THE PERCEPTION AND TREATMENT OF MENTAL ILLNESS BY SELECTED PENTECOSTAL PASTORS IN POLOKWANE: TOWARDS AN INTERVENTION PROGRAMME

BY

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DEDICATION

To my wife, Phuti "Mmasechaba,"
and my children, Phenyo, Rendani and Ronewa
I love you so much.

DECLARATION

I declare that the thesis **The perception and treatment of mental illness by selected Pentecostal pastors in Polokwane: Towards an intervention programme** hereby submitted to the university of Limpopo, for the degree of Doctor of Philosophy has not previously been submitted by me for a degree at this or any other university; that it is my work in design and in execution and that all material contained herein has been duly acknowledged.

Mauda LT (Mr)

…………………………….……   22/04/2022

Full Names   **Date**

ACKNOWLEDGEMENTS

GLOSSARY OF ACRONYMS AND ABBREVIATIONS

AFM	Apostolic Faith Mission
AICs	African Independent Churches
APA	American Psychiatric Association
AOG	Assemblies of God
BPS	Bio-Psycho-Social model
BPSS	Bio-Psycho-Social-Spiritual model
CRL	Commission for the Promotion and Protection of the Rights of Cultural, Religious and Linguistic Communities
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders-Fourth Version
DSM-5	Diagnostic and Statistical Manual of Mental Disorders-5th Version
SAHRC	South African Human Rights Commission
FBO	Faith Based Organisation
FGC	Full Gospel Church
ICD-Code	International Classification of Disease Code
HPCSA	Health Professions Council of South Africa
LMICs	Low- and Medium-Income Countries
LPMC	Licenced Professional Marriage Counsellors
LMF	Limpopo Ministers' Fraternal
LMFC	Licenced Marriage and Family Counsellors
MHCPs	Mental Health Care Professionals
PTSD	Post-Traumatic Stress Disorder
PUP	Polokwane United Pastors
SOVCAL	Sovereign Health of California
SASOP	South African Society of Psychiatrists
TAM	Traditional Alternative Medicine
TA	Thematic Analysis
TREC	Turfloop Research Ethics Committee
WCP	World Congress of Psychiatry

ABSTRACT

Mental illness is a high burden of disease especially in Low- and Medium-Income Countries (LMICs) like South Africa. In many LMICs, there is a paucity of Mental Health Professionals (MHCPs). As a result, people with mental illness call their faith healers or religious/spiritual leaders (pastors in this study) when experiencing mental health problems. Pastors are more accessible, share the same religious/spiritual beliefs about mental illness with their congregants and often provide religious/spiritual solutions to those who consult with them. Thus, they are often preferred over MHCPs. However, pastors are rarely involved as partners in community based mental health programs.

While mental illness is mainly clinically diagnosed and recognised by MHCPs using the DSM-5 and ICD-10 codes, less is known in South Africa with regards to the views of pastors with regards to their notions of what mental illness is. Thus, it may be complex for Pentecostal pastors to clearly distinguish between spirit possession and mental illness as much as it is complex for MHCPs who struggle with accommodating their patients' religious/spiritual beliefs. Religious/spiritual beliefs are significant in many Africans seeking mental health recovery. However, less has been explored in South Africa in the area of religion/spirituality and its relevance in the practice of clinical psychology. Western based psychotherapeutic methods of intervention which exclude the religious/spiritual domain of African clients continue to dominate the practise of psychology in Africa.

Given the above, this study aimed to explore and understand selected Pentecostal pastors' perception and treatment of mental illness. The research objectives were, namely: (1) to establish the notions held by Pentecostal pastors' regarding what mental illness is (2) to establish Pentecostal pastors' perception of what causes mental illness; (3) to determine Pentecostal pastors' perceptions of how and by whom mental illness can be recognised, diagnosed, treated and managed; (4) To determine Pentecostal pastors' views regarding their own roles in the

management of mental illness; and (5) To canvass and describe Pentecostal pastors' perceptions about collaboration for purposes of an intervention programme aimed at providing a holistic care and treatment of religious/spiritual patients.

The study was qualitative, and the exploratory research approach was adopted. The research was informed by the Bio-Psycho-Social-Spiritual (BPSS) model. Purposive sampling was used to select nineteen (19) participants. In-depth semi-structured interviews were conducted. Data were analysed using Thematic Analysis (TA). The following six major themes emerged from the analysed data: (i) Notions of mental illness; (ii) Causes of mental illness;(iii) Recognition and diagnosis of mental illness (iv) Notions on the treatment and management of mental illness; (v) Perceived roles in the treatment and management of mental illness; (vi) Views regarding collaboration with MHCPs.

The participants held a multifactorial view of mental illness. They were limited in their understanding of mental illness and perceived it mainly to be madness (psychosis). The participants' perception of mental illness was influenced by their theological (Pentecostal) as well as their cultural backgrounds (Black Africans). The participants indicated that they lacked training in mental health issues. As such, they were not opposed to collaborating with MHCPs. They mentioned that their roles included counselling, prayer, support, and referral. This study also discovered that Pentecostal pastors upheld three treatment approaches of mental illness namely: The Full-Collaborative Approach; The Partial-Collaborative Approach and the Non-Collaborative Approach. Findings of the study were discussed, and recommendations were made including the proposed intervention programme between pastors and MHCPs with the aim of facilitating a referral process and collaboration between the two professions.

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CHAPTER ONE
INTRODUCTION AND BACKGROUND

1.1 Introduction

This chapter starts by outlining the background to the study, the research problem, and clarifying operational concepts. Further, the chapter also provides the aim and objectives of the study as well as the study's significance. Subsequently, reviewed literature, the theoretical framework and methodology for the study are presented. The present study explores the perception and treatment of mental illness by selected Pentecostal pastors in Polokwane for purposes of developing an intervention strategy for collaboration.

1.2 Background to the Study

Globally, the rate of mental health problems has risen. According to Rehm and Shield (2019), mental and addictive disorders affected more than 1 billion people globally in 2016. Recently, a report published by the United Nations Office on Drugs and Crime (UNODC, 2020) indicates that over 35 million people suffer from drug use disorders. In LMICs including South Africa, mental illness remains underreported and underdiagnosed (Meyer, Matlala & Chigome, 2019). Meyer et al (2019) indicate that South Africa carries a huge burden of mental illnesses with the most prevalent being anxiety disorders, substance abuse disorders, mood disorders and depression. Specifically, one in six South Africans suffers from anxiety, depression, or a substance use disorder (South African College of Applied Psychology (SACAP, 2018). SACAP (2018) reveals that 40% of South Africans living with HIV has a comorbid mental disorder, 41% of pregnant women are depressed and about 60% of South Africans could be suffering from post-traumatic stress. Despite this high prevalence of mental disorders in South Africa, a large treatment gap also exists (Burns & Tomilta, 2015). Only 27% of South Africans with severe mental disorders receive treatment (SACAP, 2018).

The South African Human Rights Commission (SAHSRC, 2017) reports that the existing large treatment gap for people with mental illness is linked to these factors: (a) insufficient budget allocation; (b) poor mental health literacy and lack of information (c) stigma and discrimination; (d) lack of available human resources; (e) insufficient facilities providing mental health services; (f) unavailability of child and adolescent services; (g) inconsistent availability of medication; and (h) limited mental health service availability in the criminal justice and correctional system. This lack of health resources, including personal beliefs about mental illness, tends to propel many people in LMICs to consult with faith healers (conceptualised as pastors) in this study (Burns & Tomilta, 2015).

The consultation of pastors for the diagnosis and treatment of various diseases is not a new practice in Africa. Pastors generally serve as resources to address the mental health needs of their congregants where they feel misunderstood, being misdiagnosed, and falsely labelled (Masola et al., 2019). According to Kpobi and Swartz (2018a), pastors form a significant portion of the mental health workforce in LMICs partly due to the limited number of biomedical professionals. Thus, it is common practise that local people in Africa view MHCP's methods of assessing, recognising, diagnosing, and treating mental illness as being contrary to their faith or religious/spiritual beliefs (Ae-Ngibise et al., 2010). As such, there is a need to broaden etiological understandings and to incorporate these understandings into diagnosis and treatments to better understand and aid clients from non-western backgrounds (Laher, 2014).

For many Africans religion/spirituality has been found to provide a significant identity resource; in the period of rapid social change with unprecedented distortions to economic, social, and political lifestyles and offers a veritable means of anchor and stability and a pathway to meaningful social existence (Ukah, 2007). Moreover, culture and religious/spiritual denominations or groups provide frameworks from which to practice specific beliefs, rituals and rites regarded as pivotal for general wellbeing (Mabitsela, 2003). A variety of religiously/spiritually integrated forms of psychotherapy now give explicit attention to the ways in which scriptural and religious/spiritual teachings may be used to facilitate recovery from mental ill health (Cook, 2020).

Specifically, positive outcomes of religious/spiritual accommodative interventions for a variety of client concerns, including depression, anxiety, schizophrenia and coping with physical illness have been noted in literature (Kennedy et al., 2015). However, there seems to be a gap in the literature with regards to the existence of such tailor-made intervention programs in South Africa which involve or recognise pastors in community mental health programs.

Given the above, there is an urgent need for MHCPs to be able to appropriately treat individuals with a relevant intervention that incorporates the culture and the religious/spiritual beliefs of indigenous people (Greyvenstein, 2018). Greyvenstein (2018) further mentions that South Africa is a pluralistic society that is idiosyncratically multicultural. As such, there is a need for South African tailor-made programmes of intervention for people experiencing mental health problems which take into cognisance the relevance of their religion/spirituality and culture. Likewise, scholars like Sodi and Bujowoye (2011) also advocate for many and diverse psychotherapies that recognise and include the cultural context of local or indigenous people. For quite a long time, many psychotherapists worldwide, including those in Africa have been trained in Western based explanations of psychological distress/illness (Madu, 2015). Madu (2015) continues to state that many Western oriented explanatory models of psychological distress/illness have undermined the influence that cultural and/or religious/spiritual beliefs play in psychotherapy. As a result, even to this day, many of the Western definitions and approaches to mental illness in Africa have been critiqued for their lack of incorporation of cultural and religious/spiritual elements (Bulbia & Laher, 2013).

It cannot be ignored that religious/spiritual beliefs and culture influence South Africans' understanding of illness and health. Even though many studies indicate the significance of incorporating religion/spirituality into psychotherapy internationally (Koenig, 2009), more progress is still needed in this area in the South African context. Surprisingly so, many studies which have investigated the significance of incorporating religion/spirituality have been carried out in many countries outside Africa even though the importance of having to consider the role of spirituality/religion in health, mental

health and psychiatry in South Africa has been emphasised in recent legislation on African traditional health practice (Janse van Rensburg, Poggenpoel, Myburg & Szabo, 2012). Specifically, within the South African context, interest in spirituality, religion and culture has emerged more publicly in secular areas such as health and mental health where the need to be culturally competent has extended to competence regarding the multi-religious and spiritually diverse contexts of local medical practice (van Rensburg, 2014a). In lieu of the above, MHCPs need not neglect, devalue, or relegate religious/spiritual and cultural beliefs to private spaces.

According to Janse van Rensburg (2014b), the South African Society of Psychiatrists (SASOP) has developed research-based guidelines for the integration of religion/spirituality into psychiatry. However, to this day in the practise of Psychology, an official position statement regarding Psychology's approach to the interface of religion/spirituality and mental health to guide ethical psychological practice within the South African context is still pending (Greyvenstein, 2018). Perhaps this is because there is scant research in South Africa that has paid attention to the relevance of religious/spiritual beliefs and culture. As noted by de la Porte (2016), the theme of an 'African' interpretation of illness, health and spirituality is of relevance for the South African context. Thus, it needs further exploration.

The predominance of supernatural or religious/spiritual factors in the explanation and treatment of mental illness in Africa is extensively noted in literature. For example, the studies by Kpobi and Swartz (2018a); Mabitsela (2003) and Murambidzi (2016) all indicated that pastors uphold a religious/spiritual worldview of mental illness regarding its causes and treatment. This religious/spiritual worldview held by Pentecostal pastors acknowledges religious/spiritual beliefs, an area which is less pursued in academia. Religious/spiritual beliefs are important to the people of South Africa and Africa in general. They form the basis of their being and meaning making. Thus, it is not surprising that many people experiencing mental health problems in Africa prefer to consult first with religious/spiritual leaders (Ae-Ngibise et al., 2010) as compared to MHCPs. According to Ae-Ngibbise et al (2010), pastors and traditional healers'

understandings of mental illness have been found to be consistent with hegemonic cultural EMs of mental disease aetiology.

In South Africa and other African countries to be specific, the most sought-after church leaders by ordinary citizens recently are Pentecostal pastors (Mashau, 2013) although they are less studied in academia. Because of their charisma, their influence, their style of preaching and methods of healing and accessibility, many people with mental illnesses go to them for consultation (Kpobi & Swartz, 2018a). The researcher in the present study (who is himself an ordained Pentecostal pastor and trained clinical psychologist) has witnessed people with mental illness seeking help regarding what may be mental illness/mental health problems from Pentecostal pastors. Thus, this researcher's interest in the topic and motivation to learn more about and to contribute to the subject is obvious.

Through this thesis, the researcher seeks to contribute to the current global dialogue on religion and spirituality, mental health, and well-being. Moreover, this researcher hopes for a mutual relationship between MHCPs and Pentecostal pastors who are both consulted for mental health problems. It is worth noting that the relationship between MHCPs and pastors has not been an easy one historically (Leavey et al., 2016). MHCPs have held ambivalent positions concerning the role of religion and spirituality in psychotherapy while patients themselves, have had concerns about the theories, beliefs, and methods of psychologists (MHCPs) (Wentworth, 2013). As such, to this day, psychologists (MHCPs) still find it difficult to integrate religion/spirituality into psychotherapy (Lee, 2016). On the one hand, many pastors still struggle to incorporate psychological help for their congregants (Greyvenstein, 2018). It is against this backdrop that this study was carried out.

There is paucity of documented research about the literacy of Pentecostal pastors with regards to the perception and treatment of mental illness. Many studies on alternative healing practices tend to group practitioners together, and hence overlook the nuances that may exist between the different categories of healers, particularly in those which are based on faith (Kpobi & Swartz, 2018a). Hence, the present study. This study is carried out within the City of Polokwane, Limpopo Province of South Africa. Polokwane has diverse cultures and ethnical groups (i.e, BaPedi, Vha-Venda, Vha-Tsonga,

Matebele). Polokwane is surrounded by the following townships: Seshego, Mankweng and Lebowakgomo. The study setting is presented in detail later in Chapter 4.

In many South African provinces, especially in the indigenous societies, baruti (pastors) are consulted for different purposes, paramount among them being the execution of good health (Masola et al., 2019). Lowenthal and King (2016) also remark that at a social or structural level, the clergy (pastors) are more likely to be sought in contexts where financial and medical resources are scarce or where the clergy (pastors) are positioned as trusted gatekeepers, particularly among ethnic minority and newly arrived communities, which is exactly the case of South African rural communities like Polokwane. Many people affected psychologically seem not to have psychological services, especially in rural areas such as those around Polokwane. However, they do visit their pastors for help for their mental health needs to be met (Kruger, 2012). But it seems that the pastors concerned do not have or have inadequate training on how to deal with mental health related issues.

