional, interpersonal needs - to the basis of living - than is the case in industrial cultures where the individual has become the complete focus (Holdstock, 1977).

Validation of Animistic Beliefs in Terms of Newer Conceptions in Psychology

Although the animistic beliefs of black South Africans have been rejected by Western peoples, recent scientific discoveries have given cause for a reassessment of this attitude. One such discovery is Kirlian photography - a technique which can produce images on photographic paper using no light source except a luminous corona-like discharge on the surface of an object which is placed in a high-voltage, high-frequency electric field (Mishlove, 1975). Kirlian photographs of plants have been found to show up the presence of disease before any visible signs of the disease were present (Ostrander and Schroeder, 1971). Experiments using Kirlian photography have also shown that plants can be significantly affected by psychic influences (Mishlove, 1975).

In using Kirlian photography to investigate psychic healing it was found that there is an apparent energy transfer from healer to plant or from healer to patient (Mislove, 1975). Kirlian photography has thus provided experimental evidence which supports animistic beliefs that living organisms are charged with a vital force or power beyond the explanation of science.

Another recent area of research has shown that people are affected by their meteorological environment (Johnson, 1972; Watson, 1973). For

example, air ions, which are minute electrically charged air particles, have been found to significantly affect people's emotions (Kreuger, 1973; Maczinski, 1971). Significantly negative ions, which because of their high oxygen content have beneficial effects (Gualterotti, 1968; McGurk, 1959), predominate in those places which healers associate with the ancestors. All this supports animistic beliefs that people are affected by powers or forces beyond their control.

Another parameter of the meteorological environment to which certain animistic beliefs may be attributed is that of electro-magnetic fields. Electro-magnetic waves and impulses between the 0,01 HZ and 100 HZ frequency bands are within the range of the frequencies of major electro-magnetic biochemical processes in humans, and hence, are thought to be able to interact with a person's electrical processes (White, 1974). Weather conditions, as well as seasonal and diurnal variations, influence the frequency of low electro-magnetic fields and thus affect humans. It is possible that South Africa's black people have personified this form of energy as weather and rain gods.

APPENDIX C

Indigenous Beliefs About the Spirit World and Related Aspects

In many African languages the same word (moya, Zulu) means both spirit and air. Thus, spirits are identified with that which is vital for life and permeates every aspect of a person's being. The ancestral spirits are the most important of all spirits and a symbiotic relationship exists between them and their living descendents.

The spirit world is believed to consist of several divisions - one includes spirits of the recently deceased, another the shades (all those spirits which affect the living irrespective of descent line (West, 1975)). This category includes the ancestral spirits which can only affect those of their own descent line. After death a sacrifice is necessary to integrate the recently deceased into the world of the ancestors (amaglozi, Zulu).

The ancestors are believed to have great powers over the living. If neglected they can cause misfortune, sickness, or even death (Mönnig, 1967). If remembered, however, they can protect, and bestow good fortune. While the ancestors are important for all black people, they are particularly vital to the indigenous healers. Indeed, without the ancestors there could be no healers, for it is the ancestors who call the healers to their professions, who enter them when they divine, and guide them through their dreams when they are asleep. The relationship between healers and their shades is so close that in many respects the distinction between them is not significant and is often completely meaningless (Schweitzer, 1977a).

In Western terms the ancestors can be conceived of as Kirlian phantom leaves, specific forms of energy which exist in relation to that which they have been a part of (Holdstock, 1978).

The most powerful ancestors for healers are first or second generation relatives who were themselves healers. Also important are the less easily identified shades who can exert a good or evil influence over the living. These spirits can belong to deceased people or animals. Often healers have a specific guiding animal spirit (ixilo, Xhosa) (Elliott, 1970; Junod, 1962).

Although healers are very involved with their ancestors they do not worship them, rather there is a "speaking to them, a telling them everything" (Berglund, 1970, p.96). In other words, healers see their ancestors as elders who have died rather than as gods. Credo Mutwa (personal communication) explained "we do not worship our ancestors, we honour them. We do not directly approach Modimo (God) for that would be the greatest blasphemy. All requests must be conveyed to Modimo through our ancestors."

Modimo is believed to wield the greatest power in the spirit world. Unlike the ancestral spirits, however, Modimo is remote and very rarely invoked, and no rituals are directed towards Him (Elliott, 1970; Ngubane, 1977).

In many respects indigenous religious beliefs resemble Christianity, for example, both can explain misfortune in terms of suprahuman agencies. Because of this resemblance Christianity has been accepted by many black people. In fact, more than 2000 sects mixing Christian and indigenous beliefs have existed in South Africa (Pauw, 1975). Their popularity lies both in their stress on ancestral beliefs (Krige, 1974), and in their framework for dealing with illness and misfortune through a combination of a Biblical revivalism and African traditional practices (Kiernan, 1976).

The most powerful ancestors for healers are first or second generation relatives who were themselves healers. Also important are the less easily identified shades who can exert a good or evil influence over the living. These spirits can belong to deceased people or animals. Often healers have a specific guiding animal spirit (ixilo, Xhosa) (Elliott, 1970; Junod, 1962).

Although healers are very involved with their ancestors they do not worship them, rather there is a "speaking to them, a telling them everything" (Berglund, 1970, p.96). In other words, healers see their ancestors as elders who have died rather than as gods. Credo Mutwa (personal communication) explained "we do not worship our ancestors, we honour them. We do not directly approach Modimo (God) for that would be the greatest blasphemy. All requests must be conveyed to Modimo through our ancestors."

Modimo is believed to wield the greatest power in the spirit world. Unlike the ancestral spirits, however, Modimo is remote and very rarely invoked, and no rituals are directed towards Him (Elliott, 1970; Ngubane, 1977).

In many respects indigenous religious beliefs resemble Christianity, for example, both can explain misfortune in terms of suprahuman agencies. Because of this resemblance Christianity has been accepted by many black people. In fact, more than 2000 sects mixing Christian and indigenous beliefs have existed in South Africa (Pauw, 1975). Their popularity lies both in their stress on ancestral beliefs (Krige, 1974), and in their framework for dealing with illness and misfortune through a combination of a Biblical revivalism and African traditional practices (Kiernan, 1976).

In indigenous churches illness is healed by a profita (one called through possession by ancestral and Holy spirits to serve as a minister of an indigenous church sect). These healers cure through a combination of prayer, invocation, song, dance, and the administration of a medicinal water which has been ritually blessed (Charsley, 1973). In so far as the healing practices of profita involve song, dance, and the confession of dreams, they are similar to those of indigenous healers.

Indigenous beliefs about dreams

Indigenous beliefs about the spirit world are intricately related to their beliefs about dreams (Charsley, 1973). The paramount importance of dreams to black people was described by Lizzy S. who said "you can't live if you don't dream ... If you dream you know you are alive ... Dreams are your house." Indigenous people see dreams as channels through which the ancestors communicate with the living, and dreams form an integral part of many healing practices.

It is believed that during sleep a person's spirit leaves the body and actually undergoes the dream experience. Thus dreams about the ancestors are not merely seen as carriers of the ancestors' message but as actual experiences of it and, consequently, many dreams do not require interpretation but are acted upon directly.

African dream beliefs have synchoronicities with the beliefs of other cultures. The African belief that dreams can contain messages from God has also been expressed in certain Eastern and Western cultures. The Bible, for instance, records that "God speaks to man....in a dream, in a vision of the night, when deep sleep falls" (Job, XXX,111,12). Classical Buddhist theory, too, regards dreams as path to enlightenment and

medium of communication from Buddah. In both Yogic and African belief dreams are regarded as a distinct and real state of consciousness, and in certain American Indian tribes dreams are seen as being as real and as significant as waking consciousness (Mishlove, 1975). The Western culture is thus the exception rather than the rule in its view that dreams are simply reflections of consciousness.