When individuals experiencing mental health, problems consult with Pentecostal pastors in Polokwane, it is not known how exactly they define, describe, or explain what they are handling. Their religious/spiritual perspectives may affect their ability to provide adequate services to their congregant-members experiencing mental health problems. On the one hand, congregant members may choose to be helped by their pastors instead of MHCPs due to the trust bestowed on them (Ae-Ngibise et al., 2010). Thus, it is highly possible that amongst the Pentecostal pastors, mental illness may be perceived as a religious/spiritual problem or that a religious/spiritual problem is perceived as a mental illness requiring a spiritual solution (Sullivan et al., 2013). Conversely, MHCPs may encounter a religious/spiritual problem which manifest as mental illness in their clinical practice. Both these practitioners somehow interact with people experiencing mental health problems.

Scientifically, studies have proven that a pastor's theological beliefs significantly affect their attitudes towards seeking professional psychological help. For example, Almanza (2017) observed that some Christian pastors feel that intervention from MHCPs competes with interventions that are spiritually based. Such perceptions of mental illness from both pastors and MHCPs may be detrimental to the mental health of

religious/spiritual clients who present to both professionals as well as further affect the relationship between the professions. Thus, it is significant to be cognisant of the perceptions of mental illness held by Pentecostal pastors. This could shed much needed light on issues of how well these pastors perform when attending to congregants presenting with mental health problems. Although there is adequate empirical evidence promoting the collaboration between pastors and MHCPs, the resistance to or lack of collaboration between pastors and MHCPs as indicated earlier, is largely based on the differing EMs both have of mental health problems (Kpobi & Swartz, 2018b). To date, research exploring the perception and treatment of mental illness by Pentecostal pastors in South Africa is sparse.

While studies indicate that MHCPs rely on scientific evidence, psychological theories to understand and interpret mental health problems, pastors base their understanding of mental health problems on their theological beliefs (Jackson, 2017). The beliefs that the Pentecostal pastors hold towards mental illness have been found to cause them to influence their congregants underutilise mental health services (Uwannah, 2015). Moreover, their beliefs also affect their attitudes towards seeking professional psychological help (Gaffeney, 2016). In addition, the interpretations of illness by the clergy (pastors) within health systems may be crucial to appropriate intervention for people with mental illness (Leavey, 2010).

Mabitsela (2003) states that the worldview that Pentecostal pastors hold is based on their theology and is spiritual in nature. As such, they may obviously influence their perception and understanding of mental illness. Generally, literature points out that Pentecostal pastors' beliefs regarding mental illness include the following: (i) They feel that interventions from MHCPs competes with interventions that are religiously/spiritually based (Almanza, 2017); (ii) They view seeking secular medical or psychiatric help as a sign of lack of faith or a rejection of core beliefs (Leavey, 2008); and (iii) They incorporate prayer, laying on of hands, casting out of demons and other biblical approaches to drive out the devil (Uwanah, 2015) and many others. Important to note again is the fact that Pentecostal pastors hold perceptions of mental health differing from mainstream Christian pastors (Anglicans, Catholics, Methodists) who advise their congregants to seek medical care and view religion/spirituality as complementary (Leavey, 2008; Leavey, 2010; Payne, 2009; and Uwannah, 2015).

Hence, this researcher has opted to study Pentecostal pastors, separating them from other faith healers.

As stated before, this researcher (who is an ordained Pentecostal pastor and trained clinical psychologist) has witnessed people with mental illness seeking help from Pentecostal pastors and hopes for a holistic approach to psychology and Christianity. It seems difficult for both MHCPs to make a proper diagnosis, especially when a patient presents with a mental illness that seems to be having religious or spiritual elements. Based on the above, this researcher envisaged a collaborative or integrative programme between pastors and MHCPs that is based on the intersection between psychology and theology may attempt to answer the questions raised above.

Having said the above, there is existing evidence for scientific based intervention programmes between pastors and MHCPs. For example, Milstein et al (2008) designed an intervention programme between pastors and MHCPs coined Clergy Outreach Professional Engagement (COPE). The goal of COPE on its inception was to acknowledge the borders between parts of persons' lives and to build bridges of collaboration to facilitate care (Milstein et al., 2008). The COPE is a prevention-science-based paradigm to improve the continuity of mental health care through reciprocal collaboration between clergy and MHCPs (Milstein et al., 2008). According to Milstein et al (2008), the COPE program facilitates reciprocal collaboration between clinicians (MHCPs) and clergy (pastors), regardless of their religious/spiritual traditions. Two central ideas guide the functioning of the COPE programme: Firstly, clergy (pastors) (with their discrete expert knowledge about religion/spirituality) and clinicians (MHCPs) (with their discrete expert knowledge about mental health care) can better help a broader array of persons with emotional difficulties and disorders through professional collaboration than they can by working alone (Milstein et al., 2008).

Secondly, COPE is focused on burden reduction which the authors defined as a reduced need for one group of service providers to deliver direct care as a result of sharing expertise with service providers from another group or profession. Finally, the main objective of COPE is to improve the care of individuals by reducing the caregiving

burdens of clergy and clinicians through consultation and collaboration (Milstein et al., 2008).

Most recently, the World Council of Churches (WCC, 2021) has developed a Health Promoting Churches Programme (HPC) to support churches as healing communities. The WCC (2021) specifically seeks to assist churches through the HPC program to establish a Church Health Committee (CHC) which is well constituted, well equipped and passionate about leading the implementation of health initiatives in the congregation. According to the WCC (2021)'s Handbook, the HPC galvanises the envisaged healing ministry through four interventions which are: education, action, advocacy, and public witness. According to the WCC (2021), the church should design and explore various creative ways of promoting health education which include: health talks during the service, having individuals with lived experiences being empowered to share their experiences and motivational talks in the pulpit to inspire beliefs, values and ideas that promote health. Generally, the WCC (2021)'s handbook, provides practical guidelines on the implementation of a church-based health programme.

1.3 Research problem

Pentecostalism, as a Christian movement has become an increasingly prominent feature of Africa's religious/spiritual and political landscape (Brown, 2011). It is the fastest growing Christian movement today (Ishaya, 2011). Pentecostalism is popular in African cultures like that of Nigeria (South Africa) because it affirms the reality of God and other supernatural entities (Brown, 2011). According to Ishaya (2011), through its message of material prosperity, career success, healing, good health and freedom from oppression, Pentecostalism provides a platform for people to deal with their misery and encourage aspirations towards self-actualisation. Pentecostals are also taught to exercise faith for miraculous healing rather than seeking help from a secular source during times of ill-health (Bjorck & Trice, 2006). Consequently, Pentecostal pastors and their congregants hold beliefs that cause them to underutilise mental health services (Uwannah, 2015). Studies have also established that Pentecostal pastors assert that while mental illness may have genuine natural causes, psychiatrists are unable to detect the presence of demonic influences (Leavey, 2008).

In other settings, Pentecostal pastors view mental illness as a method by which demonic (negative/evil) spirits can possess an individual because of living a sinful life characterised by alcohol or drugs (Leavey, Lowenthal & King, 2016). Amongst Pentecostal pastors generally, there is a deep theologically based belief that mental illness is traceable to supernatural causes, most notably demonic (negative/ evil spirit) possession (Leavey, 2010).

Based on all the above, Pentecostal pastors thus call for collaboration between secular science and religion/spirituality discernment (Leavey, 2008) since they are not trained as MHCPs or in mental health issues. It may be difficult for them to differentiate between the signs or symptoms of mental illness and those of spirit possession. In agreement, Grossklaus (2015, p.49) states that "Psychological guidelines for the diagnosis of mental disorders, such as International Classification of Diseases and Related Health Problems (ICD) and the Diagnostic Statistical Manual (DSM) are unknown in the area of theology and thus better information would also help ministers here".

According to Grossklaus (2015), for pastors, it has become clear in recent years that in their theological training there is a prominent deficit in knowledge in the areas of counselling, spirit possession and mental illness. Nevertheless, many people affected with what can be said to be mental illness in psychological terms, consult with Pentecostal pastors (Kpobi & Swartz, 2018a). When they do consult with these pastors, it is not known what exactly how they define, describe, or explain what they are handling and their approaches to the treatment thereof. Even though Pentecostal pastors are often the primary and only source of support for those who consult with them, they may possess little or no training on mental health issues, especially severe psychopathology (Jackson, 2017).

Despite the lack of skill and training on mental health issues, Pentecostal pastors apply their methods such as discernment, prayer and fasting; and deliverance/casting out demons (Kpobi & Swartz, 2018a) and seldom refer to MHCPs or not at all. While acknowledging on an extremely limited basis the insights that psychology and psychiatry may provide, the Biblical counselling model held by pastors posits a spiritual/religious basis for most mental disorders (Stanford & Philpott). In light of the

above, it is important to note that Pentecostal pastors are very influential and role models to their congregants (Mabitsela, 2003). So, how they perceive mental illness is significant. Their perception of mental illness determines the route they will seek or prescribe for their congregants (Uwannah, 2015).

While many previous studies have provided insight into Pentecostal pastors' perception of mental illness are available, most of them were carried out in the United Kingdom (UK) (Leavey, 2008; Leavey; 2010) the United States of America (USA) (Hardwick; 2013 Jackson, 2017; Harris, 2019) for example. As such, this researcher considers those states as more affluent nations as compared to Polokwane which is semi-rural. This means that the results obtained could be influenced by the educational level or socio-economic statuses of the pastors investigated. Notwithstanding such previous findings, there is a paucity of research and little is known regarding Pentecostal pastors' perception and treatment of mental illness in Polokwane. Therefore, the present study sought to fill in this existing gap in literature and contribute towards a comprehensive intervention programme for Pentecostal congregants encountering mental health problems.

This researcher is aware of only one study by Mabitsela (2003) that paid attention specifically to Pentecostal pastors separating them from mainline Christian pastors (i.e., Anglicans, Roman Catholics, Methodists, and others). In that study, which was carried out in Soshanguve, Mabitsela (2003) found that Pentecostal pastors' worldview and description of psychological distress/mental illness is similar with established frameworks in psychology. The results of Mabitsela (2003)'s study cannot not be generalised to all Pentecostal pastors in South Africa based on the small sample size, the geographical location of the study and the period when the study was conducted. Again, another study was conducted in Polokwane although it was generally amongst Afrikaans speaking pastors from various Christian denominations by Kruger in 2012. This researcher is of the view that there has been a lot of transformation in psychology, as well as within the Pentecostal transformation over the years, which could influence findings in this study.

1.4 Operational definition of concepts

- **Perception:** According to the *Cambridge Dictionary* (2018), perception is a belief or opinion often held by many people and based on how things seem: In the present study, perception is understood to mean how Pentecostal pastors understand, explain, describe, recognize, diagnose and treat mental illness.

- **Treatment**: Refers to care provided to improve a situation (especially medical procedures or applications that are intended to relieve illness or injury) (Definitions.net, 2018). In the present study, treatment refers to the care and applications Pentecostal pastors provide to people with mental illness.

- **Pentecostal**: This refers to the global Christian revivalist and missionary church that places more emphasis on the transcendent workings of the Holy Spirit and charismatic practice (Hampelmann, 2009). In the context of the present study, the term Pentecostal refers to both the classical and Neo Pentecostal/ Charismatic pastors.

- **Pastor(s)**: It is the common term usually used to refer to the shepherd of a church in Christianity. For the sake of the present study, the term pastor refers to a Pentecostal church leader, overseer or minister, irrespective of their specific gift, calling or office, i.e., Bishop Apostle, Prophet, Teacher or Evangelist).

- **Mental illness**: According to the National Alliance on Mental Illness (NAMI, 2017), mental illness is a condition that affects a person's thinking, feeling or mood. Such conditions may affect someone's ability to relate to others and function each day. In the context of the present study, mental illness is understood to mean psychological distress or any diagnosable mental disorders, which are characterised by abnormalities in thinking, feelings, or behaviours.

- **Polokwane:** In the context of the present study, this refers to Pentecostal churches within and around Polokwane city.

1.5 Purpose of the study

1.5.1 *Aim of the study*

- The aim of the study is to explore the perception and treatment of mental illness by selected Pentecostal pastors in Polokwane towards developing an intervention programme.

1.5.2 *Objectives of the study*

- To establish the notions held by Pentecostal pastors' regarding what mental illness is.
- To establish Pentecostal pastors' perception of what causes mental illness.
- To determine Pentecostal pastors' perceptions of how and by whom mental illness can be diagnosed, recognised, and treated.
- To determine Pentecostal pastors' views regarding their own roles in the management of mental illness; and
- To canvass and describe Pentecostal pastors' perceptions about collaboration for purposes of an intervention programme (Milstein et al., 2008).

1.6 Significance of study

This researcher hopes that findings of this study, which aimed at exploring Pentecostal pastors' perception about causation, treatment, and diagnosis of mental illnesses, could provide insight into attitudes Pentecostal pastors hold about mental illness and the influence such views may have on their congregants who consult with psychologists. Secondly, given that there are still misunderstandings and doubts regarding the integration of religion and spirituality into psychotherapy, the present study could provide insight that might allow new ways to be adopted to better provide effective tools to serve the Pentecostal community in Polokwane and better inform psychological services. Thirdly, due to the paucity of documented research about the literacy of Pentecostal pastors, especially in South Africa, in the recognition of mental illness and the causal factors of psychological distress, the researcher hopes that the

findings of the present study will contribute to the growing body of knowledge in the critical field of religion and transcultural psychology. Finally, findings of this study could help shed light for MHCPs on Pentecostal pastors and their notions of mental illness for purposes of enhancing effective referral pathways or collaborative systems. This could assist policy or model development for effective integration of religion/spirituality into counselling and psychotherapy within the formal mental health sector.

1.7 Concluding remarks

This chapter presented an overview of the prevalence of mental illness, globally and in South Africa. It emerged that the number of people living with mental illness has risen in the country. However, the proportion of people living with mental illness in South Africa and other countries in Africa does not match with the number of available formal service providers. For this and other reasons, many people with mental illnesses eventually consult with their pastors who are said to be readily available and accessible to them. Currently, empirical evidence exists calling for the integration of religion/spirituality into psychotherapy as well as partnership among religious leaders (pastors in this study) and MHCPs. However, there is still doubt as to whether this can be a possible feat in the South African setting. Amongst the Christian groups or sects that are explored by researchers, it appears that the Pentecostal sect of Christians has received little attention in academia, though they are the fast-growing sect of Christians globally. The Pentecostals hold views that are quite interesting for this study since their perceptions of mental illness also guide how they perceive its treatment and ultimately collaboration.

1.8 Thesis outline

This study comprises seven chapters that are outlined as follows:
In Chapter One, the background to the study, aims and objectives of the study are presented. Chapter Two discusses views from other relevant literature. Attention is devoted to the relationship between religion and mental illness; the role of religion in mental health; positive and negative effects of religion and spirituality; the integration

of religion and spirituality into psychotherapy; Christianity and mental illness; Pentecostalism; as well as perceptions of what mental illness is, what causes it, the diagnosis and recognition of mental illness, pastors' perceived roles in the treatment and management of mental illness, views on by whom and how mental illness should be treated and their perceptions regarding collaboration with MHCPs.

In Chapter Three, Explanatory Models of mental illness, and the main theoretical framework of this study, which is the Extended Bio-Psycho-Social/Bio-Psycho-Social-Spiritual (BPSS) model, are presented. Chapter Four discusses the research methodology with reference to the design, being qualitative exploratory research design. Inclusive in this discussion is the sampling procedure, description of the research area, data collection, data analysis steps, and observed ethical issues. In Chapter Five, the participants' narratives of their experiences and understanding of the research concept are depicted. The researcher presents the narratives and extracted the themes and analysed them using the inductive thematic content. In

Chapter Six, the results of the study are discussed. The researcher deconstructs the narratives to see what themes emerged and how these relate to each other. The results of the study were also discussed within the context of existing literature to create a deeper understanding of the data. The research is also discussed within the theoretical framework of the BPSS model of mental illness.

Finally, Chapter Seven provides a concluding chapter where an overview of the study is given. An evaluation of the study with reference to its strengths and limitations is included. This chapter also gives attention to the recommendations for further research.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This chapter begins by giving an overview of the differences and similarities between religion/spirituality and their relationship with mental illness and mental health, and a general review of the literature regarding the integration of religion/spirituality into psychotherapy. Subtopics to be further examined include the relationship between Christianity and mental illness, Pentecostalism, Pentecostalism in Africa, and Pentecostalism in South Africa, Classical and Neo-charismatic/Pentecostal churches. Finally, in this section, the researcher presents a review of Pentecostal pastors' perceptions of mental illness; their views on how and by whom mental illness can be diagnosed and treated; Pentecostal pastors' views regarding their own role in the management of mental illness; and their perceptions regarding collaboration for purposes of an intervention programme are described.

2.2 Overview of religion, spirituality, and mental health

Religion and spirituality are among the most intriguing research topics for the academic community of psychology. Recently, interest in this subject, is mostly dedicated to exploring how specific religious/spiritual stances influence the way in which religion and religious beliefs impact the individual's well- being (Katzaman et al., 2019). Ryan (2017) also mentions that religion/spirituality has emerged as one of the key public issues of the 21st century, both nationally and globally. This is contrary to previous times whereby the criticism of religion/spirituality emerged in the realm of the behavioural sciences (Sullivan et al., 2013). This stance which MHCPs have upheld for many years was fuelled by early psychoanalysts like Sigmund Freud (Levin, 2010). According to Levin (2010), Freud viewed religious practices and beliefs in God as signs of obsessive neurosis, narcissistic delusion, and an infantile life outlook (Levin, 2010). Freud's atheistic stance was then widely adopted by the practitioners of psychoanalysis, further cementing psychiatry's position as unfriendly to religion (Webber & Pargament, 2014).

In the last 20 years, more attention has been paid to the scientific study of religion and its relationship to mental health and mental illness (Koenig, 2007). Many church goers and their clergy (pastors) are aware of the historical and possible current negative perceptions that MHCPs have about religion (Sullivan et al., 2013). According to Sullivan et al (2013), such perceptions continue to exacerbate the tension between the couch (psychology/psychiatry) and the pew (religion/spirituality). Sullivan et al (2013) further mention that the relationship between religion/spirituality and mental health has been one of commonality, controversy, and distrust. Thus, being aware of this complex relationship is essential to clinicians and clergy (pastors) who seek to holistically meet the needs of people in clinics, churches and communities, particularly rural communities (Sullivan et., 2013).

The role of religion and spirituality on mental health has long been debated with studies suggesting that the effect on the individual can be both positive and negative (Uwannah, 2015). Indeed, some studies have obtained mixed results concerning the association between religiosity and mental health (James & Wells, 2003). In other words, religion/spirituality can promote or damage mental health (Webber & Pargament, 2014). As such, the dual nature of religion/spirituality in the lives of psychiatric patients demands increased awareness of the religious/spiritual aspects of patients' lives, as well as resources available to assist those who are struggling (Webber & Pargament, 2014).

Religious/spiritual involvement is common with surveys showing that a significant proportion of the world's population has religious/spiritual beliefs and practices that are important to daily life (Bonelli et al., 2012). According to Webber and Pargament (2014), religion/spirituality, usually including a community of shared beliefs, offers support and structure for coping with stressful inevitable events. Koenig (2009) also indicates that in many countries around the world, systematic research has found that religious/spiritual coping is widespread and that psychiatric patients use religion/spirituality to cope (Koenig, 2009). For many Africans religion/spirituality provides significant identity resource; more significantly, in the period of rapid social change with unprecedented distortions to economic, social and political lifestyles, religion offers a veritable means of anchor and stability and a pathway to meaningful social existence (Ukah, 2007). Uwannah (2015) adds that faith communities can be

considered an environment where the individual with mental health conditions can find social support, encouragement, and a place of refuge.

Historically, researchers and psychotherapists have raised doubts about the appropriateness of the use of spiritual and religious resources in psychotherapy and have even questioned the practice of psychotherapy for schizophrenia altogether (Mizock et al., 2012). These practitioners have argued that religion/spirituality has no space in the psychotherapy setting given a need to be grounded in science (Mizock et al., 2012). In contrast, Koenig (2009) has called for the psychiatrists and psychologists to be aware of patients 'religious/spiritual beliefs and seek to understand what function they serve. Psychiatrists and psychologists may have difficulty separating normal and pathological expressions of religiosity/spirituality, which becomes a barrier to understanding their patients (Ayvaci, 2016). As such, Koenig (2009)'s call is a well informed and a relevant one.

2.2.1 Defining Religion and Spirituality

Defining religion and spirituality remains complex. Religion as a concept has always been difficult to define with anthropologists, philosophers, sociologists and psychologists still debating the concept (Ally & Laher, 2008). The complexity of defining religion and spirituality has contributed to the delay of incorporating these elements into psychotherapy. One of the challenges being that there is often an overlap between religion and spirituality (Pillay et al., 2016). Ally and Laher (2007) point out that "Religion, religiosity, religiousness, faith and belief are concepts encountered regularly in literature on religion sometimes even used interchangeably". Although these concepts have often been used interchangeably, various scholars agree that the concepts do not mean the same thing (Arrey et al., 2016) and therefore should be measured separately or differently. Above all, the use of the concepts of religiosity and spirituality interchangeably has caused a great debate in religion and spirituality research (Koenig, 2012). However, some scholars have justified the use of the concepts as a single construct their research. For instance, Pillay et al (2016) used the two concepts interchangeable so to demonstrate that an individual can be spiritual without being affiliated to any religious organisation.

While some theorists and clinicians attempted to use the terms religion and spirituality interchangeably, others argue that these two constructs are entirely different (Newman, 2004). However, some scholars in the religion and spirituality research have noted that the concepts consist of similar practices. For example, Hardwick (2013) noted that spirituality involves complex belief systems which are lived out in practices and rituals to find purpose and personal significance. On the one hand Cox and Verhagen (2011) noted that the domains of spirituality (the quality of being spiritual) and of religious practice overlap in that most religious traditions encourage adherents to undertake private spiritual exercises such as prayer and penance, as well as attending the Mosque, Temple, Synagogue or Church. Spirituality, as noted by Verghese (2008) is also a sacred realm of human experience.

Verghese (2008) argues that spirituality is a globally acknowledged concept. According to Verghese (2008), spirituality involves belief and obedience to an all-powerful force usually called God, who controls the universe and the destiny of man. Furthermore, Verghese (2008) mentions that spirituality involves the ways in which people fulfil what they hold to be the purpose of their lives, a search for the meaning of life and a sense of connectedness to the universe. Moreover, spirituality is very much personal and unique to each person (Verghese, 2008).

Newman (2004) highlights the similarity between both religion and spirituality in that both require faith or consists of the element of faith. Specifically, Newman states that both religion and spirituality require faith as a foundation. Given this commonality, Newman (2004) developed a model which looked at all three constructs (i.e., religion, spirituality and faith) separately. Based on her model, Newman (2004) argued that despite notable attempts by scholars to distinguish among the three concepts terms as described above, the current trend is to treat these three concepts as equal and interchangeable. For instance, one might use religion to mean faith in one instance and in the next instance someone else may use spirituality to mean religion (Newman, 2004). Furthermore, Newman (2004) alludes that depending on use or application, one may substitute any of the three terms to mean the other. Thus, the distinguishing line between spirituality, religion and faith can be fuzzy at times (Newman, 2004). As such, to some, they would be interchangeable, while others use them synonymously.

Some research-based evidence indicates that although spirituality and religiousness appear to be different, they are not independent (Arrey et al., 2016) of each other. Thus, they are interdependent. However, it is critical to note that while religion is a way of experiencing spirituality, spiritual experiences cannot be compared with religion (Paul Victor & Treschuk, 2020). Paul Victor and Treschuk (2020), further mention that spirituality can be expressed through various religious practices such as rituals and living by certain religious/ practices. According to Newman (2004), although religion, faith and spirituality are related to each other and different in scope, they are the constructs that build on the foundation of faith. Indeed, recently more people now are making the distinction between being religious and being spiritual, although some experience a spirituality that is religiously defined and thus claim to be both religious and spiritual to varying degrees (Williamson & Ahmed, 2019). However, Williamson and Ahmed (2019) also emphasize that a consensus of agreement has yet to exist on definitions for these important phenomena.

According to Cox and Verhagen (2011), a distinction between intrinsic (personal, subjective) religiosity and extrinsic (rules and regulations, creeds, and disciplines) religiosity is nevertheless useful. Specifically, Cox and Verhagen (2011) indicate that intrinsic religiosity is a more personal spirituality derived from and structured by religious tradition whereas spirituality is a private quest for answers to ultimate existential questions about life and death, meaning and purpose, and can include experiences of the transcendent. Moreover, spirituality requires personal experience and changes in heart whereas religion involves coding and conceptualising that experience (Cox & Verhagen, 2011). Cox and Verhagen (2011) further illustrate that spirituality is attributed to church affiliation, church attendance, believing in a higher power and association in a religious community. Moreover, spirituality produces in man qualities such as love, honesty, patience, tolerance, compassion, a sense of detachment, faith, and hope (Verghese, 2008).

Different from religion, spirituality is also identified with personal beliefs not typically aligned with institutionally and traditional associated behaviours and practices (Pour-Ashouri et al., 2016). In addition, spirituality includes both a search for the transcendent and the discovery of the transcendent, involves traveling along the path that leads from non-consideration to questioning to either staunch non-belief or belief,

and if belief, then ultimately to devotion, and finally, surrender (Koenig, 2012). According to Pour-Ashouri et al (2016) spirituality is more identified with personal beliefs whereas religiosity is typically aligned with institutionally and traditionally associated behaviours and practices.

Koenig (2012, p.2) defines religion as:

> An institution involving beliefs, practices, and rituals related to the transcendent, where the transcendent is God, Allah, HaShem, or a Higher Power in Western religious traditions, or to Brahman, manifestations of Brahman, Buddha, Dao, or Ultimate Truth/Reality in Eastern traditions.

Similarly, Paul Victor and Treschuk (2020) define religion to be a set of beliefs and practices that revere a god or a centre of power and value. As such, there are several religions having different sets of beliefs, traditions, and doctrines (Verghese, 2008). In essence, Verghese (2008) indicates that religion is institutionalised spirituality. Thus, persons do things, such as attend worship services or pray, to show reverence and worship (Paul Victor & Treshuck, 2019) to revere their god. They have different types of community-based worship programs (Verghese, 2008). In all these things (i.e., religious activities), spirituality is the common factor (Verghese, 2008). However, Verghese (2008) warns that is possible that religions can lose their spirituality when they become institutions of oppression instead of agents of goodwill, peace and harmony. Thus, religions can become divisive instead of unifying (Verghese, 2008).

Cox and Verhagen (2011) note that the overlapping elements of religion and spirituality are attributable to most research on spirituality which has been measured by religious interventions. Perhaps if research was conducted outside religious interventions, the distinction would be clearer. Nonetheless, for both spirituality and religion, faith is the guiding principle by which individuals are either religious or spiritual (Newman, 2004). Newman (2004) emphasises that faith serves as both the source and the target of both religion and spirituality. Thus, devotion to religion or perception of growth in spirituality may be seen as a measure of greater valence of understanding one's faith (Newman, 2004).

In her model, Newman (2004) argues that religion can be present without spirituality and vice versa. For instance, it is possible for someone to have faith (KNOWING), but

not necessarily be religious (DOING) (Newman, 2004). Conversely, someone may have faith and be religious, but not necessarily spiritual (BEING) (Newman, 2004). Thus, this religion, spirituality and faith model by Newman (2004) seems to afford researchers in this field the opportunity and freedom to discuss the three terms interchangeably while giving a context for them. In essence, Newman (2004) points out that with faith as a foundation, spirituality and religion can be seen as by-products, those things or ways of life which allow an individual to live out his or her faith.

It is important to take note that the term spirituality is abstract and more subjective, and it is different from religion and faith (Paul Victor & Treschuk 2020). However, Katzman et al (2019) argue that objectively defining spirituality as a different construct from religion is often overlooked due to the conceptual similarities. While spirituality can be viewed as a connection to God and surrounding and is associated with quality and meaning in life (Paul Victor & Treschuk, 2020) in the contrary, religion is attributed to traditional values and practices related to a certain group of people of faith and it is guided by tradition, rules and culture. Spirituality also involves a personal quest for life involves a personal quest for life, while religion involves an organised entity with rituals and practices focusing on a higher power or God (Arrey et al., 2016). Thus, one may argue that spirituality is more individualistic or personal whereas religion is more group oriented (Verghese, 2008).

Despite the noted differences above, both religion and spirituality tend to refer to aspects of belief and behaviour usually in relation to a transcendent or supernatural being. In both, there is a firm belief in a higher, unseen controlling spiritual power or authority (Hardwick, 2013). Based on the reviewed literature in this subject and the theoretical framework of the study religion and spirituality are thus treated as a single construct. Reviewed studies have shown that both serve the same purpose with regards to mental health and well-being as well as the understanding of illness generally. As such, this research will refer to the two concepts as referring to a single construct in this study. The religious activities, teachings, culture and spiritual experiences especially with regards to mental illness and its treatment are of interest to this research. To be specific, the subjects of this study basically belong or identify themselves as Christians. However, they subscribe specifically to the Pentecostal sect of Christianity which is characterised by spiritual experiences which may be different

from other Christian sects such as Lutherans, Methodists, Catholics etc. Pentecostalism is dealt with in detail later.