Ironically, recent findings in the West have lent support to certain African dream beliefs. Psychic research, for example, has suggested possible explanations for the dream experiences of diviners (see Appendix E). Western psychologists lay great emphasis on the therapeutic value of dreams (Perls, 1973; Hadfield, 1954). Furthermore, the view that dreams are good and that even a bad dream is positive (in that it contains a reprimand which curbs wrong doing) parallels Jung's theory (1964) that the contents of the collective unconscious, which are manifested in dreams, are not destructive but positive in the messages they convey. The finding by Berglund (1976) that black people also see dreams as reflecting the dreamer's own conscience and awareness of good and bad shows another similarity between indigenous and psychoanalytic thought.

Indigenous beliefs relating to health and healing

Health and healing have a wider and far more inclusive meaning in South Africa than in Western societies. For black people the criterion for health is both a healthy body and a harmonious relationship between the person and his or her natural, social and spiritual environments (Ngubane, 1977). When this relationship is upset the ancestors can retaliate by causing illness. Healing then involves determining which

traditional laws have been transgressed by the sick person and then ritually, ceremonially or symbolically rectifying this, and thus re-establishing a balanced relationship with the spirit world.

It is the ancestors' message conveyed by the illness rather than the illness itself that is feared. Consequently illness is not seen primarily as something to be cured and controlled, but rather as something to be understood and acknowledged (Harding, 1977). Usually, it is the indigenous healers who are called upon to interpret the meaning of the illness' message.

Generally the family and community are implicated in the ancestors' message. Consequently sick people are seldom rejected but are listened to with respect and acceptance. Even in Johannesburg where many black people live apart from their familes; friends and the healer curing the illness share the sick person's responsibility. In fact many urban healers refer to their patients as 'their children'.

Illness not ascribed to the ancestors is often ascribed to sorcery or witchcraft. Sorcery involves the use of medicines of a tangible form for evil purposes, while witchcraft involves the use of invisible agents or familiars for evil purposes (Elliott, 1970). In urban areas the tokoloshe is the most commonly feared familiar. He is a small warped man of knee height, with a hairy baboon-like face and large hairy ears. He has only one buttock and a large penis that is carried over his shoulder or around his waist. To escape the tokoloshe urban Africans raise their beds on bricks. Other familiars, which are more prevalent in rural than urban areas, include the lightening bird (impundulu) and a variety of snakes (mamlambo, ichanti) which change form (Elliott, 1970; Hammond-Tooke, 1975a).

The fear of sorcery and witchcraft is very real for urban black people. Cheetham (1975) reported that two-thirds of the patients in a large hospital ward attributed their illness to sorcery. Furthermore, throughout South Africa people have been brought to trial for their actions against those accused of witchcraft (Sampson, 1969).

The belief in witchcraft is related to the animistic belief that there is an unseen force in nature which can affect a person's health. This force is also believed to enable medicine to operate from a distance without physical contact (Gelfand, 1964).

Indigenous beliefs about medicine in South Africa span the natural, supernatural and spiritual realms. Medicine is not only used to cure disease, but also to ensure good-luck, fertility, success and promotion, to ward off bad-luck, and to protect against evil, witchcraft and sorcery. There is no clear-cut distinction between the magical and physiological properties of medicine. While it is understood to have a rationally explainable, physiological influence, it is also believed to have a magical influence which is supernatural and has no rational explanation (Mönnig, 1969).

Some medicines are not effective in themselves but derive their potency from the ritual and symbolic language that accompanies their use. Songs must be sung during the collection and preparation of certain herbs, while other herbs demand abstinence from certain foods. The potency of yet other herbs is derived from their colour. The symbolism of black, red and white herbs and their rigid sequence in usage is very important (Byrant, 1966; Callaway, 1884; Krige, 1950; Köhler, 1941). Red and black symbolize both good and bad; white symbolizes only good. Initially the sick are treated with the former to strengthen them

and to expel evil from their bodies. White medicines are then used to restore good health (Ngubane, 1977).

Symbolism is also related to the cosmic order of day and night - white represents day which is associated with light, goodness and health; red represents sunset or sunrise, the transition between day and night; and black represents night, darkness and evil.

In conclusion, it must be stressed (a) that indigenous beliefs about the spirit world, dreams, and health, permeate all aspects of the work of indigenous healers and (b) that these beliefs are animistic and cannot be understood from a Western, scientific perspective.

APPENDIX D

Indigenous Beliefs Relating to Spirit Possession

Spirit possession involves the control of a person by a spirit external to him or her. Spirit mediumship, by contrast, involves the person as a mediator for the spirits, the accent being on communication rather than control (Firth, 1969). Various forms of spirit possession and mediumship exist amongst the healers of South Africa. Possession taking place during a ritual leaves healers with no memory of what they said or did. Mediumship, which occurs during divination, leaves healers with full control over their behaviour and a complete memory of what was said.

Although spirit possession has been extensively investigated (Byrant, 1966; Hammond-Tooke, 1975a; Hunter, 1936; Junod, 1962; Krige, 1950; Lewis, 1970), there is little agreement as to what it actually involves. Much confusion has arisen from the difficulty of defining and categorizing the possession states, for the same state is often known by different names and there is also much variation in the behaviour, customs and beliefs about possession amongst the different ethnic groups of South Africa.

Furthermore, mediumship cannot be understood from the Western view that a person who is possessed is suspect or sick. In indigenous cultures spirit mediums are regarded as well integrated, respected members of their communities. Spirit possession, too, is not an isolated, individual phenomenon, but an accepted cult that is part of a complex series of ideas and practices orientated to the recognition of extra-human powers (Beattie and Middleton, 1969).

In South Africa there are two main categories of spirit possession - possession by an alien spirit and possession by an ancestral spirit.

Possession by an ancestral spirit, which is the main focus of the present study, leads to initiation into the izangoma or ukuthwasa cult.

Alien spirit possession

This category includes the states of amandiki and izizwe (or amabutho), all of which may lead to the endowment of healing powers upon the possessed person. This category is very amorphous in its characteristics and is very poorly understood.

Indiki possession. First reported in the early 1900's (Byrant, 1911; The Collecters 1911) indiki possession spread rapidly from its place of origin north of the Pongola river and today is common throughout South Africa. Its rapid spread was connected with the series of influenza epidemics in 1919 and 1920, and malaria epidemic in 1933, for initiation into the cult was believed to be therapeutic (Lee, 1969; Sundkler, 1961).

The word amandiki (plural) means spirits, and those suffering this possession were reported to bark like dogs, speak in strange tongues and move around the country dancing (The Collecter, 1911). Amandiki have also been described as being both prophets and diviners, as well as doctors who are possessed by spirits, other than the ancestral spirits (Lee, 1969). Byrant (1966) reported that those possessed by amandiki are mainly young girls who congregate in bands and have convulsive fits during which they speak in tongues. He suggested that this behaviour was a combination of epilepsy and hysteria.

Informers for the present study could not clarify the general confusion about indiki. They described amandiki as spirits which have not been integrated into the body of the ancestral spirits and return

to the living and cause sickness. Some healers believe amandiki to be spirits of people who died violently. Others say they are spirits of foreigners who died in this country and were not given the rituals necessary to facilitate their return to their homelands. Ngubane (1977) supported this latter theory and detailed further that amandiki are usually male spirits which reside in the chests of those they possess.

Treatment for possession involves initiation into the indiki cult. Red emetics and white herbs are used to replace the foreign spirit with an ancestral male spirit who protects the person from future attacks. Indiki initiates, like traditional thwasa initiates, must withdraw from society, observe forms of abstinence, take medicines and make sacrifices (Ngubane, 1977). A main difference between indiki and thwasa initiates is that possession by an ancestral spirit is consciously induced in the former, while in the latter it is unconscious. Both initiates however can develop their possession to promote powers of prophesy and healing.

Izizwe possession. Izizwe, like indiki, has been described as a state of hysteria (Sundkler, 1961) which also involves speaking in tongues, and a rythmic shaking of the body. Lee (1969) reported that while it is not always accompanied by physical distress psychological stress is usual.