As mentioned earlier, even individuals who do not subscribe to the Pentecostal beliefs, do visit Pentecostal pastors when experiencing mental health problems. Above all, spiritual beliefs, faith and religious practices are an integral part of an individual's beliefs and value system and can influence a person's knowledge, attitude and practices about health, illness, the healing process, recovery and choice of healthcare provider (Paul Victor & Treschuk, 2020). In lieu of the above, this study will adopt the two definitions used by Arrey et al (2016) in their study of religious/spiritual coping of people living with HIV in Uganda and South Africa. In that study, spirituality was defined as a personal; belief that may include individual prayer, meditation and meaning in self. On the one hand, religion referred to organisational beliefs or adherence to an institutionally based belief system or dogma (Arrey et al., 2016). As mentioned by Arrey et al (2016), defining the two concepts is aimed at minimizing the line between them because some elements associated with spirituality are essential elements of a broad conceptualisation of religion.

It is significant for the psychology profession to understand what the definition of spirituality is (Paul Victor & Treshuk, 2020). It is difficult to define and there is no universal definition because of the variation attached to both concepts (Paul Victor & Treshuk, 2020). As such, attempts to develop a psychology of spirituality have been hindered by this lack of a cohesive definition of what spirituality is and is not, and in particular, how it differs from religion (Katzman et al., 2019). Furthermore, Katzman et al (2019) indicate that tearing apart spirituality within religion and secular spirituality is a difficult matter in research, and many papers have researched them as a singular construct. However, Katzman et al (2019) comment that understanding the benefits of secular spirituality can help determine optimal care for irreligious patients, or for patients whose spirituality extends beyond their religious inclinations. According to Katzman et al (2019), certain therapeutic approaches have used religious teachings as a foundation for developing mental health treatment plan. Based on the observations made between the two concepts (religion and spirituality), it is of importance for MHCPs and other clinicians to be acclimatized with the belief systems

and key values of the organized religions to enhance effective service delivery to members of those religions (Koenig, 2012).

2.2.2 *The significance of religion/spirituality in mental health*

Universally, religion/spirituality is a highly valued phenomenon and appears to play a pivotal role in people's lives. During times of crisis and many other significant events or experiences in people's lives, communities and their people resort to religion/spirituality and their leaders for help (Koenig, 2012). Specifically, religious/spiritual leaders provide diverse services to their congregants. Thus, religion/spirituality serves as a psychological and social support to mankind in nature (Arrey et al., 2016). To confirm the above, Boehnlein (2006) indicates that all the major world religions have belief systems, values and practices that allow survivors to adjust to and create meaning from severe loss and trauma (Boehnlein, 2006). Boehnlein (2006) further indicated that all the major religions like Buddhism, Hinduism, Islam, Judaism and Christianity, have oral traditions that facilitate the creation of meaning and hope for the future. Therefore, such religious/spiritual traditions should be taken into consideration when clients present to psychology (Bulbia & Laher, 2013). That is what as MHCPs we must strive to achieve in psychotherapy-viewing the client and their symptom presentation and understanding them from their cultural context or social reality. As such, religion/spirituality is an important aspect in the creation of that social reality or meaning making (Paul Victor & Treschuk, 2019). Thus, it should be explored or in whatever way in psychotherapy.

The importance of religion/spirituality is extensively noted in academia. Theologians, philosophers, theorists, MHCPs, politicians, and ordinary people acknowledge the pivotal role that religion plays in life. Ukah (2007), for example, noted that religion/spirituality is important because it brings restoration in the face of brokenness or damage to man's body, relationships, and social and religious/spiritual networks. As an emphasis, Raiya and Koenig (2007) indicate that religion/spirituality is a multifunctional phenomenon that serves multiple purposes which have been linked to psychological goals, such as anxiety reduction, personal control, and peace of mind, self-development and the search for meaning. Thus, it is important for psychology to understand how pastors meet the above stated psychological goals for their

congregants to facilitate a collaborative/integrative programme for the congregants who consult both MHCPs and pastors.

2.2.3 *The importance of religious/spiritual practitioners (pastors) in mental health*

One of the reasons as to why many people showing signs and symptoms of mental illness consult with pastors for example as noted by Koenig (2009) is that unlike many other coping resources, religion/spirituality is available to anyone at any time regardless of financial, social, physical, or mental circumstances. In agreement, Leavey et al (2016) remark that at a social or structural level, the clergy (pastors) are more likely to be sought in contexts where financial and medical resources are scarce or where the clergy (pastors) are positioned as trusted gatekeepers, particularly among ethnic minority and newly arrived communities, which is exactly the case of South African rural communities like Polokwane. Many people affected psychologically seem not to have psychological services, especially in rural areas. However, they do visit their pastors for help for their mental health needs to be met. But it seems that the pastors concerned do not have or have inadequate training on how to deal with mental health related issues (Jackson, 2017). Nonetheless, it is recorded in literature that from ancient days, religious/spiritual leaders from various religious/spiritual groups have played a pivotal role in the lives of people (Koenig, 2009).

Religious/spiritual methods have also often been used to treat the mentally ill and pastors have been involved in the religious/spiritual counselling of their congregants alongside MHCPs (Stanford & Phillport, 2011). In agreement, Leavey et al (2016), has observed that historically, the clergy (pastors) have provided 'healing' through various religious/spiritual and medical modalities and even in modern, developed welfare economies they are still an important help-seeking resource Individuals with mental disorders. Given long-term relationships with church members (Chatters et al., 2011), it is argued that the clergy (pastors) have knowledge about individual and family circumstances that are consequential for individual and family adjustment. However, it should be noted that the above, does not make the pastor to be a psychologist. Similarly, the knowledge of a client's religious/spiritual orientation and beliefs by the

psychologist, does not qualify them to be a pastor to the client unless they are ordained as one.

Based on the above, this researcher is of the opinion that when religious/spiritual elements are integrated into therapy with religious/spiritual patients, the outcomes of psychotherapy can be enhanced in many ways. Thus, the collaboration or integration between psychology and religion/spirituality is necessary from the point of assessment to treatment planning and the intervention (Greyvenstein, 2018). Specifically, because:

> Theology overlaps with psychology at this point, since pastors believe in the existence of demons/spirits based on their theological education, but in a counselling situation they do not have the necessary psychological knowledge to enable them to differentiate between, for example, a demonic burden (theology) and schizophrenia, personality disorder, or catatonic states or delusions (psychology).
>
> (Grossklaus, 2015, p.34)

Grossklaus (2015, p.35) further indicates that, "[t]he need to differentiate and understand the distinction or overlap between demonic and psychological experiences, is, imperative.

2.2.4 *The positive effects of religion/spirituality on mental health*

Documented research on the effects of religion/spirituality on general health indicates that religion/spirituality usually plays a positive role, I must reiterate. There is a substantial body of evidence currently existing confirming the potential that religion/spirituality must serve as a psychological and social resource for coping with stress (Bonelli et al., 2012; Pour-Ashuri et al., 2016). Highly esteemed and renowned scholar in the field of religion/spirituality and mental health Harold Koenig, in 2009 established that religious/spiritual beliefs and practice provide guidelines for human behaviour that reduce self-destructive tendencies and pathological forms of coping. The practice of religion/spirituality also has a significant effect on happiness and an overall sense of personal well-being (Joshi et al (2008). Bonelli et al (2012) also found

that religious/spiritual beliefs and practices help people to cope better with stressful life circumstances, give meaning and hope, and surround depressed persons with a supportive community. Moreover, Kennedy et al (2015) also report positive outcomes of religious/spiritual accommodative interventions for a variety of client concerns, including depression, anxiety, schizophrenia and coping with physical illness.

According to Joshi et al (2008) prayer has been used as a self-enhancing intervention for centuries and is inherently a religious/spiritual affair and activity and it is still universally used as such even today. Furthermore, Joshi et al (2008) indicate that meditation is also a part of religious/spiritual practice, which is used as a way of reducing the physiological and psychological stress. In general, religion/spirituality has been found by scholars to have a protective effect to those experiencing mental health problems and psychiatric distress (Koenig, 2009). Moreover, religion/spirituality can be a major source of ego support when life is difficult, and the world presents an unpredictable and risky environment (Salem, 2006). In South Africa, for example, which was somehow marred by a negative past due to apartheid and other socio-economic challenges, many people, especially Black people, have used religion/spirituality to cope and make meaning out of life (Mabitsela, 2003). Even today, a vast majority of South Africans, still use or value religion/spirituality as a place of solace.

2.2.5 *Religion/Spirituality as a source of meaning making and purpose*

Besides being a source of ego strengthening and support in difficult times, religious/spiritual beliefs can also shape a person's psychological perception of pain or disability. According to Joshi et al (2008), religion/spirituality, creates a mind-set that enables a person to relax and allows healing on its own. Joshi et al (2008) further state that individuals who report higher religious/spiritual strivings indicate greater purpose in life, better life satisfaction and higher level of well-being. In agreement, Salem (2006) mentions that religion/spirituality enhances positive experiences, such as hope and optimism, while Lowenthal (2006) states that religious/spiritual groups and beliefs offer feelings of psychological transformation, healing, and rebirth. This impact of religious/spiritual beliefs on individuals cannot be ignored by clinicians rendering services to clients from religious/spiritual backgrounds. Religion/spirituality is the significant dimension in holistically explaining and understanding human

behaviour which was less considered by the dominant Western models such as the Biomedical and the Bio-Psycho-Social-Spiritual model (BPSS) (Monteiro, 2015).

Based on the reviewed literature above, it is evident that religious/spiritual beliefs form the basis in which people explain, understand and deal with mental health issues. It appears that people presenting to MHCPs with mental health problems would appreciate that their religious/spiritual beliefs be addressed during psychotherapy since, to them, it bears many significant meanings. Over and above, regarding the significance of religion/spirituality, Koenig (2008, p.15) documented the following reasons for the high use of religion/spirituality amongst both medically and psychiatrically ill patients:

- The sense of meaning and purpose provided by religion/spirituality assists with psychological integration during difficult times.
- An optimistic, hopeful worldview is promoted.
- Sacred scriptures often provide role models that facilitate the acceptance of suffering.
- Religion/Spirituality provides a sense of indirect control over circumstances that often leave people feeling helpless and powerless, reducing the need for personal control; and
- Religion/Spirituality is available and accessible regardless of financial, social, physical, or mental circumstances.

Religion/spirituality is a resource for finding meaning and hope in suffering and has been identified as a key component in the process of psychological recovery (Mohr, 2011). Although many studies have demonstrated positive effects of religious/spiritual beliefs on psychological well-being a small number has demonstrated either negative or neutral effect (Joshi et al., 2008). For instance, Mohr (2011) indicates that religion/spirituality may be associated with psychopathology, suffering and non-adherence to psychiatric treatment. Thus, this acknowledgement is significant if dialogue is to be initiated between pastors and MHCPs.

2.2.6 *Religion/Spirituality as a source of social support and sense of belonging*

Commitment to religious/spiritual belief system may benefit mental health by promoting healthy behaviours conducive to wellness such as: avoidance of tobacco, alcohol, drugs and antisocial behaviour (Levin, 2010). According to Levin (2010), many people with mental illness need this kind of setup. It helps them to be part of a meaningful social group. In the process, they can avoid relapse and being preoccupied with their personal distress. They can also share experience and learn from their religious/spiritual family and gain an understanding that, they are not alone. As noted by Levin (2010), fellowship with like-minded congregants embeds one in formal or informal social networks that facilitate receipt of tangible and emotional support. In agreement, Arrey et al (2016) illustrate those religious/spiritual resources, including prayer, meditation, church services, and religion/spirituality activities and believing in the power of God, helped people to cope with HIV/AIDS. For many Africans, affiliation with religious/spiritual ideology is viewed as an important component of their psychological health since religious/spiritual issues may represent integral parts of many Africans' self-identity (Mabitsela, 2003).

2.2.7 *The negative effects of religion/spirituality on mental health*

Reeves et al (2011) observed that any modality of medical or psychological treatment, no matter how beneficial, can have adverse effects. This may also hold true for religion/spirituality. Even though researchers have noted their positive effects (Arrey et al., 2016), there could be some negative effects on mental health brought about by religious/spiritual beliefs and /or practices. For example, Levin (2010) noted that religious/spiritual practices, and belief in God, were taken by clinicians as signs of obsessive neurosis, narcissistic delusion, and an infantile life outlook, and thus a dangerous threat to individual psyches and to society and were believed to be determinative of, or indeed to reflect, an unhealthy psychological status. Thus, such ideations and practices were viewed as contributing to or reflecting pathology. Webber and Pargament (2014) also noted that religion/spirituality can be damaging to mental health by means of negative religious/spiritual coping, misunderstanding and miscommunication, and negative beliefs.

Williams and Stentharl (2007) mention that religion/spirituality can also be pathological with harmful effect such as superficially literal, authoritarian, or blindly obedient, etc. According to Williams and Sternthal (2007), failure to conform to community norms may evoke open criticism by other congregation members or the clergy (pastors). In the context of this study, Pentecostal pastors and believers who may be open to other healing methods and conceptualisation of mental illness other than what is commonly upheld by the group may be stigmatised or viewed as weak in faith. Such views pose a serious challenge to the envisaged collaborative programmes of intervention between MHCPs and pastors.

According to Pour-Ashouri et al (2016) religion/spirituality is linked with some shapes of psychopathology, including authoritarianism, rigidity, dogmatism, suggestibility, and dependence. Similarly, Bonelli et al (2012) noted in some populations that an individual's religious/spiritual beliefs may increase guilt and lead to discouragement as people fail to live up to the high standards of their religious/spiritual tradition. Thus, those unable to live according to the standards may face rejection from their faith community, resulting in social isolation (Bonelli et al., 2012). To be specific, strain and even conflict may result from religious/spiritual disagreements and from negative attitudes that may develop between the patient and others because of differing religious/spiritual opinions (Reeves et al., 2011).

2.2.8 *Religion/Spirituality as a defence mechanism*

In the past, religion/spirituality was often stereotyped as defensive or regressive in character by some early clinicians and scientists by scholars like Sigmund Freud. To be specific, psychologists previously viewed religious/spiritual beliefs as fostering a passive retreat from problems, the outright denial of pain and suffering, or florid symptomatology (Levin, 2010). In agreement, Williams and Sternthal (2007) observed that certain types of religious/spiritual coping adversely affect health. Moreover, Zagożdżon and Wrotkoska (2017) argued that though religious/spiritual beliefs may represent an important source of hope and meaning, they often interfere with treatment adherence. For instance, it may be possible that some patients choose to solely rely on religion/spirituality to address psychiatric issues; thus, substituting faith for treatment, or deny that they have mental illness but religion/spirituality problems.

Kamanga (2019) notes that in faith communities, religious/spiritual leaders exalt their own healing ways or methods as compared to those used by formal MHCPs (Kamanga et al., 2019). In agreement, Sullivan et al (2013) state that leaders in the faith community (pastors) who tend to ignore or demonise the biomedical model for mental health treatments run the risk of delaying or blocking access to available mental health resources. Thus, the outcome produced by this misuse of religion/spirituality is not a part of medical treatment but occurs more often in the realm of cults (Reeves et al., 2011). However, this study envisages an intervention programme incorporating modern psychological theories and religious/spiritual beliefs for treating congregants presenting or diagnosed with mental illness.