Informants for the present study described those with izizwe as "not knowing what they are doing. They eat anything, take things that are not theirs, and become very aggressive with those who try to help them." They were also reported to suffer from insomnia and to have pronounced mood swings.

Izizwe is generally believed to be caused by witchcraft (Ngubane, 1977; personal communication with urban healers). It can be sent in a

concoction of ants and soil from a graveyard. It can also be caused by izizwe spirits which, having been exorcised from one person, attach themselves to people unfortified against them. The treatment of izizwe aims to replace the alien spirits with benign ancestral spirits called amabutho or soldiers (Ngubane, 1977; Sundkler, 1961). Informants supported reports that izizwe possession does not lead to cult membership or give healing powers (Lee, 1969; Ngubane, 1977).

Credo Mutwa (personal communication) gave a different account of izizwe. He said that izizwe means "foreigners" and involves possession by foreign spirits who appear as "short, red-haired, long bearded, white men who carry clubs - similar to the Irish lepricorn." Possession by these spirits can make a person behave totally irrationally. Significantly, however, Mutwa believed that izizwe spirits can be used benevolently. Rosie K. supported this view and added that certain healers keep their izizwe spirits in large beaded calabashes. Mutwa explained that izizwe possession can turn some people 'mad' and help others because, like most forms of possession, it can be used for good or evil ends.

Conclusion. There is much confusion about alien spirit possession. While some believe that it actually occurs, others believe that it is merely a manifestation of psychological stress. Many have related it to social and economic stress caused by acculturization and the changed living conditions of black South Africans (Lee, 1969; Lewis, 1970; Ngubane, 1977). These authors suggest that treatment which replaces the alien spirit with an ancestral spirit leads to the re-instatement of the desired, traditional pattern of behaviour.

Others, including urban healers, have related alien spirit possession to various pathologies (Byrant, 1966; Sundkler, 1961).

A healer Israel S. explained that while izizwe and indiki can be caused by witchcraft they are also often the result of "over-thinking", of "having too many problems at once" and of "a heavy heart" (a heavy heart is an African euphimism for depression (Cheetham and Cheetham, 1976)).

Whatever the beliefs about the aetiology of alien spirit possession its treatment is successful because it does not make people feel responsible for their illness, or feel that there is anything wrong with their minds, but rather stresses that they are victims of external forces which can be removed. Furthermore, the support and sympathy which the community give to the sick person, has also been shown to be therapeutically effective (Kruger, 1977).

Ancestral spirit possession

Ancestral spirit possession leads to initiation into the ukuthwasa cult. Thwasa refers both to the person experiencing a state of possession as well as to the possession state itself. Those who undergo thwasa become izangoma (Zulu). Thwasa has a long history throughout which it has been invariant in its form, treatment, and in the rituals and social behaviour consequent upon its onset (Lee, 1969). The literal meaning of thwasa is a 'coming out' or emergence after a temporary absence, as in the reappearance of a new moon. The word conveys the idea of a person's rebirth. The thwasa process by which this 'rebirth' takes place is described on pp.33-37.

There are several hierarchically organized thwasa possession sub-cults which differ according to the nature of the spirits involved. A healer explained that "just as there are different divisions of the Christian church, so are there different divisions of the African spiritual tradition." The sub-cults have their own rituals and spheres of influence,

although within each sub-cult training differs from place to place and from healer to healer.

The sub-cults identified in Johannesburg during the present study were the Mdawu cult and the Nguni cult. A third sub-cult, the Malopo Dance cult, was reported to occur very infrequently in urban areas.

The Mdawu cult. This is considered the most powerful of the thwasa cults for the Mdawu spirits are believed to have the strength, power, mastery and other attributes of the lion - the king of beats. Mdawu spirits are those which did not get traditional burial rites and cannot be assimilated into the realm of the shades (Boshier and Costello, 1975). These spirits were described by urban healers as being of the sea, of the water, and of the 'white man'. The possession of black people by the spirits of white people is a recent and apparently common phenomenon in urban areas. One healer described the following experience "When I was a child a white man often came to me in my dreams. I was afraid, but my mother told me these dreams were a good sign. As a sangoma I now realize that these dreams meant that I would one day be guided by a white shade, and that I would be able to help white people " (Percy A.).

The Mdawu cult is the oldest of the izangoma cults. It was first mentioned in the literature in the early 1900's by Junod who described about a hundred cases of Mdawu possession in Moçambique. It originated along the East coast of Africa, and was spread to Eastern Rhodesia by the Nguni tribes of South Africa. Van der Hooft (1978) reported that Mdawu possession is infectious and has also spread to the Transvaal. Originally the Mdawu ancestors only spoke Sendawu, today a more Nguni-like language is spoken during possession.

Mdawu possession is very powerful and demands a stringent training, consequently it is very unpopular. Training generally must be undertaken in a rural area, far from Western influences. There is a widespread belief that under certain circumstances - for example when a thwasa's shades are not very powerful - the shades (in the form of a snake) take the thwasa into a river to be trained there by the 'ancestors of the water' (Laubscher, 1937; personal communication with urban healers). This place was described by informers as "a dry place, with green grass, just like the world above the water, with everything you need." Three healers in the present study claimed to have been trained 'under the water'.

The traditional sacrificial animal for initiation into the Mdawu cult is a white chicken; sometimes a white goat is used - although this is traditionally associated with the Nguni cult. The Mdawu cult has many rituals, tabcos and restrictions associated with it. One healing ritual fits the definition of the Behaviour Modification technique of flooding for it involves "the prolonged exposure (of the client) to high intensity aversive stimulation" (O'Leary and Wilson, 1975, p.238). Like flooding the izangoma ritual is used to cure anxiety or phobic disorders, for through a series of rituals the healer enacts the object of the client's phobia in order to desensitize the client to this object. In another ritual, used against witchcraft, the healer vembas or sweeps the evil from the client with a beaded brush filled with herbs. Other rituals involve a fast vigorous dance which leads to possession by the Mdawu ancestors and endows the healer with special powers.

Mdawu healers can be identified by their red and white bead necklaces and bracelets, their ochred wigs and their red and white capes printed with a lion's head. The symbolism of these colours is described

on p. 93. On ritual occasions a maroon and white print skirt and white sheet symbolizing the healer's state of purity are worn. This white sheet is also used when healers tell their shades of their problems, hopes, etcetera. This practice resembles the Gestalt 'Empty Chair' technique (Perls et al., 1973).

Just as Western psychologists frequently follow an eclectic approach to healing, so many urban healers train in both the Mdawu and Nguni cults. One healer explained "Although I am Nguni, I trained in both the Mdawu and Nguni cults. This is because one of my ancestors killed a Mdawu inyanga and that Mdawu spirit now comes to me and speaks through me."

The Nguni cult. South Africa's indigenous population is divided into four main language groups. The Nguni and Sotho are both large groups, the Venda and Tsonga are much smaller groups. The Nguni groups occupy the Eastern part of the country and include the Zulu, Swazi, Mpondo, Xhosa, Thembu and Baccha peoples.

Nguni izangoma are guided by ancestors of the Nguni tradition, whom healers described as "the ancestor from the family". This ancestor is believed to have had an unnatural death and to be restless despite sacrifices performed by the family. Nguni possession is not as powerful as Mdawu possession, so training is less severe and can take place in urban areas. A healer said of the relationship between Mdawu and Nguni shades "the Mdawu spirit is the boss who tells the Nguni spirit, the slave, what to do." Another said "Nguni comes from the chest, Mdawu comes from the "head." Parkin (1972), too, distinguishes between possession by the spirits of the head or mind, and possession by the spirits of the body.

He found that while possession of the head awards both powers of divination and mediumship, possession of the body does not provide this. This would explain why Mdawu healers can divine without divination tools using only their 'heads' while Nguni healers are dependent of divination materials.

There are many Nguni songs which are sung during ceremonies. The Nguni drum beat is slow and rythmic and the Nguni dance is less intense than the Mdawu dance and does not always lead to possession. Traditionally, plain white beads are worn by Nguni healers.