Reeves et al (2011) also notes that religious/spiritual patients may ignore reality and make little attempt to use practical methods to address their psychological or social issues. Consequently, patients may assume unrealistic expectations of their religion/spirituality and adopt a sort of magical thinking that God will solve all their problems or even grant all their wishes (Koenig, 2007). As such, it becomes important to determine empirically, the factors that influence such behaviours and attitudes since they have both research and clinical implications. Mathison and Wade (2014) mention that one such influence comes in the form of mental illness and help-seeking stigmas. These could be extreme cases whereby some individuals may unscrupulously use religion/spirituality to manipulate and control certain psychologically vulnerable patients (Reeves et al., 2011).

2.2.9 *Religion/Spirituality as a precursor of mania and psychosis*

Research indicates that religious/spiritual practices may precipitate manic episodes. This is illustrated by Lowenthal (2006) who indicates that although religious/spiritual factors are not thought to play a role in the actual aetiology of psychotic illnesses, they may play a role in precipitating episodes of illness in people already prone to mood disorders. This could somehow hold true for many Pentecostal believers who are unique, vibrant, and mostly expected to be responsive during their gatherings (Kgatle, 2017). Thus, when someone is not so responsive and vibrant as expected during a Pentecostal church service, they may be perceived as weak in faith or formal in the 'presence of God'. According to Lowenthal (2006), such a suggestion is the context of the difficulty in deciding whether excited group-sanctioned behaviour (whether

religious/spiritual or other) is necessarily manic or psychopathological. Moreover, Lowenthal (2006) indicates that there are many cases of possible psychosis in which the religious/spiritual content is very prominent, and religious/spiritual beliefs colour the expression of symptoms. Thus, it renders the work of both clinicians and pastors difficult, especially when it comes to making a proper diagnosis. As such, this researcher is of the view that the inclusion or involvement of pastors in a psychotherapeutic setting may change the status quo and vice versa.

It appears that generally, there seem to be a difficulty in distinguishing religious/spiritual experience and enthusiasm from psychosis in which there is evidence of deterioration in other areas of behaviour and feeling (Lowenthal, 2006). Thus, religiously/spiritually inspired beliefs may lead to behaviour that is unacceptable to others, and they highlight the difficulty of distinguishing between collectively carried religious/spiritual beliefs and individual delusional systems, particularly in cases where these beliefs are bizarre and unacceptable to others, and can lead to unacceptable behaviour (Lowenthal, 2006). However, Reeves et al (2011) argue that it does not mean that the delusions are caused by religion/spirituality, but religion/spirituality serves as the basis of their content. With that said, both MHCPs and pastors, may struggle to delineate between behaviours emanating from religious/spiritual beliefs or practices and behaviour influenced by mania or psychosis in the church or in clinical practice. As noted by Menezes Júnior and Moreira-Almeida (2009), behaviour related to religion/spirituality such as reported contact with spirits or commands from God may be misdiagnosed as psychiatric disturbances. Menezes Júnior and Moreira-Almeida (2009) state that the psychotic or dissociative like presentations are not necessarily symptoms of mental illness and may result from religious/spiritual experience. Thus, the differentiation of religious/spiritual delusions with religious/spiritual content is significant and challenging (Lowenthal, 2006).

This researcher has observed that during Multi-Disciplinary-Team (MDT) ward rounds, sometimes delusions in some psychiatric patients appear to be fuelled by religious/spiritual ideas. In support, Levin (2010) indicates that unchecked manic expressions of religion/spirituality have been throughout history sources of delusion, instability, and pathology readily visible to clinicians who serve essentially as first respondents to clients whose religious/spiritual practice has taken pathological form

(Levin, 2010). Such arguments and debates certainly trigger calls for collaboration/integration in the care of psychiatric patients. If such cases are only attended by MHCPs without any knowledge of religious/spiritual issues, there is a high risk of either under diagnosing or over diagnosing and eventually mismanaging of patients. The same applies to pastors. Hence this study envisaged a co-dependency programme of intervention between pastors and MHCPs with the same goal as COPE (Milstein et al., 2008).

2.2.10 *Shared roles of pastors and MHCPs in mental health care*

Religious/Spiritual and psychological studies both reveal that MHCPs and pastors share the same commitment towards the alleviation of their patients' suffering (Mabitsela, 2003). It is common that many people with mental health problems consult first with their pastors for help (Jackson, 2017). Most pastors usually care for their members with mental health problems using solely a religious/spiritual approach (Murambidzi, 2016). The danger of using a solely religious/spiritual approach to care for congregants with mental health problems is that some aspects of personhood may be left unattended to. The same applies when an individual is cared for from only a biological, social, or psychological approach (Sulmasy, 2002). So, for an inevitable and efficient treatment and care of congregants with mental health problems, this researcher advocates for a holistic approach to care and treatment. Thus, this researcher has opted for the BPSS model which provides a framework for understanding a human being holistically (Hefti, 2011).

More often, MHCPs and pastors use different methods and resources in the process of helping those who consult with them (Potgiter, 2015). The methods and resources may be similar or different. Thus, pastors need to acknowledge the expertise of MHCPs in explaining human behaviour from their theoretical perspectives (Mabitsela, 2003). Conversely, MHCPs need to rely on pastors to understand people's behaviour from a religious/spiritual perspective (Koenig, 2012). There are valuable lessons that both can learn from each other. As stated by Mohr (2011), to integrate religion/spirituality into treatment, therapists (MHCPs) need to be open, sensitive, and willing to learn about the role religion/spirituality plays in their patients' lives.

2.2.11 *The significance of incorporating religion/spirituality into psychotherapy*

The debate between religion/spirituality and psychology continues though there is adequate empirical evidence pointing out to the relevance of religion/spirituality into psychotherapy. For example, Sullivan et al (2013), argue that while MHCPs may view religion/spirituality as additional content for psychotic patients, parishioners may use religion/spirituality as a coping mechanism or frame of reference for explaining their mental illnesses. Thus, benefits of collaboration become more salient when clinicians (MHCPs) and the clergy (pastors) can recognise how multiple factors can be interrelated to the psychological and spiritual health of individuals (Stanford & Philpott 2011).

The importance of having to consider the role of religion/spirituality in health, mental health and psychiatry in South Africa particularly has been emphasised in recent legislation on African traditional health practice (Janse van Rensburg et al., 2012). Elsewhere, research indicates that professionals wishing to serve clients with high quality and professional services must be aware of and respect religion/spirituality as a multicultural issue (Plante, 2016). Perhaps this is because, many patients presenting to MHCPs are religious/spiritual and have religious/spiritual needs related to medical or psychiatric illnesses (Koenig, 2012). Specifically, religion/spirituality determines how people interpret and deal with events that happen to them, shape their behaviour, and influence their perception of life and/or deal with crisis.

For many Africans, religion/spirituality has always provided a significant identity resource; in the period of rapid social change with unprecedented distortions to economic, social and political lifestyles and offers a veritable means of anchor and stability and a pathway to meaningful social existence (Ukah, 2007). On the one hand, culture and religious/spiritual denominations or groups provide frameworks from which to practice specific beliefs, rituals and rites regarded as pivotal for general wellbeing (Mabitsela, 2003). Thus, alternative practitioners, including traditional healers and religious advisors (pastors), play an important role in the delivery of mental health care in South Africa (Sorsdahl et al., 2009). However, there is a lack of established or clear-cut guidelines or legislative frameworks governing such. This practice is more prominent in many African countries, especially those considered to be LMICs whereby religion/spirituality is considered as an integral part of the mental health

system due to lack of human resource and other reasons. In these countries (i.e., LMICs), just like in South Africa, individuals with mental illness and their caregivers frequently consult the clergy (pastors) when mental symptoms cause distress (Igbinomwanhia & Omoaregba, 2014), due to the limited number of bio-medically trained professionals (Kpobi & Swartz, 2018a).

In view of the above, instead of nurturing the tension that always remained between religion/spirituality and mental illness, organizations such as the American Psychological Association (APA), have in the last few years evolved toward a more positive and receptive stance toward religion/spirituality (Webber & Pargament, 2014). Thus, they recognise the significance of religion/spirituality in mental health. As a result, the organisation, and its affiliates World Congress of Psychiatry (WCP) have made amendments in the DSM driven towards the acknowledgement of religion/spirituality and culture by including a cultural formulation of illness in the DSM-5 (APA, 2013). In South Africa specifically, organisations such as SASOP (Janse van Rensburg, 2014a) have come up with practise guidelines to aid their affiliates to practice within the frames of reference of spirituality. However, there has not been much progress made to this researcher's knowledge with regards to practise guidelines which calls for the recognition or acknowledgement of religious/spiritual beliefs in Psychology.

Religion/spirituality was and is still, to a great extent, left out in psychological explanations of mental disorder and treatment planning (Koenig, 2012). Thus, incorporating religious/spirituality beliefs in psychiatry and psychology can be effective in psychotherapy by having a dialogue with custodians of such beliefs-religious/spiritual leaders (pastors). They are the leaders in the field. They are the experts and sources of the information required for efficient collaboration (Greyvenstein, 2018). It is important for us as MHCPs to note that religion/spirituality is tied to one's culture (Bodenstein & Naude, 2017). Given the above, an informed therapist, should, at the very least, be willing to explore or address the patient's religious/spiritual beliefs (Henderson, 2018).

 In South Africa, South Africans seeking mental health care have different cultural backgrounds that can impact on the type of psychological intervention methods

needed (Bodenstein & Naude, 2017). Therefore, when considering the psychologist-to-population ratio, it is required of MHCPs be able to work across racial and language borders to provide mental health care services to the whole continuum of the population. According to Hardwick (2013), one of the core competencies of counsellors is to embrace client diversity and practice in a culturally appropriate manner. However, such tailor-made programs envisaged by this researcher are still scant especially in Africa (Madu, 2015).

Mohr (2011) points out that the integration of spirituality into the care of people with severe mental disorders must consider the cultural context of the psychiatric service, the characteristics of religion/spirituality of each patient as well as pathological specificities. For instance, in a culturally diverse South Africa, psychiatric diagnosis should consider alternative explanatory models that provide a more balanced view of the complex and dynamic relationship between biological and sociocultural forces in the manifestation of psychopathology (Kriegler & Bester, 2017). The above, should also apply to Psychology. Nonetheless, more progress is needed in culture-sensitive research and in understanding the complex and dynamic relationship between biological and sociocultural forces in the manifestation of psychopathology.

This research was carried out with the hope of developing an intervention programme like COPE as discussed in Chapter one which seeks to facilitate collaboration between pastors and MHCPs at a community-based level to lessen the large treatment gap of mental illnesses in Africa (South). Besides the large treatment gap in Africa, there is an increasing awareness of the need to incorporate other worldviews into the teaching and practice of psychology (Laher, 2014) in South Africa. This diversity in culture has important consequences for those diagnosed with mental illness since the diagnosis and treatment is quite often discussed with everyone in the nuclear and extended families as well as in the community (Laher, 2014). Religion/spirituality and culture influence the way in which individuals perceived mental illness (Bulbia & Laher, 2013). Thus, it is important to recognise clients' unique cultural contexts and the resulting "lens" in which they view the world (Hardwick, 2013). Thus, it is critical to consider the historical inequalities in the South African context, which make it difficult to ensure culture-matching for clients (Bulbia & Laher, 2013). Unfortunately, many psychologists

rendering psychological services in South Africa are trained in Western based notions of illness and disease which are different from African based epistemologies.

2.3 Christianity in South Africa

A larger number of South Africans are Christians. As noted in literature, approximately 80 per cent of South Africa identifies with Christianity. Specifically, most South Africans belong to the African Independent Churches (AICs) such as Zionists and Apostolic Christian Churches. However, important to note is that there is another group of Christians which is currently rising with great vigour worldwide and in South Africa specifically-the Pentecostal Christians (the Classical and the New Charismatics) churches/ministries. Recent research points out that many people with mental health problems visit their church leaders (pastors) before they consult with MHP (Kruger, 2012; Leavey, 2008). As such, it is important to explore and understand how Christian pastors attend to the members who consult with them.

In South Africa, there is scant research regarding how Christian pastors perceive mental health problems and how they should be treated and managed. However, it should be that Christian beliefs play an important part on the perception of mental illness by a pastor or church member. According to Almanza (2017), Christians continue to be a powerful source that not only affects current understandings of mental illness but are also affected by those understandings.

2.3.1 *Brief history of Christianity*

Almanza (2017) records that Christianity originated from among the surviving disciples of Jesus Christ, a Jewish preacher from Galilee in what is now Northern Israel and who was executed by occupying Roman forces in circa AD. As noted by Almanza (2017), early Christians hesitated to ascribe the immediate cause of affliction in every case to the sufferer's personal sin. Christian teaching holds that all human beings are fallen and in need of redemption and are deemed to be held responsible for their own failings (Ryan, 2017). Ryan (2017) quotes a passage of scripture from Romans 3 verse 23 to support his assertion. The scripture as quoted by Ryan (2017) states that:

For all have sinned, and come to short of the glory of God; being justified freely by his grace through the redemption in Christ Jesus: whom God hath set forth to be a propitiation through faith in his blood, to declare his righteousness for the remission of sins that have passed through the forbearance of God Christ who God.

(King James Version, p. 970).

2.3.2 *Christian beliefs and theology*

As we see above, in the Christian faith, the Bible is regarded as a sacred book, containing God's inspired Word and instructions on how life should be perceived and lived (See, 2 Timothy 3:16). The Christian theology, which is Biblically based, teaches that individuals are created in the image of God (Genesis 1:27, New Living Translation), that people have infinite worth and value (Psalm 139:13, NLT; Ephesians 1:13, NLT), and that sin is what impedes (Romans 3:23, NLT) (Swain & Collier, 2016). On the other hand, Choi (2013) states that the Bible is also full of stories in which people are demon possessed, which some MHCPs or even lay people today would refer to as being mentally ill.

2.3.3 *The perception of mental illness by Christians*

Amongst Christians generally, the attribution they have on mental illnesses is determined by their theological position. For instance, mental illness can be attributed to a demon or spiritual and other sources (Choi, 2013). Besides their theological orientation, Mathison and Wade (2014) also discovered a difference due to race. Mathison and Wade (2014) noted that primarily Black and Hispanic churches, particularly more conservative ones, endorsed more spiritual aetiologies of mental illness than primarily white churches. In their study, Christian church members were discouraged from or forbidden to take psychiatric medication and/or were told they did not have a mental illness despite having a diagnosis from an MHP.

Furthermore, Mathison and Wade (2014) argued that these beliefs led to non-adherence to psychiatric treatment, thus increasing the risk of relapse and hospitalization; and lack of treatment for those with severe mental illness resulting in increase of high-risk symptoms such as suicide and psychotic or manic episodes.

Based on their findings, Mathison and Wade (2014) concluded that there was a need for Christian pastors to collaborate with MHCPs in a situation whereby both would learn from each other.