Important to healers of all cults are echoba or fly-whisks, which are believed to have the power to ward off evil influences. Originally an eshoba was made from the tail of a wildebeest, today, however, the tail of a sacrificial cow is used. Boshier and Costello (1975) described the eshoba as being the equivalent of the medieval magician's wand.

In essence the Nguni and Mdawu cults share many commonalities and most urban healers train in both these cults.

The Malopo Dance cult. This cult is not popular among healers in Johannesburg and mainly occurs in the Northern Transvaal among the Pedi. It has also spread north to the Venda, and recently Mönnig (1967) reported its spread to other tribes, particularly the Tsonga in Sekhukhuneland.

The Malopo cult also involves dance and divination, but as possession is very mild and undemanding it does not rank high among the possession cults, and has been described as a social outing with a lot of dancing (Van der Hooft, 1978). Initial symptoms sometimes follow the traditional thwasa pattern (pp. 27-30), though often pain and sickness are not experienced. Cure from the possession involves initiation into

the Malopo cult. Many initiates do not finish training but just train long enough to stem their ancestral spirits. They must, however, undergo an initiation dance (called thwasicha), a feast, and a sacrifice, and medicines must also be taken to satisfy the shades. Those who complete training become Ngaka ya Malopo. During possession Ngaka ya Malopo, who undergo a complete change in personality and voice, speak in old Sipedi and often need interpreters to explain their divinations.

The name Malopo is derived from the word holopo which means both to call, and to hear the call; to pay what you are due to pay. It also means to ask very strongly and to very strenuously get something done. Thus the name conveys the essential nature of the cult.

Western Explanations of Thwasa and Conclusion. While thwasa, and indeed any state of spirit possession, has a clear-cut meaning within the indigenous cultures, within Western cultures there has been much controversy about its meaning. Those suffering the condition of ukuthwasa have been described as mentally ill (Firth, 1969); hysterical and neurotic (Hammond-Tooke, 1962); showing symptoms of conversion hysteria and anxiety (Lee, 1969); and having unbalanced temperaments (Schapera, 1937). Furthermore, experiences which black people understand to be communications from the shades have been labelled as auditory hallucinations and delusions (Laubscher, 1937; Lee, 1969; Sampson, 1969). This view ignores the fact that certain visions and hallucinations are legitimate expectations in the indigenous culture and do not have the grave prognosis that they have in Western society.

Theories about the aetiology of thwasa have been equally culture bound. Hammond-Tooke (1962) suggested that causes differ for males and

females and that in females menstruation, pregnancy and menopause are causal factors. Mutwa (personal communication) also suggested that menopause is a causal factor of ukuthwasa in women. Gussler (1973), however, saw thwasa to be caused by malfunctioning due to nutritional deficiencies. Shack (1971), too, explained spirit possession in terms of hunger-frustration. Laubscher (1937), by contrast, emphasised the biogenetic and psychotic nature of the thwasa symptoms and aetiology. Other illnesses to which thwasa symptoms have been ascribed include tertiary syphilis, hyperventilation tetany, and anorexia nervosa (Lee, 1969).

Whether thwasa is indicative of pathology or not, thwasa healing communities are therapeutic in indigenous cultures (Cheetham, 1975; Kruger, 1976; Scheweitzer, 1977a,b). Further there has been a growing awareness of the limitations of the Western approach in non-Western cultures. Recently Western attitudes towards thwasa have been more open and thwasa has even been described as a creative illness (Bürhmann, 1977) and as a meaningful experience purposefully directed towards altering and determining the person's new role in society (Schweitzer and Bührmann, 1978). Schweitzer (1977a) saw the thwasa symptoms as manifesting a disharmony between a person and the natural, spiritual and social elements of his or her culture. He suggested that thwasa is positive because it forces the person to enter a supportive healing community which is based on traditional beliefs and is aimed at correcting the disharmony.

Kruger (1974) saw thwasa as resulting from a serious life crisis and suggested that it is positive as it resolves this crisis by facilitating growth and change by providing a framework within which the person can lead a new life.

females and that in females menstruation, pregnancy and menopause are causal factors. Mutwa (personal communication) also suggested that menopause is a causal factor of ukuthwasa in women. Gussler (1973), however, saw thwasa to be caused by malfunctioning due to nutritional deficiencies. Shack (1971), too, explained spirit possession in terms of hunger-frustration. Laubscher (1937), by contrast, emphasised the biogenetic and psychotic nature of the thwasa symptoms and aetiology. Other illnesses to which thwasa symptoms have been ascribed include tertiary syphilis, hyperventilation tetany, and anorexia nervosa (Lee, 1969).

Whether thwasa is indicative of pathology or not, thwasa healing communities are therapeutic in indigenous cultures (Cheetham, 1975; Kruger, 1976; Scheweitzer, 1977a,b). Further there has been a growing awareness of the limitations of the Western approach in non-Western cultures. Recently Western attitudes towards thwasa have been more open and thwasa has even been described as a creative illness (Bürhmann, 1977) and as a meaningful experience purposefully directed towards altering and determining the person's new role in society (Schweitzer and Bührmann, 1978). Schweitzer (1977a) saw the thwasa symptoms as manifesting a disharmony between a person and the natural, spiritual and social elements of his or her culture. He suggested that thwasa is positive because it forces the person to enter a supportive healing community which is based on traditional beliefs and is aimed at correcting the disharmony.

Kruger (1974) saw thwasa as resulting from a serious life crisis and suggested that it is positive as it resolves this crisis by facilitating growth and change by providing a framework within which the person can lead a new life.

Ngubane (1977) supported the traditional belief that thwasa indicates a calling by the shades. She suggested that it is positive because it creates channels through which the shades can guide the living, and thus helps maintain traditional morals, values and standards.

Whether thwasa is, in fact, a calling by the shades as indigenous people believe, or whether it is a mental illness as Western researchers suggest, has not been established. More and more people, however, including mental health professionals like Bührmann (1977), Cheetham (1975), Hol[illegible] (1977, 1979), Kruger (1974), Le Roux (1973), and Robbertze [illegible] have recognized that thwasa is more complex than just a mental illness. Certainly within their cultural context the thwasa symptoms do not fit into Western nosological categories. Furthermore, the thwasa person, unlike the Western psychiatric patient, emerges from his or her 'cure' as a qualified healer who commands great respect and influence in the indigenous culture.

Western medicine has only relatively recently become an organized and controlled science. It was only a century ago that the registration of doctors became compulsory, and psychiatry has been a recognized science for less than a century. Indigenous healing, however, has been in use for thousands of years and, considering the recency of Western medicine, the important contribution that it can make to medicine should not be ignored.

APPENDIX E

Indigenous Healing and Parapsychology

The indigenous people of South Africa have long believed in an extra-sensory reality in which ancestor, dream, plant and body all belong together (Kruger, 1974); past, present and future all co-exist; and information can come from channels other than the known sense organs. Black people also accept the precognitive nature of certain feelings and experiences, and believe that the dead continue to exist and exert an influence over the living.

In contrast to African cultures, Western cultures are generally sceptical about the existence of an extrasensory reality. In fact organised research into extrasensory perception (ESP) began only a century ago.

Psychic research has aimed to prove (a) that ESP can occur, and (b) that mind can act independently of the material brain (Douglas, 1976). By 1947 the reality of paranormal faculties had been scientifically proved. The most important faculties included the ability to become directly aware of events occurring in other peoples' minds (telepathy), occurring in remote places (clairvoyance), and which have not yet occurred (precognition); as well as the ability to influence the behaviour of matter with which there is no contact (psychokinesis).

Although many psychic abilities have been demonstrated by South Africa's healers, few people have linked parapsychology and indigenous healing. On the contrary most anthropologists resist the view that genuine ESP may be occurring in some religious ceremonies and during certain healing rites (van de Castle, 1974). Indigenous healers are believed to have continued to exist mainly because they help diminish intra-and-extra group tensions in indigenous communities (Marwick, 1970).

Furthermore, since healers claim to have powers in which many Westerners do not believe, it has been suggested that healers are suffering from delusions or some form of mental illness (Firth, 1969; Hammond-Tooke, 1962). This view ignores evidence that healers do have a psychic power which is manifested as a telepathic sensitivity to thoughts and emotions and a clairvoyant awareness of certain events (Laubscher, 1937, 1975). The many documented instances of healers' psychic feats verify Laubscher's reports (Boshier, 1974; Callaway, 1884; Holdstock, 1977; van de Castle, 1974).

The present study supports the suggestion that there are important links between parapsychology and indigenous healing. These links include the healers' ability to divine, to psychically effect changes in the physical environment, to presage the future, to receive messages from the dead, and to heal the sick.

Healing is perhaps South Africa's healers greatest function. Many urban blacks reported that they had been successfully cured by healers. Generally these cures involved both the use of herbal medicines and psychic healing. Psychic healing has an ancient history, and there are many documented instances of its success with such disorders as epilepsy, lameness, deafness and partial blindness (Douglas, 1976). Significantly, both lameness and blindness are common thwasa symptoms.

Recently psychic healing has been scientifically proved (Douglas, 1976; Grad et al., 1961; Strauch, 1963; van de Castle, 1974). It has been suggested that healing is effected by the activation of a psychic field which causes an energy exchange within the body cells of the sick person (Smith, 1968). Whatever its cause the psychic factor in healing is "having a seminal influence on the overall system of modern

psychiatric thought" (Ehrenwald, 1977a, p. 347).

The relationship between psychic phenomena and mental disorders, particularly dissociated states like hysteria and certain psychoses, has been stressed by both contemporary and early researches (Alberti, 1977; Ehrenwald, 1977a; Janet, 1886; Myers, 1903). Significantly ukuthwasa has also been associated with such dissociated states as hysteria and psychosis (Firth, 1969; Lee, 1969). Research has shown that a breakdown in normal communication with the world often results in a heightening of psychic abilities (Ehrenwald, 1977b). The condition of ukuthwasa, usually marked by a physical and emotional withdrawal from the world, also coincides with a heightening of the thwasa's psychic abilities.

Healers' knowledge that psychic abilities can be developed and taught has recently been experimentally validated (Ryzl, 1966; Tart, 1976). Furthermore, the healers' practice of developing psychic abilities during altered states of consciousness (ASC) attained through dance was lent validity by studies which showed that psychic ability is increased during ASC (Fahler and Osis, 1966; Ryzl, 1966).

Precognition has also been related to ASC, for precognitions occur with greater frequency and accuracy in dreams than in the waking state (Rogo, 1974; Ullman and Krippner, 1970). This could explain why it is mainly in dreams that healers receive precognitive and other kinds of psychic messages from their ancestors. Studies have also shown that information can be received telephatically in dreams (Krippner et al., 1971; Ullman and Krippner, 1970). It was suggested that deep emotional involvement in an experience excites the older part of the brain into creating images strong enough to transmit to another brain

without sensory contact (Krippner et al., 1971). This theory could explain why ancestral dreams increase during the traumatic thwasa period. It could also explain the telepathic contact that can occur between healer and patient, initiate and teacher. Finally, it could also explain how healers can have accurate precognitive dreams about their prospective thwasas.

Indigenous healers attribute all their psychic abilities to the ancestors who are believed to be aware of things happening in distant places, and events to occur in the future. There have been many accounts of healers precognizing future events, and describing remote objects and beings (Boshier, 1974; Laubscher, 1937, 1975). A thwasa demonstrated her psychic ability to the author in the following way. Ten metres from a mud hut in which the thwasa was isolated, a healer drew three figures. The thwasa, who was of Hottentot descent, correctly reproduced the two Hottentot symbols, she failed to reproduce the third, a Xhosa symbol.

Most urban healers use divination tools when divining. The clairvoyant premise that objects are subject to psychical influences, could explain the remarkable feats that healers have performed. Experimental research has not, however, produced scientific evidence for divination. This indicates an urgent need for research amongst the thousands of South African diviners.

Research has suggested that psychic abilities are centred in the right cerebral hemisphere (Bogen, 1969; Ornstein, 1972; Sperry, 1964). Reports by healers who divine by using their body sensations support this suggestion, as the following report illustrates:

"When I became ill from the thwasa sickness it was only the left side of my body - the side that comes from my mother and is governed by my mother's ancestors who were izangoma - that was effected. This was because it was my mother's ancestors that needed attention."

From a Western perspective it appears that this healer's need to develop his psychic abilities was manifested in symptoms in the side of the body controlled by the right cerebral hemisphere. This hemisphere is the centre of intuitive and non-analytic processes, while the left hemisphere is the centre of logical, linear and analytic processes (Bogen, 1969). In this context it is also significant that as children, many healers tend to avoid the left hemisphere dominated Western education system - often because of somatic symptoms.

The finding that psychic communications can take the form of transient somatic symptoms (Ehrenwald, 1977b; Schwartz, 1967; Stevenson, 1970), could explain the somatic thwasa symptoms, and the claim that certain healers can feel a client's pain in their own bodies (report cited on p 62). Jung explained the above type of phenomena as being a meaningful coincidence between two acausal parapsychological events (Jung, 1963).

Today there is growing support for the concept that people are influenced by forces beyond their conscious control or understanding. Furthermore, where there were originally believed to be only five states of consciousness, today more than twenty states have been identified or suggested (Playfair and Hill, 1978). There is also a growing awareness that perception involves more than just the five sense organs. Studies in the 1950's showed that perception is directly influenced by the needs, emotions and past experiences of the perceiver. Muscular tension,

> "When I became ill from the thwasa sickness it was only the left side of my body - the side that comes from my mother and is governed by my mother's ancestors who were izangoma - that was effected. This was because it was my mother's ancestors that needed attention."

From a Western perspective it appears that this healer's need to develop his psychic abilities was manifested in symptoms in the side of the body controlled by the right cerebral hemisphere. This hemisphere is the centre of intuitive and non-analytic processes, while the left hemisphere is the centre of logical, linear and analytic processes (Bogen, 1969). In this context it is also significant that as children, many healers tend to avoid the left hemisphere dominated Western education system - often because of somatic symptoms.

The finding that psychic communications can take the form of transient somatic symptoms (Ehrenwald, 1977b; Schwartz, 1967; Stevenson, 1970), could explain the somatic thwasa symptoms, and the claim that certain healers can feel a client's pain in their own bodies (report cited on p 62). Jung explained the above type of phenomena as being a meaningful coincidence between two acausal parapsychological events (Jung, 1963).

Today there is growing support for the concept that people are influenced by forces beyond their conscious control or understanding. Furthermore, where there were originally believed to be only five states of consciousness, today more than twenty states have been identified or suggested (Playfair and Hill, 1978). There is also a growing awareness that perception involves more than just the five sense organs. Studies in the 1950's showed that perception is directly influenced by the needs, emotions and past experiences of the perceiver. Muscular tension,

psychological arousal, and other bodily states have also been shown to significantly influence perception. Of great importance too, is the recent awareness that certain people experience a mixing of senses known as synesthesis. One stimulus actually stimulates more than one sensory modality so that synesthetics experience 'coloured hearing', and visual images produced by taste or smell (Marks, 1975).

The growing awareness of the complexity of the processes o. perception has increased the need for physiological psychology to find biological bases for psychic phenomena. Research has found significant correlations between brain wave patterns and psychic phenomena, and between body electricity and psychokinesis (Playfair and Hill, 1978).

The findings of physiological and parapsychology, astrology, Kirlian photography, acupuncture, yoga, and meditation, all indicate that there is a field of mind surrounding the earth, analogous to the gravitational and magnetic fields (Douglas, 1976). There is consequently, an urgent need for more research to investigate individuals with paranormal abilities.

Paradoxically, in South Africa where the belief system of the indigenous people is orientated to the recognition and promotion of paranormal abilities, researchers and medical professionals alike doubt the authenticity and value of indigenous healers' work. Ironically, however, laws have been passed to maintain the healers' standard of divination. Today the Code of Native Law, first passed in 1891, forbids healers to practice without a certificate attained by passing certain tests of psychic ability.