Overall, the attributions that Christian pastors have of mental illnesses, determine by whom and how they perceive it to be treated. For example, in a review of literature carried out by Almanza (2017), a vast majority of Christians believed that prayer alone is the standard treatment of mental illness, giving an impression that some Christians are liable to refuse clinical intervention and psychotropic medications as primary treatment approaches. According to Almanza (2017), such neglect can delay additional treatment and further increase the morbidity, mortality, and possibility of life-threatening consequences amongst mentally ill Christians. Almanza (2017) further indicated that many Christians believe that all mental illnesses result from sinful lifestyles and that only via repentance and getting right with God, can people with mental illness find relief from their conditions. Consequently, Christians who adhere to this belief, often discontinue treatment for mental illness without discussing their decisions with their doctors, largely due to their belief that complete healing occurred at a church service or prayer meeting (Almanza, 2017). Such a discontinuation can put patients at risk of experiencing acute or recurring episodes related to their mental health conditions (e.g., manic, and psychotic episodes) (Almanza, 2017). Another major finding made by Almanza (2017) regarding Christians is that it is common amongst Christians who experience active, prominent symptoms of mental health conditions to delay treatment for year as they wait to be healed by God.

Empirically, it has been proven that a significant portion of the Christian community worldwide subscribes to uniquely religion/spirituality conceptualisations of psychopathology (Almanza, 2017). This also holds true for South Africa, whereby Christian denominations have varying beliefs, teachings and practices adopted by people of diverse ethnicities as well. As noted by Ukah (2007) African Christianity is complex in its history, structures, doctrines, and practices. In South Africa specifically, community and religion/spirituality are traditionally tied (Kalender, 2019). Kalender (2019) indicates that among native populations and rural areas, originally non-African religions are often mixed with indigenously religious/spiritual beliefs as already indicated.

Due to this broadness of Christianity and its practices, it is possible that Christian pastors vary on how they view mental illnesses (Leavey, 2008). In his study, Leavey (2008), observed that there are variations amongst the different denominations of Christianity in their approach to mental health services. Christians vary in their interpretation of the Bible and practices, which also leads them to vary in their treatment and management approaches. There is no clear understanding of what exactly mental illness in the Christianity community (Leavey, 2008). More often, mental illness is perceived to be madness (Kpobi & Swartz, 2018a). In South Africa and many other African countries, many Christian churches include ancestral, natural, and supernatural elements (Kalender, 2019) to understand the world and events happening around them. Therefore, it is possible that Christianity as practised in Africa whereby majority of people are Black be different from Christianity practised in Western countries, whereby most adherents are White people.

Academic work competed by Collier and Swain (2016) shows that Christian pastors work from a philosophical and therapeutic lens that is reductionist in nature and often at odds with Humanistic Psychology. Thus, Christian pastors view mental illness, not solely a chemical imbalance, but rather a religious/spiritual issue with broader implications for the individual. The theological lens that pastors uphold put God squarely in the centre, rather than the individual (Collin & Swain, 2016). While persons with mental illnesses do not always feel supported by the religious/spiritual community, only a handful of studies have directly assessed the attitudes of Christian groups toward mental illness (Webb, 2009).

Notwithstanding what Webb (2009) found, there is a need for more studies to be conducted to that effect. As noted by Almanza (2017), there is a tendency to perceive mental illness as religious/spiritual in nature amongst Christians which could prevent Christians from seeking help or following a physician's recommendations. As an example, Graber (2014) indicates that many Bible-believing Christians with Obsessive Compulsive Disorder (OCD) experience incredible emotional suffering over concerns that they might have committed 'the unpardonable sin'. As a result, Christians do not get help because they believe anxiety is a sign of religious/spiritual failure, or they fear the stigma in their faith community that is associated with an anxiety disorder (Graber, 2014).

2.3.4 *The differences between Christian beliefs (Theology) and Western Psychology*

An attempt to integrate Psychology and Christian faith (Theology) is a daunting task because of the divergent approaches of these academic disciplines (Santrac, 2016). Thus, in thinking about how psychology and Christian faith (Theology) should relate today, Johnson and Jones (2000) highlight that it is essential to recognise that the present state (one of tension and debate) is like and yet different from the state of psychology through much history. Specifically, Christian fundamentalists often share a core conviction that is regarded as substantially flawed in that natural knowledge, which is knowledge coming from sources other than the Bible including scientific knowledge is the enemy of the Christian faith (Johnson & Jones, 2000). For example, the basic view of fundamentalist Christians is that the natural and social sciences (Psychology) must inquire finally of Theology (The study of God), (in this case, Christian Theology) (Santrac, 2016) and not the other way round.

Over the past century, a complex a complex and rich body of knowledge and practice has arisen that attempts to understand and treat human personality and behaviour in ways which are usually disconnected from Christian perspectives on life (Johnson & Jones, 2000) Johnson and Jones (2000) observed that some of the ways available to treat human personality and behaviour seem to contradict what Christians have regarded as biblically grounded truth about humanity. According to Johnson and Jones (2000), disagreement was rampart about how much and in what ways the theories and findings of the secular version of Psychology should influence, be absorbed into, and even transform the way Christians think about persons. This, as noted by Johnson and Jones (2000) led to the Christian disagreement about how they should understand and relate to the enormous, impressive body of knowledge and set of practices that have developed in the twentieth century known today as psychology, since it offers us a largely secular version of psychology.

According to Johnson and Jones (2000), Christian fundamentalists argue that any appropriation of secular psychology is heresy, that secular psychology is a poison which taints and infects all Christians who imbibe it. Specifically, Johnson and Jones (2000) indicate that fundamentalist Christians believe Christians should only affirm what is in the Bible and reject any input from "worldly" sources, especially secular

psychology. According to Johnson and Jones (2000), such critics go so far as to decry one-on-one counselling since it is not expressly taught in the Bible. Thus, as we have seen above, Christians falling within the fundamentalist category may completely reject and/or undermine Western Psychology theories or treatment modalities (Collin & Swain, 2016). In essence, while some Christians believe there are marvellous things to learn from modern psychology, embracing psychological findings and theories with enthusiasm, others approach secular psychology with great caution (Johnson & Jones, 2000).

The differences between Christian faith (Theology) and Psychology lie in the fact that Psychology does not assume the existence of a devil, demons etc. as theology does, but rather attempts to classify these phenomena in a different way (Grossklaus, 2015). Thus, early psychologists like Freud, Ellis and Skinner belong to the secular reductionist group have been labelled as secular reductionists in that they deny the spiritual as well as insist irrelevance of faith (Young, 2017). Their treatment involves removing faith. In short, psychology reductionists insist that theology is unhealthy at all (Young, 2017). On the one hand as observed by Young theological reductionists emphasize the superiority of special revelation. Spiritual reductionists treat scientific psychology as hostile. In other words, science is hostile to faith or Scripture (Young, 2017). Like the secular reductionists, theological reductionists insist psychology as a science is hostile. They believe that psychology promotes unbiblical behaviour (Young,). Nonetheless, Grossklaus (2015) indicates that some national and international scientists do accept terms such as trance and the condition of possession although they contextualize and explain these terms differently to theologians. This variance has a significant bearing on the integration of Christian faith (Theology) and Psychology (Santrac, 2016).

In their book, Johnson and Jones (2000) noted three main issues that distinguished the approaches towards Psychology and theological counselling. Firstly, the issue concerning the possible sources of psychological knowledge: empirical research, Scripture and theology, philosophy, and history (Johnson & Jones, 2000). With the dawn of such developments was a veritable revolution in the treatment of the soul:

psychoanalysis (Johnson & Jones, 2000). While pastors, priests, spiritual directors, and rabbis had cared for the souls of Christians and Jews for centuries, this controversial new approach to the soul offered a disturbing but profound analysis of what was wrong with humans and how to help (Johnson & Jones, 2000). According to Johnson and Jones (2000), besides its intellectual complexity, sophistication, and alluring examination of the mysterious unconscious realm, this approach distinguished itself from pastoral care with its alleged empirical basis and by its lack of reference to supernatural causes or cures (Johnson & Jones, 2000).

To illustrate the above, psychologists would likely ascribe a spirit possession to a psychological experience; while theologians will attest to the presence of a spiritual illness (Graussklaus, (2015). Moreover, Grossklaus (2015) indicates that, Psychology does not assume the existence of a devil, demons etc. as theology does, but rather attempts to classify these phenomena in a different way. However, some national and international scientists do accept terms such as trance and the condition of possession; however, they contextualize and explain these terms differently to theologians (Grossklaus, 2015).

Secondly, Jones and Johnson (2000) indicate that some Christians are very concerned about the influence of non-Christian thinking on Christians and work hard at uncovering the underlying secular biases they discern in the non-Christian texts they read. On the other hand, other Christians are more trusting of non-Christian authors and emphasise that truth can be discovered by anyone (particularly if the research is done with proper controls) (Johnson & Jones, 2000). As such, those Christians reserve their Christian critique for explicit, antireligious statements (Johnson & Jones, 2000). The third issue of concern is with regards to whether Christianity provides a distinctive view of human nature that should bear on psychological theory-building, research, and counselling practice (Johnson & Jones, 2000).

The question above is asked on the premise that the goal of modern science has been to construct a universal understanding of things (like human nature) that can be agreed to by all interested parties willing to do the research and replicate studies (Johnson & Jones, 2000). However, as argued by Johnson and Jones (2000), Christian

phenomena like the image of God, sin, and the role of Holy Spirit in spiritual development cannot be studied by neutral observation; it requires faith to "see it." Based on all the above observations by Johnson and Jones (2000), it became evident that there are differences with regards to whether there should be a distinctive Christian approach to psychology and counselling or whether Christians should work together with non-Christians. An argument which I believe still stands to this day.

As noted by Grossklaus (2015), Psychology has grown as a discipline from viewing mental illness as spirit possession to understanding it scientifically through various schools of thought. Grossklaus (2015) remarks that since these schools of thought now dominate, what happens to those individuals who still experience, or believe that they have experienced, spirit possession. According to Grossklaus (2015), the psychological perspective predominantly assumes the appearance of dissociative identity disorders and for these suggests treatment techniques and medication. On the one hand, pastors believe in the existence of demons/spirits on the basis of their theological education, but in a counselling situation they do not have the necessary psychological knowledge to enable them to differentiate between, for example, a demonic burden (theology) and schizophrenia, personality disorder (Grosskalus, 2015). Given the above overlap, several evangelicals (Christians) began to sense the need for advanced training in psychology shaped by a Christian worldview (Johnson & Jones, 2000).

As observed by Johnson and Jones (2000), most Christian psychologists and counsellors do not dispute the more basic observations of psychology (e.g., brain structure, visual perception, or animal learning; we might say the first half of an introduction to psychology course). However, the disagreement largely concerns the more complex aspects of human nature: motivation, personality, psychopathology, psychotherapy, and social relations (the last half of the course) (Johnson & Jones, 2000). As such, for the Christian, counsellor or pastors, the purpose of integration is to demonstrate the superiority of a holistic Christian theory of personality to compartmentalised and disintegrated psychological theories of personality (Santrac, 2016). Santrac (2016, p.2) argues that "The problem of integration is this: To integrate Christianity with Psychology one must convert or reduce biblical wisdom (mind of Christ) to Theology, or a theory about the basis and purpose of living. But the Bible

does not address the head, but the heart" Thus, while Psychology is more concerned about the mind, Christian faith (Theology) is more concerned with the heart.

According to Johnson and Jones (2000), all evangelicals affirm the value of the Bible for Christian belief and practice. However, the differences exist in terms of (1) whether the Bible is relevant to the theory and practice of psychology and counselling and (2) if so, the extent to which the Bible's teachings should be allowed to shape psychological theories, research, and counselling practice (Johson & Jones, 2000). For Christians, however, the reference point of the Christian theory of personality is Christ, as he unifies the faculties of the soul into a holistic perception of human nature created in God's image (Santrac, 2016). In contrast, Johnson and Jones (2000) indicate that modern Psychology self-consciously moved away from reliance on non-empirical sources (philosophy, theology, and Scripture) and redefined itself by restricting itself to the actual study of human beings (and animals).

Up to this time, in modern psychology, the idea of 'self' has largely replaced the theological concept of the soul (Collier & Swain, 2016). As such, when looking at mental illness, it is important to draw distinctions between how a secular psychologist might frame the problem versus a Christian pastor (Collier & Swain, 2016). For pastors, healing (or recovering from a severe mental illness) is not solely about finding the correct medication or intervention to address a mental disorder (Collier & Swain, 2016). Instead, a Christian pastor strives to help the suffering congregant to find God at the centre of their suffering. This theological framework is helping for understanding how pastors approach their work with congregants expressing symptoms of mental illness (Collier & Swain, 2016) and is different from the dominant Western Psychological perspectives though agreeing with some. Basically, there are primary differences between theology and psychology. For example, theology begins with God's self-revelation in Scripture, nature, and history, whereas psychology usually begins with human beings (Johnson & Jones, 2000).

According to Whitney (2020), while psychology is the exploration of human thought and behaviour, it can also be seen theologically as one particular way humans can explore, develop, and shape creation in particular ways-recognizing that one's ability to explore creation through psychology relies on capacities given by God. In addition,

Whitney (2020) mentions that one can affirm that psychology is a science-and yet, for the Christian, it is also the activity of humans engaging in the process of discovering and exploring God's world (Whitney, 2020). Thus, the more central concern for those practicing integration is the acknowledgement that through God's general revelation, the world and the human creature have an order that may be discerned by observations through the psychological sciences (Whitney, 2020). As such, this revelation may not directly reveal things about God as Redeemer, but this general revelation reveals something of the manner and order of the way that God has put together the created realm and the human creature (Whitney, 2020). Thus, for Christian pastors and MHCPs to integrate, the vast differences and/or similarities discussed above should be taken into cognisance by both disciplines and professions.

2.3.5 *Christian pastors' treatment and management of mental health problems*

Christian pastors are involved in counselling their members about various life issues, including mental health problems (Potgiter, 2015). Regarding their approach to counselling for example, Swain and Collier (2016) noted that though Christian pastors vary in their interpretations of scripture, their approach to counselling is informed by the Bible rather than the DSM. Thus, as already mentioned, the Bible is principal in the Christian community and influences how pastors and their members perceive mental health and mental health problems. However, Swain and Collier (2016) also note that much of the distrust and suspicion on the part of certain faith communities comes from certain subjective interpretations of Biblical scriptures. Swain and Collier (2016) observed that there are other Biblical passages that are interpreted as a direct warning about the dangers of mixing psychological and Biblical principles.

In support, Sullivan et al (2013) quotes the KJV scripture of the Bible when Paul says, "O Timothy! Guard what was committed to your trust, avoiding the profane and idle babblings and contradictions of what is falsely called knowledge" to demonstrate that that professing such scriptures, some have strayed from the faith. Although all scriptures are subjectively interpreted, the meanings certain interpretations evoke can play a powerful, though sometimes implicit, role in how Christians perceive mental health services (Collier & Swain, 2016).

Graber (2014) highlighted that the management of mental illness by pastors should include Christian counselling to address behaviours, thoughts emotions and religious/spiritual well-being for the one affected one affected by bipolar disorder and, in many cases, their family and loved ones as well. However, from the study by Graber (2014), it was not clear as to whether the proposed Christian counselling would deal with specific mental illnesses or some of them or whether pastors should collaborate with MHCPs in the process. Specifically, in his proposed model Graber (2014) suggested that prayer partners, Christian fellowship and a strong, safe support system consisting of family and friends can assist in successful management of bipolar disorder.

2.3.6 *Christian pastors' roles in the treatment and management of mental Illness*

As noted by Potgieter (2015), pastoral care is a Biblical mandate to the church to be involved in the lives of God's people. According to Potgieter (2015), the demand for pastoral care and assistance with various personal problems is on the increase, with many non-church goers turning to churches for help. This holds true for South Africa, like many LIMCs where there is an acute shortage of trained professionals to offer care and counselling. Besides, due to the long history of antagonism between religion/spirituality and psychiatry/psychology and mistrust, pastors are often hesitant to refer their congregants to secular counsellors. In support of the statement above, respondents in a study conducted by Chatters et al (2011) indicated that church members were more likely to seek help from ministers (pastors).

Chatters et al (2011) indicate that problems involving bereavement are especially suited for assistance from ministers (pastors) owing to their inherent nature (e.g., questions of ultimate meaning) and the extensive array of ministerial support and church resources that are available to address the issue. Choi (2013) recommended that any Christian approach to mental health must answer a fundamental question about where the mind sits within the theory of human existence rather than ignore the other aspects of being human. The recommendation by Choi (2013) is in keeping with the guiding model of this study, the BPSS model, which addresses under its R/S domain the 'theological language' for clients to verbalise their own experiences without

ignoring the other factors to avoid 'over spiritualising' problems. As such, MHCPs need to gain competence in the various aetiologies that Christian clients may endorse (Mathison & Wade, 2014).

2.3.7 *Mental illness and stigma amongst Christians*

Stigmatising beliefs because of mental illnesses were also investigated amongst Christian pastors. For example, Mathison and Wade (2014) found that common religiously stigmatizing beliefs amongst Christian pastors included that the aetiology of mental illness was moral weakness, sin, unfaithfulness with religious/spiritual practices, or demonic influence. Another study, conducted by Matthew and Stanford (2008), revealed that the church dismisses the diagnoses of significant large number of participants. In the study, participants who were told that they did not have mental illness were more likely to either attend church more than once a week or describe their church as conservative, and/or charismatic. Matthew and Stanford (2008) also identified that there was a lack of support for the use of prescribed medications for depression and anxiety or any other mental illness diagnosis among patients attending Christian churches.

Now, the question that arises is whether the delay is because of inability to access formal mental health services, or the stigma attached to pastors seeking for help from secular professionals which might be interpreted as being 'spiritually' weak? Similarly, Webb (2009), noted that among segments of the Christian population, particularly more conservative groups, experiences of psychological distress, such as anxiety and depressed affect, are not expected or appropriate elements of Christian life. Such experiences are viewed as demonstrations of lack of faith or sin.

2.4 Pentecostalism

2.4.1 *The origin of Pentecostalism*

Pentecostalism is one of the largest Christian sects or movements which currently exist worldwide. Pentecostalism derives its name from the word 'Pentecostal' as noted in Acts Chapter 2 in the New Testament of the Bible. The technical use of the word Pentecostalism started in the 20th century (Mashau, 2013). It refers to a group or sect of Christians, who believe in the power and works of the Holy Spirit, including

glossolalia (speaking in tongues). However, having said the above, Roux (2019, p.29) cautions us thus:

> "When embarking on a study of a global movement such as Pentecostalism, one difficult to answer questions is: 'What is Pentecostalism?' How does one define/describe a movement that is so complex and diverse in nature? Not only is it far from being a homogenous movement, Pentecostalism also manifests differently in various churches, localities and contexts"

Thus, as mentioned by Alves (2017, p.1), "since various criteria apply to recognize Pentecostals or Charismatics, it is difficult to categorize their different churches, loose networks, independent congregations, or internal movements."

2.4.2 *Defining Pentecostalism*

Based on the complexities of defining and describing Pentecostalism (Roux, 2019), for the purpose of the present study, this researcher uses the term 'Pentecostalism' to refer to churches that base their beliefs on the events of Pentecost as outlined in Acts Chapter 2, believe in the Baptism of the Holy Spirit, in glossolalia (speaking in tongues) and the manifestation of the gifts of the Holy Spirit. This study specifically paid more attention to Mission and Neo-prophetic/Pentecostal/Chasrismatic Pentecostal churches. Alves (2017, p.1) states that, "the multifaceted aspect of Pentecostalism is problematic to draw its boundaries using essentialist terms." Nevertheless, what seems to be clear is that Pentecostalism is distinct and has remarkable features differentiating it from other Christians. As described by Mashau (2013), Pentecostalism is a global phenomenon with a large following in North America, Latin America, Asia, Africa, and other parts of the world (Mashau, 2013). In 1906, the movement was strengthened by the addition of a black and multi-racial following that emerged after the Azusa Street revival in Los Angeles (Centre for Development Enterprise, 2008).

From the reviewed literature, it seems that the diversity, uniqueness, and the practices of Pentecostals make it difficult for scholars and researchers to define the concept- Pentecostalism. To illustrate this, Hardwick (2013) mentions that Pentecostals are

comprised of a heterogeneous group of Christians with varied backgrounds, races, ethnicities, socioeconomic status, and educational levels. Hardwick (2013) further indicates that the Pentecostal Christians display an interesting difference from the public and most of the Christian studies. Therefore, this researcher who is an ordained Pentecostal pastor, but has limited knowledge about Pentecostalism as a whole, but has a professional training as a clinical psychologist, sought to explore more of Pentecostal pastors' understanding of mental health problems, people with mental health problems and professionals in the mental health field with the hope of establishing an integrative intervention programme. This programme will need to blend or incorporate psychological underpinnings of human behaviour, as well as Pentecostal theological beliefs into psychotherapy.

2.4.3 *Basic tenets of Pentecostalism*

As noted by Mashau (2013), one of the basic tenets regarding the teachings of the Pentecostals is salvation which is earned by faith in Christ. Mashau (2013) further states that in Pentecostal strategy, evangelism takes the highest priority (Mashau, 2013). Evangelism refers to going out and reaches the lost for Christ in the power of the Holy Spirit. Other distinguishing characteristics and features of Pentecostal spirituality is that it focuses on experiences and phenomena (e.g., miracles, visions, deliverance from possession, ecstatic states) that go beyond spirituality/religion (Hampelmann, 2009). Hampelmann (2009) further indicates that at the centre of this spirituality/religion is the quest for experience of the Spirit as 'strength from above' that takes hold of the believer, heals them and enables them to bear a witness that is accompanied by signs, miracles and the driving out of demons. Amongst the Pentecostals, deliverance is the second component of prosperity gospel, hence is called 'Wealth and Health Gospel' (Hampelmann, 2009). As also noted by Mashau (2013), Pentecostals emphasise that God's will and his blessings for all his people is that everyone must be healthy and rich. Thus, believers are coerced to exercise their faith without reservation and are also encouraged to: 'Name-it-Claim-it' (Mashau, 2013).

Across the globe, Pentecostals involve practices such as: salvation, healing, baptism in the Holy Spirit and expectation of the immanent Second Coming of Christ. Literature points out that in Africa, Asia, and South America, where there is richer scope for

inculturation, Pentecostal spirituality is spreading much more vigorously than in modern industrialised societies (Hampelmann, 2009). While some evangelical reformed churches are experiencing a nosedive in terms of church growth, Mashau (2013) indicates that new Pentecostal churches are planted and growing in numbers daily in the same context. The Centre for Development Enterprise (CDE, 2008) indicates that the growth of the Pentecostals is attributed a highly marketable message and an extremely slick marketing method they have.

2.4.4 *Pentecostal theology and doctrine*

Hampelmann (2009) mentions that, as a Christian movement or sect, the faith of the Pentecostalists is strongly Biblicist, and in many of its manifestations also fundamentalist; being based, as it is, on the infallibility of Holy Scriptures and the Pentecostalists' direct identification of their own faith practice with the example set by the first Christians. In many Pentecostal writings, faith is a necessary component to receiving healing (Hardwick, 2013) and Pentecostals are known to expect God to deliver them miraculously and instantaneously from their suffering; through this expectation, suffering becomes an implicit opportunity for the glory of God to be displayed through immediate deliverance (Engelbert, 2017).

2.4.5 *Pentecostal beliefs regarding healing*

Besides the Pentecostal believers' varying explanations of causes of mental illnesses or what mental illness is, Pentecostals seem to vary on their views regarding healing. To emphasise this, Hardwick (2013) discovered that amongst the Pentecostals, there has been a variety of reasons given as to why healing does not occur. Firstly, as recorded by Hardwick (2013) some Pentecostals cite personal sin, insufficient faith, or demonic influences as reasons; while others assert that the believer who prays for the individual could be an obstacle to healing. Secondly, in other instances, some Pentecostals assert that it could simply be God's sovereign will to not heal the individual for the betterment of the sufferer as a part of discipline or to glorify God and reflect his character. This is in concert with what is recorded in John Chapter 9 verse 1-3, whereby a man had been born blind. In the scripture, Jesus' disciples asked Jesus why the man had been born blind. In response, Jesus uttered, "Neither has this man sinned nor his parents: but that the works of God should be made manifest in him" (See, John 9:1-3, KJV).

Hardwick (2013) noted that most Pentecostals acknowledge that God is still with those he does not choose to heal and is concerned about their eternal destiny, not just their physical well-being. In agreement, Engelbert (2017) states that Pentecostals can say, suffering is not devoid of God's presence. Engelbert (2017) further alludes that while being in the presence of God, whether it is while being alone or while being in the presence of others, the Pentecostal on the path of suffering also makes meaning. As such, when the desired divine instantaneous deliverance fails to occur, a Pentecostal's worldview is disrupted, and it is necessary to integrate unmet hopes and expectations into a new framework (Engelbert, 2017). As a result, Pentecostals represent the greatest challenge to engagement with health services; perhaps paradoxically so because of their zeal for partnership with psychiatry (Leavey, 2008). According to Leavey (2008), Pentecostal pastors vigorously pursue supernatural explanations for disease within a dualistic theological framework whereby only goodness can emanate from God and all that is malevolent is, therefore, demonic. Moreover, Pentecostal teachings stress the frailty of humankind; unempowered by faith in the Holy Spirit, the flesh is selfish and weak (Leavey, 2010).

2.4.6 *Transformation within the Pentecostal movement*

There seem to be transformation or a revolution within the Pentecostal church. For example, Williams (2008) observed some significant changes within the Pentecostal healing movement over years. However, Williams (2008) states that though there have been drastic changes over the course of the twentieth century, God has remained intimately tied to the healing process. According to Williams (2008), deep antagonism characterised Pentecostals' relationship with orthodox physicians in the early 1900s. Williams (2008) also noted that Pentecostals' attitudes towards healing and towards the medical establishment grew out of the divine healing movement among late-nineteenth-century evangelicals, most of whom identified with the nineteenth-century Wesleyan holiness and Reformed Higher Life movements. As a result of its naturalistic explanations, previously many Pentecostals saw psychology as an inherently atheistic discipline that denied humanity's need for divine assistance (Williams, 2008).

Likewise, Hardwick (2013) observed that some Pentecostals ignored or rejected medical advice as a sign of their faith. Conversely, authors like Roux (2019) have observed that as new generations are converted to the Pentecostal faith and as the Pentecostal ministry is passed down from one generation to the next, some of the uniqueness of the Pentecostal heritage is retained, and some is lost. In agreement, Williams (2008) observed that the willingness of Pentecostals and charismatics in the latter decades of the twentieth century to utilise natural healing methods represents a sharp break from early Pentecostal teachings.

Williams (2008) indicates that back in the days, most Pentecostals associated psychology with moral relativism. Moreover, Williams (2008) states that they saw psychology as undermining the social fabric maintaining unity and order within society by explaining away behaviours that Pentecostals categorised as sins. Specifically, as early Pentecostal believers distrusted anything that seemed to diminish God's active intervention in their lives or that seems to deny the need for individuals to place their physical wellbeing in God's hands (Hardwick, 2013). However, today, it appears that Pentecostals tend to not contrast medical healing and divine healing and do not view medical treatment negatively. They now recognise that medicine and the skills of medical professionals are ultimately part of God's healing (Hardwick, 2013). This contrasts with Early Pentecostal asserted that the Spirit of God showered a wide array of spiritual gifts on the saints, including the ability to prophesy regarding the future, to supernaturally know things they had no reason to know, and to watch illness retreat as they prayed (Williams, 2008). On the one hand, Williams (2008) also noted that advocates of holistic healing who stressed the religious/spiritual dimensions of health proved natural allies for Pentecostals and their charismatic successors, and the language of holism provided a context in which many healers in the movement retained their resistance to naturalism while still adapting to modern healing methodologies.

2.4.7 *Pentecostalism in Africa*

Before, delving deeper in describing Pentecostalism in an African context, it is important to note that African Christianity is complex in history, structure, doctrines, and practices (Mashau, 2013). According to Wariboko (2017), there are, principally,

three recognisable types of movements or churches that fall under the rubric of Pentecostalism in Africa. Specifically, Wariboko (2017) indicates that firstly, there are spirit-empowered movements, which arose either independently or out of Western mission churches, which are generally known as African- independent churches (AIC). Furthermore, the second set comprises churches that were established on the continent by Western Pentecostal denominations (such as the Assemblies of God, Four Square Gospel Church, and the Apostolic Church), known as classical Pentecostal churches (Wariboko, 2017). Finally, there are neo-Pentecostal or charismatic churches (Wariboko, 2017). As observed by Ukah (2007) there are three distinct strands may be identified although some of these overlap at significant points. For the present study only the Classical/Mission Pentecostal Churches and neo-Pentecostal churches are further discussed.

Wariboko (2017) states that African Pentecostals, like the rest of African Christians, have appropriated the gospel; adapted the faith to their cultural sensibilities, concerns, and agendas; nudged its worldview to properly align with their indigenous maps of the universe; and contextualised its practices. Wariboko (2017) further mentions that Pentecostals in Africa are reading, interpreting, and understanding the scriptures in their own cultural contexts and engendering domesticated theologies. Thus, Pentecostalism has proven to be better at inserting itself into the culture, worldview, and sensibilities of Africans (Wariboko, 2017). Moreover, Wariboko (2017) indicates that Pentecostalism has become the religious/spiritual and cultural switching node and heart of African Christianity. Thus, the doctrine and beliefs of Pentecostalism as a whole, fit well with the beliefs of most African people.

2.4.8 *The growth of Pentecostalism in Africa*

Pentecostalism represents the fast-expanding sector of Christianity in Africa (Ukah, 2007). The rapid growth of Pentecostalism in Africa can be attributed to the movement's core message (Wariboko, 2017). According to Wariboko (2017), the Pentecostal message is principally about spiritual empowerment, or access to divine power to meet human needs amid daily struggles of power. Thus, Pentecostalism is the most complex and socially visible strand of religion in Africa, not only because it is still evolving and changing rapidly, but the proliferation of division and innovation is dizzying (Ukah, 2007). As noted by Mashau (2013), the rapid growth of Pentecostalism

in Africa is attributed to the following: (a) emphasis on the 'flexibility of the spirit', which enables to transplant itself easily onto any cultural context; (b) emphasis on the working of the Holy Spirit, especially the power to provide deliverance not only from sin, but also from demonic attacks, demon possession and poverty through healing and prosperity promises; and (c) spontaneity and communal participation in worship.