APPENDIX F

Indigenous Healing and Western Psychotherapy

Western therapists operating within the framework of natural science are limited for those people whose illness is related to their need to find a meaning in life. Existential psychologists have attributed this loss of meaning to be the cause of many mental illnesses (Frankl, 1967; May, 1953).

The world view of indigenous cultures, by contrast, does provide the sick person with a meaning and often a new role in life. This was clearly seen in the healers' approach to the cure of the thwasa symptoms. Significantly this cure uses concepts and practices that are only recently being used by Western psychologists. This illustrated in the Person-centred, Gestalt, Jungian and Erhard Seminars Training (est) approaches to therapy.

Person-Centred or Rogerian Therapy. The person-centred approach upholds that a person's growth potential is released in a relationship in which there is empathy, and a sincere realness and caring, as well as a sensitive, non-judgmental understanding (Meader and Rogers, 1973). These conditions are present between thwasa and teacher who actually live together. Their relationship is non-judgmental because judgement would be reflection of the shades rather than of the healer. Similarly, failure is not attributed to the thwasas, but to their failure to fulfil certain obligations in relation to the shades (Motsi, 1957). The teachers' empathetic understanding is based on their own parallel experiences during thwasa. In addition the suffering which all healers undergo enables them to empathise with their clients in a truly Rogerian way.

Rogerian therapists facilitate change by increasing their clients'

ability to be aware of, to own, and to express their feelings. Thwasa, too, facilitates change by making initiates aware of their inner experiences through the confession of dreams and deeds.

Both the person-centred and indigenous approaches stress the importance of the healers' awareness of self and of the other. Some indigenous healers even develop an extrasensory awareness of their clients' pain.

Finally, like Rogers (1974), healers also stress that the self should not be withheld from a client. One healer explained this as follows: "When I quarrel with my husband, my heart is sore, and my shades run away from me - so I have no power and cannot divine."

Although similar in many ways, person-centred therapy and indigenous healing occur in very different environments. Furthermore, thwasa and teacher often interact on a twentyfour hour basis while Rogerian therapists only relate to their clients on an hourly basis. Nevertheless that two such similar approaches are used by two such different kinds of healers is important.

Gestalt Therapy. Like indigenous healers Gestalt therapists see the person in the context of the greater whole of nature, and regard the functioning of a person's body, emotions, thoughts, culture and social expressions as all combining to form a unified whole. A healer explained "Your heart goes with your head, unless your heart is clear, your head will never be able to see to divine." Another said "When a Zulu is sick, it is the whole man that is sick, his physical as well as spiritual being which is affected " (cited by Berglund, 1976, p.68).

Indigenous healers recognize the problems that can arise from

splitting mind and body in their divination sets. The divination bones encompass the physical and spiritual, natural and supernatural, worlds of the client (Junod, 1962), and thus enable a completely wholistic approach to be taken in diagnosis. Indigenous healers maintain a wholistic approach throughout the treatment, or training, of initiates and, although this differs from Gestalt techniques, the two have many synchronicities. This is seen in the stress that healers lay on training the person within the context of nature, as well as in their true respect for the functioning of the persons' emotional, spiritual and physical parts.

Jungian Therapy. Jung's theories have several synchronicities with indigenous healing. During training initiates have to reassess themselves, their way of life, and their relationship with their ancestors. Then through the integration of the ancestors and traditional beliefs, training enables initiates to fully develop their potential and to live more meaningful lives. This process has parallels with the process of individuation by which a person becomes a 'psychological individual' (Jung, 1963). Both processes are, in effect, the realization of the whole man through the integration of conscious and unconscious into an indivisible unity.

The most striking similarities that exist between Jungian and indigenous beliefs, however, is with respect to dreams. Jung suggested that people have a collective unconscious containing patterns, or archetypes, of life and behaviour derived from ancestral inheritance. These archetypes emerge when consciousness is reduced, for example during dreams (Hadfield, 1954). He also hypothesised a personal unconscious that contains memories of personal experience. From

here personal dreams reflecting everyday situations emerge. Significantly, indigenous healers too distinguish between 'little' dreams (which correspond with personal dreams), and ancestral dreams (which correspond with archetypal dreams). Many African tribes disregard 'little' dreams but share ancestral dreams which they believe to have a general (collective) rather than personal meaning (Bennet, 1961).

Jung (1963) identified archetypal dreams by their poetic force and beauty, and by their common themes of flying, mythology and religion. Significantly, dreams with these qualities occurred in many of the dreams of urban healers. Jung (1963) suggested that archetypal dreams tap a very deep level of the unconscious and so reflect the basic, universal processes of psychological development. From this perspective there is an urgent need for more research into the dreams of South Africa's healers.

Jung's theory that archetypal dreams increase during critical stages in life (Jung, 1975), could explain why ancestral dreams increase during thwasa (Krige, 1950). Jung suggested the increase to be due to the compensatory nature of archetypal dreams which reflect the typically human and universal nature of the stressful experience (Jung, 1975).

A lack of dreaming which black people understand to indicate the shades' disinterest causes them great anxiety (Gelfand, 1964). Jung suggested a possible explanation for this. He suggested that a lack of dreams causes anxiety because it causes psychic tension which, he believes, arises when repressive forces keep the contents of the

unconscious from the conscious (Hadfield, 1954).

Jungian theory regarding precognitive dreams contradicts indigenous beliefs. Jung suggested that just as our conscious thoughts often occupy themselves with the future and its possibilities so does the unconscious. In his view precognitive dreams are merely accurate speculations about future events (Jung, 1963). Experimental research, however, has shown that precognitive dreams do occur. (Fahler and Osis, 1966; Targ and Puthoff, 1977).

Jungian theory holds many possible explanations for the beliefs of healers and certainly indicates a need for further research and investigation in this area.

Erhard Seminars Training (est). Although est, a popular new therapeutic approach in America, differs from the humanistic therapies, it has parallels with certain izangoma healing approaches. Est groups are very authoritarian and leader dominated. Members are held to absolute discipline and subjected to long hours of ridicule and abuse during which their beliefs are condemned and they are dismissed as worthless (Rogers and Meader, 1977). This leads to feelings of confusion and breaks down feelings of self-importance and pride.

There are parallels between est groups and the isikathisobunja or dog period of certain thwasa training schools. During isikathisobunja thwasas are also held to absolute discipline and are subjected to demeaning and humiliating tasks. They may only crawl (like a dog) and must obey all orders - even from the smallest children. They may not eat, urinate or defecate without the teacher's permission (as also occurs in est groups). During this time of humiliation they must confess all their dreams, yet these are always dismissed as untrue. By the end of this period thwasas must be

humiliated in spirit and be without any sense of pride or identity (Mutwa, personal communication).

In both est and thwasa groups after the initial period of humiliation the messages are reversed. Group members are now praised, honoured, and listened to. Now thwasa's dreams are given great value and are analysed and, where indicated, acted upon.

The therapeutic value of est lies in its facilitation of a 'conversion type' experience during which the person feels that his or her life has changed for the better (Rogers, 1977). A similar rationale appears to be in operation in thwasa training. During thwasa initiates must relinquish their own identities and ambitions for only then are they receptive to their ancestors (or that part of them that lies beyond their ordinary understanding and awareness), and only then can they truly accept their new identities as izangoma.

Even in this authoritarian type of training the support of the healing community and the empathetic understanding of the teacher are necessary to make the experience a positive one despite its negative elements.

Conclusion. As healers approaches to training are so varied, an initiate's selection of a teacher is vital. One sangoma searched for years amongst the many izangoma in Soweto for the particular teacher of whom she had dreamed. An inyanga told that when he found the teacher of whom he had dreamed, she told him that his uncle had paid for this training many years before.

The difficulty in defining and categorizing healers, discussed earlier, is due partially to the differences created by such varied training orientations. Differences are also determined by the cult

orientation of the training, the nature of a healer's ancestors as well as practical factors like the length, place, cost, etcetera, of training. In this respect, too, indigenous healing can be compared with Western therapies which also show great differences in their orientation and practice.

The training of indigenous healers does not provide a complete parallel to psychotherapy. Nonetheless, it has a similar function as, like psychotherapy, it facilitates growth and change and enables the person to take up a new relationship with his or her environment. Kruger (1974) even suggested that thwasa training is more successful than psychotherapy, for, whereas therapy aims only at adjustment and cure of symptoms, thwasa aims at transforming the 'patient' into a fully-fledged healer equipped to deal with the problems of others.

APPENDIX G

Interview

1. When were you born ?
2. To which ethnic group do you belong ?
3. Are you married/ single/ divorced / separated ?
4. What level of education did you attain ?
5. To which church do you belong ?
6. Are you also a profita (where applicable)?
7. Are you in full-time or part-time practice ?
8. Did you have the thwasa sickness ?
9. What were your thwasa symptoms ?
10. Did your ancestors guide you through your dreams ?
11. Can you remember any of the dreams you had at this time ?
12. How long did your thwasa sickness last ?
13. Were you different to other children when you were a child ?
14. When did your training start ?
15. Where did you train ?
16. For how long did you train ?
17. How did you find your teacher ?
18. Tell me about your training ?
19. What ceremonies did you have ?
20. Was dance and song a part of your training ?
21. How much did you pay for your training ?
22. How many thwasas did you train with ?
23. Do you divine ?
24. What do you use to divine ?
25. Do you divine with your head ?
26. How much do you charge for a divination ?
27. Do you work with medicines ?

28. Do you use your dreams in prescribing and finding medicines ?

29. How many guiding ancestral spirits do you have ?

30. Can you name these ancestors ?

31. About how many people come to see you every week ?

32. How long have you been working as a sangoma/inyanga ?

33. Have you trained any thwasas yourself ?

If this question was answered in the affirmative the following questions were asked.

34. How many thwasas have you had ?

35. How much did you charge them ?

36. How long did you train them ?

37. Where did you train them ?

APPENDIX H

Biographical Data of the Urban Informants

The healers biographical data are presented according to indigenous healing classifications. The ethnic group, age, marital status, and full-time occupation of each healer, as well as information about training and clients will be included.

Male Izinyanga

Alfred S.

Sotho, 42 years, married, gardener in Houghton.

Alfred trained in Johannesburg on a part-time basis for one year. Presently he divines with the bones and is learning about indigenous medicines. He has one or two clients a week.

Dladla G.

Zulu, 43 years, married, domestic servant in Parktown.

Dladla trained in Zululand for four months, but learned most of his knowledge about medicine from his father's shade who appeared to him in his dreams. He does not divine but prescribes and dispenses medicines on the basis of his dreams and body messages. He has practiced since 1971 and has over 50 clients a week.

John H.

Shangaan, 50 years, married, in full time practice in central Johannesburg.

John trained for the duration of 1948 in Rhodesia. He travels around Johannesburg staying either with one of his clients or with one of his three apprentices. He both divines and prescribes medicine and sees about 25 clients a week.

Peter A.

Matabeli, 45 years, single, gardener in Illovo.

Peter had no official training but gained his knowledge of medicines through his dreams. He does not divine. He has been working as an inyanga since 1976 but says that his powers are not very strong in an urban environment. He averages only about three clients a week.

Peter B.

Shangaan, 65 years, married, cleaner in Killarney.

Peter trained in Louis Trichard on a full-time basis during 1936 and 1937. He both divines and prescribes medicines and sees about twenty clients a week.

Israel S.

Tswana, 50 years, married, domestic servant in Rosebank.

Israel trained in Johannesburg on a part-time basis for two years. He has been practicing since 1968. He both divines and prescribes medicines and has between six and ten clients a week. He is married to Lizzy S. who is a sangoma.

Selias K.

Tswana, 63 years, married, cleaner in Saxonwold.

Selias, who is also a teacher, learned his medicinal and divinatory skills in Beltfontein during a twelve month training. He has been practicing since 1940 and feels that he has lost some of his extrasensory powers over the past few years. Nonetheless, he still has about 12 clients a week.

Frans D.

Pedi, 32 years, married, gardener in Bryanston.

Frans learned his knowledge of divination and medicine through his

Peter A.

Matabeli, 45 years, single, gardener in Illovo.

Peter had no official training but gained his knowledge of medicines through his dreams. He does not divine. He has been working as an inyanga since 1976 but says that his powers are not very strong in an urban environment. He averages only about three clients a week.

Peter B.

Shangaan, 65 years, married, cleaner in Killarney

Peter trained in Louis Trichard on a full-time basis during 1936 and 1937. He both divines and prescribes medicines and sees about twenty clients a week.

Israel S.

Tswana, 50 years, married, domestic servant in Rosebank.

Israel trained in Johannesburg on a part-time basis for two years. He has been practicing since 1968. He both divines and prescribes medicines and has between six and ten clients a week. He is married to Lizzy S. who is a sangoma.

Selias K.

Tswana, 63 years, married, cleaner in Saxonwold.

Selias, who is also a teacher, learned his medicinal and divinatory skills in Beltfontein during a twelve month training. He has been practicing since 1940 and feels that he has lost some of his extrasensory powers over the past few years. Nonetheless, he still has about 12 clients a week.

Frans D.

Pedi. 32 years, married, gardener in Bryanston.

Frans learned his knowledge of divination and medicine through his

dreams which started when he was 24 and were sent by his father and grandfather (both of whom had been healers themselves). He has between six and ten clients a week.

John P.

Shangaan, 70 years, married, cleaner at a school in Parktown.
John completed his training over seven years during his periods of leave when he returned to his rural home in Natal. He has practiced "for many years" and presently sees one or two clients a week.

Sam A.

Zulu, 5[illegible] years, married, freelances as a painter.
Sam was taught most of his skills by his father whom he helped in his work as an inyanga for many years. When his father died Sam underwent a three month apprenticeship with another inyanga. At the time of the interview Sam was concentrating his energies on his work as a painter and saw only a few clients a week.

Wellington E.

Zulu, 49 years, married, waiter in a Berea Hotel.
Wellington learned to divine in Rhodesia. His training lasted seven months. He has been working as an inyanga for two years and sees about 50 clients a week.

Jim L.

Pedi, 45 years, married, gardener in Glenhazel.
Jim learned his skills through his dreams over an 11 month period. At present he has been working as an inyanga for ten years and sees about 25 clients a week.

Female Izinyanga

Lea P.

Pedi, 29 years, single, nanny in Killarney.

Lea trained for nine months in Soweto. Initially she sought training with a sangoma but in a dream was directed by her ancestors to apprentice herself to an inyanga. Although she is presently seeing clients (about three a week) she still consults with her teacher.

Nester K.

Shangaan, 40 years, single, domestic servant in Bryanston.

Nester was directed by her ancestors to train as an inyanga rather than a sangoma. She was sent in her dreams to Wellington E. (described above), and trained with him on a part-time basis for a year. Although she has a thorough knowledge of herbs, she obtains all herbs from herbal shops and does not know how to find her own medicines. She sees two or three clients a week.

Male Izangoma

Samuel D.

Shangaan, 27 years, married, waiter in Berea hotel.

Samuel trained in Louis Trichard on a full-time basis for one year. He has been working as a sangoma for two years and both divines and prescribes medicine. He sees about 80 clients a week.

Mdungazi K.

Shangaan, 40 years, married, assistant in a herbalist shop in central Johannesburg.

Mdungazi was taught his skills as a sangoma by his father who was also a sangoma. He has worked as a sangoma for 16 years and has between 24 and 34 clients a week.

Lucas M.

Zulu, 38 years, married, full-time sangoma (Soweto).

Lucas spent a year training in Swaziland and then trained for a second year in Bushbuck Ridge. He both divines and prescribes medicine. He has been qualified for four years and has about 25 clients a week.

Richard L.

Pedi, 28 years, single, domestic servant in Parkhurst.

Richard trained for eight months in Supmegal. He has been practicing for one year and both divines and prescribes medicine. He has about six clients a week.

Sam D.

Shangaan, 51 years, married, domestic servant in Bertrams.

Sam trained in Louis Trichard for nine months. He divines and uses medicine and averages between 15 and 20 clients a week.

John I.

Shangaan, 45 years, married, gardener in Rosebank.

John worked as a sangoma for two years prior to the interview. He trained for three months in Natal. He then ran out of money to pay for training and found employment as a gardener in Johannesburg. He supplements this income by divining and has about six clients a week. When he has saved enough money he plans to return for further training, in the meantime is continuing training on a part-time basis with a teacher in Soweto.

Stephen A.

Ndebeli, 50 years, married, policeman in Soweto.

Stephen trained at Bushbuck Ridge for one year (divination and

medicine) and qualified ten years ago. He dislikes his work as a sangoma as it interferes with his career as a policeman. Nonetheless, he sees about 14 clients a week.

James Y.

Zulu, 40 years, married, domestic servant in Morningside. James underwent six months training in the Northern Transvaal (divination and medicine), he supplemented this with part-time training in Johannesburg. He has been practicing for two years and sees about ten clients a week.

Joseph C.

Zulu, 37 years, married, gardener in Houghton. Joseph, who trained for two years in a rural area of Natal sees between 50 and 70 clients a week - he both divines and works with medicines. He has also trained six initiates of his own.

Percy A.

Xhosa, 36 years, separated, full-time sangoma in Soweto. Percy trained, in the Eastern Transvaal, for three years. He has practiced for three years and sees "over 30" clients a week.

Kndima T.

Ndebeli, 38 years, married, domestic servant in Rosettenville. Kndima trained both in Rhodesia on a full-time basis (divination and medicine), and in Johannesburg on a part-time basis. He has practiced for 15 years and has about 30 clients a week.

Godfrey G.

Tswana 20 years, single, full-time healer (Soweto). Godfrey had a six month training in Potchefstroom. Although he has only been practicing for four years he has 40 clients a week and

reports that he has trained an initiate of his own. He works with medicine and divination.

Female Izangoma

Wilhelmina V.

Tswana, 49 years, married, cleaner at General Hospital in Hillbrow (lives Soweto).

Wilhelmina trained in Soweto for three months and had a further month's training in Rhodesia. She did not learn about medicine but dreams of what medicine to prescribe. She has worked on a part-time basis for the past four years and sees about ten clients a week.

Maureen D.

Zulu, 37 years. single, commutes daily from Soweto to her work in Johannesburg.

Maureen trained in Soweto in the Nguni cult for 18 months. The completion of her training in the Mdawu cult will take a further three months. She divines only with her "head" and combines this with medicine.

Betty M.

Zulu, 60 years, married, free-lance washerwoman.

Betty trained in Soweto for six months. She uses medicine and divines "with her head". She has worked as a sangoma for 23 years. Recently she has found her healing powers are lessening and sees only about four clients a week.

Irene E.

Sotho, 58 years, married, unemployed, lives in Soweto.

Irene trained in Orlando township for one year in 1941. Her initial strong resistance to becoming a sangoma was overcome when, as a

extra-sensory powers are lessening and she has only about three clients a week.

Ethel P.

Xhosa, 45 years, single, domestic servant in Houghton.

Ethel served as an intermediary for the author of the present study. She trained on a part-time basis for nine years, and went each year for a month to train with a second teacher in Queenstown. She had a thorough knowledge of divination and medicine. She could not estimate her average number of clients per week.

Lizzy S.

Tswana, 40 years, married, domestic servant in Parktown North.

Lizzy trained (in both medicine and divination) at Bushbuck Ridge. She estimated her clientelle at 40 per week and has been in practice for over a year.

Rosie K.

Rosie served as an assistant for the author of the present study. She experienced the symptoms of her calling from an early age. At the age of 27 years she awoke from a dream at the place of her teacher in Bushbuck Ridge. She trained for two years in both medicine and divination and has herself had several initiates during her six years of practice.

Maselo S.

Pedi, 38 years, married, full-time practice in Soweto.

Maselo did her training in a rural area for eight months. She reported that she initially strongly resisted her calling and as a consequence her ancestors caused the death of her husband. Later, however, following her training they rewarded her by sending her a

extra-sensory powers are lessening and she has only about three clients a week.

Ethel P.

Xhosa, 45 years, single, domestic servant in Houghton.

Ethel served as an intermediary for the author of the present study. She trained on a part-time basis for nine years, and went each year for a month to train with a second teacher in Queenstown. She had a thorough knowledge of divination and medicine. She could not estimate her average number of clients per week.

Lizzy S.

Tswana, 40 years, married, domestic servant in Parktown North.

Lizzy trained (in both medicine and divination) at Bushbuck Ridge. She estimated her clientelle at 40 per week and has been in practice for over a year.

Rosie K.

Rosie served as an assistant for the author of the present study. She experienced the symptoms of her calling from an early age. At the age of 27 years she awoke from a dream at the place of her teacher in Bushbuck Ridge. She trained for two years in both medicine and divination and has herself had several initiates during her six years of practice.

Maselo S.

Pedi, 38 years, married, full-time practice in Soweto.

Maselo did her training in a rural area for eight months. She reported that she initially strongly resisted her calling and as a consequence her ancestors caused the death of her husband. Later, however, following her training they rewarded her by sending her a

second husband. She both divines and uses medicine and has about 25 clients a week.

Liz H.

Zulu, 40 years, married, cleaner at a school in Houghton (lives in Soweto).

Liz trained in Soweto for nine months. She learned both divination and medicine. She was unable to estimate how many clients she sees a week.

Grace U.

Shangaan, 48 years, married, domestic servant in Johannesburg.

Grace trained at Bushbuck Ridge for 21 months. She had ten co-initiates and retains contact with all those who are presently in Johannesburg. She has been practicing, in both divination and medicine, for 16 years and has had one initiate of her own.

Lucy G.

Sotho, 40 years, separated, cleaner at the University of the Witwatersrand.

Lucy trained in Soweto for two and a half years. She divines with the bones, with a horn, and with her "head", and prescribes medicine.

Magdelene T.

Xhosa, 40 years, single, domestic servant in Rivonia.

Magdelene trained on a part-time basis in Soweto for three years. She has been practicing (in both divination and medicine) for three years and sees 30 clients a week.

Christine F.

Zulu, 37 years, single, cook in Johannesburg.

Christine trained in Johannesburg on a full-time basis for six months

and was continuing training on a part-time basis. She sees about four clients a week under the close supervision of her teacher.

Pholesia B.

Xhosa, 39 years, single, washerwoman in Morningside.

Pholesia trained in a rural area of Natal on a full-time basis for nine months. She was then forced, through financial pressures, to return to Johannesburg to take up employment. She continued her training on a part-time basis with a second teacher. She has been practicing for several months and sees "many" clients.

Grace P.

Zulu, 45 years, married, full-time practice in Soweto.

Grace trained in Bushbuck Ridge for one year. She uses both divination and medicine in her practice which started ten years ago. She has "many" clients every week.

Author Farrand D
Name of thesis An Analysis of indigenous Healing in Suburban Johannesburg 1980

PUBLISHER:
University of the Witwatersrand, Johannesburg
©2013

LEGAL NOTICES:

Copyright Notice: All materials on the University of the Witwatersrand, Johannesburg Library website are protected by South African copyright law and may not be distributed, transmitted, displayed, or otherwise published in any format, without the prior written permission of the copyright owner.

Disclaimer and Terms of Use: Provided that you maintain all copyright and other notices contained therein, you may download material (one machine readable copy and one print copy per page) for your personal and/or educational non-commercial use only.

The University of the Witwatersrand, Johannesburg, is not responsible for any errors or omissions and excludes any and all liability for any errors in or omissions from the information on the Library website.