Mashau (2013) also noted that the Pentecostal message and their prominent features are the most relevant message for a poverty-stricken continent, which at the same time faces malnutrition, malaria, HIV and AIDS pandemic. Ukah (2007) also posits that Pentecostalism in Africa emerged through many pathways, and perhaps, it may be proper once more to use the plural, Pentecostalisms, to denote the many, sometimes mutually exclusive, strands (Ukah, 2007). As observed by Mashau (2013), Pentecostalism offered a way to fulfil Africans' needs for healing, protection from evil spirits, and restoration for the weak. Specifically, Mashau (2013) noted that many thousands of African preachers from the Pentecostal circle emphasise the manifestation of divine power through healing, prophecy, speaking in tongues and other Pentecostal phenomenon. Thus, exorcism and protection form evil are the most prominent features of the Pentecostal gospel as well as being the most important of their evangelism and church recruitment tactics in Africa (Mashau, 2013).

2.4.9 *Pentecostalism in South Africa*

In South Africa, Pentecostalism was brought by pioneers like John G. Lake in 1908 (Molobi, 2014). Kgatle (2017) notes that despite its largest influence and growth in South Africa, this group of Christians has been studied by a few researchers. As recorded by the (CDE, 2018), South African Pentecostal churches are strongly influenced by global Pentecostalism, with particularly dominant strands coming from the United States, and from Latin America, especially Brazil, as well as West Africa, especially Nigeria.

2.4.10 *The influence of Pentecostalism in South Africa*

The Pentecostal message is popular, especially in South Africa because it is spiritual (Mashau, 2013). It emphasizes the role of divine healing, particularly exorcism, and the receiving of the power of the Holy Spirit, which seem to offer help to all of life's problems and not just the spiritual ones (Mabitsela, 2003). The Pentecostal Churches

have as their key focus the workings of the Holy Spirit as a powerful force among believers (CDE, 2008). Interestingly as stated earlier, Pentecostals in South Africa have some features that are unique to Africa, namely, a degree of cross-fertilisation between Pentecostals and the African Independent Churches in the Black township settings (CDE, 2008). Like Pentecostals throughout the world, Black Pentecostals in South Africa, are noted for being exuberant, enthusiastic, and experience-dominated Christianity. In addition, because of their appealing messages and activities, Pentecostal churches have managed to attract many young people from mainline/mainstream churches (Mashau, 2013), a trend that is still happening currently.

Some people in general and some Christian sects, see Pentecostal churches either as shallow, as emotively irresponsible or as a rather weird phenomenon-mass congregations of suggestible 'happy clappers' pursuing Salvation through hysterical outbursts of disconnected spiritual passion while dreaming of prosperity (CDE, 2008). In South Africa, it seems like there is still antagonism between Pentecostal Christians and the medical professionals. The reluctance to work together could be perhaps based on the Pentecostal pastors' attributions of mental illness (Williams, 2008). Besides, in an African context the rivalry could be exacerbated by the fact that in Africa Pentecostalism is also practiced alongside traditional African beliefs which have been for quite a long time, "demonised" (Ukah, 2007). As such, this researcher hoped that there could be an initiation of a constructive dialogue between Pentecostal pastors and MHCPs in view of delivering service to their congregants.

2.4.11 *Classical/Mission Pentecostal churches*

Scholars use the term "Classical Pentecostals" to distinguish them from "Neo-Pentecostals" who were Mainline Protestants or Catholics practicing a variant of Pentecostalism in their respective denominations (Kentie, 2015). In the beginning of the early twentieth century, the Classical Pentecostalism burst out in the Azusa Street in which led to a large series of missionaries and church planting (Lawance, 2001) Classical/mission Pentecostals are direct descendants of the 'first wave' of the Pentecostal revival in the early part of the last century (CDE, 2008; Mashau, 2013).

According to CDE (2008), Classical Pentecostal churches have formalised their liturgy and have established rituals. In other words, they are more denominational and have a notable structure of leadership and governance as compared to Neo/Independent Pentecostal churches. Three of the largest Classical Pentecostal churches as mentioned previously are the Apostolic Faith Mission (AFM) established through the direct missionary activities of Azusa Street missionaries, the South African Assemblies of God (AOG) and, the Full Gospel Church of God (FGC) (Wariboko, 2017). While classical Pentecostal churches in Africa are not North American impositions on Africans, they clearly are products of North American experiences and missionary impulse (Ukah, 2007). Important to note however is that classical Pentecostal churches and neo-Pentecostal categories of Pentecostalism share the basic doctrines, beliefs, and practices (Kentie, 2015). Although "speaking in tongues" (glossolalia) is practised by both categories of churches (Classical and Neo-Pentecostalism), it is many churches in the Neo-Pentecostal category insist on "speaking in tongues" as the "initial evidence" of having received the Holy Spirit, though this insistence is by no means universal (Thompson, 2013).

Classical Pentecostalism teaches that the initial evidence of Spirit baptism is speaking in tongues and that a person who has been baptised by the Holy Spirit is also endowed with spiritual gifts (charismata) (Mashau, 2013). Similarly, Alves (2017) asserts that Classical Pentecostals stress the role of speaking in tongues, considering a gift, or the baptism of the Holy Spirit. Likewise, Lawance (2001, p.16) mentions that "the most peculiar and unique characteristic in the Classical Pentecostalism is glossolalia, an expression of the experience of the Spirit in large groups of church participants." According to Lawance (2001), the Classical Pentecostal mission is argued as three-fold empowerment: transcending race and class, transforming Christianity and de-traditionalising institution, because its focus is on the empowerment of Black people by the outpouring of the Spirit beyond race and class as well as the enculturation of African customs. Classical/mission Pentecostal churches originated from missions or contacts with the emerging Pentecostalism and they have achieved autonomy or acquired a distinctively local character (Alves, 2017). Thus, although they are independent, many classical/missions Pentecostal churches maintain their relationship or linkage to international networks of Pentecostalism (Alves, 2017). It appears that, besides issues of leadership structure and governance, as well as being

led by much elderly pastors, classical/mission Pentecostals do not differ that much from Neo-Pentecostals.

2.4.12 *The Neo-Pentecostals/ New-Pentecostals*

Literature in the field of Pentecostalism indicates that the third category of the Pentecostal or Pentecostalism is known as "The New Charismatics/Neo-Pentecostal or even Neo-prophetic Pentecostals. According to CDE (2008), the New Charismatics/Neo-Pentecostals refer to those churches that emerged from the charismatic renewal of the sixties and seventies. As much as divine healing is proclaimed and administered within Classical Pentecostalism and the charismatic movement, it is the third wave (New charismatics/Neo- Pentecostals) where healing and prosperity are highly popularised (Mashau, 2013). In South Africa, Neo-Pentecostal churches refer to churches that have crossed denominational boundaries (Kgatle, 2017). The leadership and membership in these churches tends to be young, charismatic and relatively well educated though not necessarily in theology (Mabitsela, 2003). The New Charismatics are concerned with the immediacy of what God is saying to them and their followers tend to be concentrated in the emerging and aspirant lower middle classes (older, long-established middle classes tend to be in mainstream denominations) (CDE, 2008).

In comparison with the Classical Pentecostals, the New Charismatics/Neo-Pentecostals are highly geared for growth and expansion in terms of their message, structures, and organisation (CDE, 2008). At the core of their leadership is a team modelled on the 'five-fold ministry', as set out by Paul in Ephesians 4: the apostle, prophet, evangelist, pastor, and teacher (CDE, 2008). According to (CDE, 2008), the 'apostolic team' is a highly mobile, trans-local instrument that works nationally and internationally to evangelise, plant churches, ordain elders, and give teaching and direction. Furthermore, the new Pentecostals espouse specific doctrines that mark them out among other groups of Christians (CDE, 2008). They believe they constitute a special people of God who alone are saved, and the rest of humanity is doom to perdition. Theologically, a person is saved who is "born again" and is regenerated or sanctified by an inward feeling of holiness. Sanctification purifies a believer from sin and all forms of pollution (Ukah, 2007).

2.4.13 *Healing in Neo/New Pentecostal Churches*

The story of healing in the movement also adds new insight into the complex relationship between Pentecostals and their charismatic successors (Williams, 2008). Ukah (2007) alludes that there are certain important social characteristics of the new churches espousing the theology of prosperity and abundance. One of the important features of these churches is the emphasis on faith healing (Ukah, 2007). The pastors of these new churches believe that they have been endowed by God to bring physical healing to their followers as a proof of the validity of their preaching (Ukah, 2007). As noted by Ukah (2007), one of the prominent Neo-Pentecostal churches Christ Embassy, for example, claims to heal all diseases, including economic and financial failures that are interpreted as forms of "barrenness". As such, the church opened a large 'Healing School' at Randburg, near Johannesburg, where people from all over the world experiencing ill-health throng for healing. Generally, Pentecostals have a strong belief in divine healing (Roux, 2019). Jesus – the Healer - is one of the components of the Fivefold Gospel. As noted by Roux (2019), Pentecostals believe that healing was a central aspect of Jesus' ministry and is a common theme in the Bible. Specifically, Jesus' healing methods were not limited to the physical, but were holistic; in that he connected the cause of disease to the roots of a person's whole being (Roux, 2019).

2.5 Pentecostal pastors' perception of mental illnesses

Mental illness is perceived differently amongst various cultures and religions. Moreover, it seems challenging and difficult to understand or explain what mental illness is for pastors and MHCPs alike. Specifically, the cultural context within which mental illness occurs renders it more complex to comprehend. This is illustrated by Okasha and Okasha (2012) who state that the concept of mental illness differs in various cultures from possession of evil spirits, magic, evil eye, wrath of ancestors, lack of faith, other mystical beliefs, etc., to biological causes. In agreement, Waldron (2010) states that conceptualisations of illness, disease, symptom presentation and treatment/healing that are shaped by various social, cultural, ethnic, economic, and political variables within individual societies are interpreted, assessed, diagnosed and treated in unique ways in different cultures. Likewise, Sodi and Bojowuye (2011) also

assert that culture influences conceptualisations about illness, health and healthcare. Thus, it can be said that perceptions of mental illness held by the community influence the type of treatment subsequently sought, with the choice of treatment often being traditional and religion/spirituality healing (Sehoana & Laher, 2015). As such, Pentecostal Christians' religious/spiritual views may directly conflict with seeking services from a MHP (Gaffeney, 2016).

2.6 The influence of theological and cultural beliefs on the perception of mental Illness

Religious/Spiritual beliefs are often applied to perceptions of mental illness and evil spirits and witchcraft viewed as causes of mental illness and prayer is an acceptable method of treatment of mental illness (Bartlett, 2017). More often, pastors and other religious/spiritual leaders' conceptualisation of mental illness bear a religious/spiritual element and are influenced by their theological beliefs. As an example, Roux (2019, p.131) states that:

> Pentecostal theology differs from the mainstream theology of the West (and long-term theological traditions, i.e. Reformed, Baptist, Methodist, etc.), in that it is pragmatic, oral, narrative oriented affective-experiential, and makes use of a particular epistemology that is open to other ways of knowing, such as imagination, experience, affective, emotional, physical, relational, and spiritual ways, rather than intellectual or rational ways. Such theological beliefs may even exist as part of their culture.

In agreement, Jackson (2017) indicates that the Pentecostal lens is unique in how mental health challenges are conceptualized. Black Pentecostal pastors, for example, do perceive mental health in a negative capacity, in addition to perceiving mental health issues as a religious/spiritual matter.

Theological beliefs have a significant impact on how pastors perceive mental illnesses and their treatment. The theological beliefs that Pentecostal Christians hold in general, may cause them to underutilise mental health services (Uwannah, 2015). In South

Africa and other African countries, it is evident from existing literature that in an African context, the practise of Pentecostalism as a Christian movement is somehow influenced by African cultural beliefs (Ukah, 2007). Thus, besides their theological beliefs which are biblically rooted, as Africans, the African cosmology, epistemology, and context they exist in have an impact on African Pentecostal pastors' EMs of mental illness. For example, a study undertaken by Kamanga et al (2019) in Mzuzu, Malawi, found that all the participants' cultural background had a strong influence regarding the understanding of what causes mental illness. All the groups had a similar perception as regards to causes of mental illness and its management. Mental illness was understood to be emanating from a violation of cultural beliefs, norms or rules (Kamanga et al., 2019). Thus, the affected was perceived to be punished by a supernatural being as a result.

Kamanga et al (2019)'s study consisted of Pentecostal pastors and traditional leaders. In the study by Kamanga et al (2019), most pastors and traditional leaders in that research contended that mental illness had a supernatural cause and that patients can be healed through faith healing prayers and traditional medicine. Essentially, significant findings recorded by many previous researchers amongst Pentecostal pastors in Black or African communities was that mental illness is less spoken of and is usually perceived or referred to as madness (E.g., Kpobi & Swartz, 2018a). Thus, amongst many African cultures there seem to be no uniform concept specifically relating to what mental illness is except to refer to it as, "madness/craziness" and spiritually inclined methods are usually employed for healing.

2.7 Mental Illness is a multifactorial phenomenon

Pentecostal pastors hold a multi-factorial perception of mental illness which is dominated by religious/spiritual factors (Murambidzi, 2016). There is no single view of mental illness though all Pentecostal pastors seem to use a spiritual framework or world view to explain and understand mental illness (Leavey, 2008). In support, Leavey (2010) indicates that there is no definitive or singular clergy (pastoral) view on the origins of mental illness (Leavey, 2010). Pastors hold different views of what exactly mental illness is. However, what is clear as observed by Leavey (2010) and other researchers are that the clergy (pastors) decreasingly inhabit worlds or maintain

worldviews devoid of secular content. Thus, their EM of mental illness contains a religious/spiritual element (Mabitsela, 2003).

In addition, it appears that it is difficult for Pentecostal pastors to distinguish between mental illness and spirit/demon possession (Grossklaus, 2015). Thus, there seem to be no uniformity regarding how Pentecostal pastors describe and define what mental illness is. It is explained in a multifactorial manner, though the dominant factor is a spiritual explanation. Studies conducted by Asamoah et al (2014); Kamanga et al 2019; Kpobi and Swartz (2018a); Mabitsela (2003); Leavey (2010) and Payne and Hays (2016) have all provided evidence indicating that Pentecostal pastors hold a multi-dimensional perception of mental illness.

To illustrate the above, Kamanga et al (2019) explored the concept of mental health among pastors and possible collaboration with MHCPs. In that study, Pentecostal pastors unanimously agreed that the causes of mental illness were of a biological/physical, psychological, sociocultural/spiritual, and biopsychosocial inclination. Likewise, Kruger (2012) discovered amongst Afrikaans speaking church leaders (pastors) in Polokwane that there is a paradigm shift, whereby the interviewed pastors seemed to be moving from a single dimensional view of mental illness to incorporating an individual's emotional or behavioural world. Participants in Kruger's (2012) study which investigated the treatment of mental illness concluded that, mental illness resulted when there is a disturbance in a person's emotional and spiritual components. Thus, mental illness was not viewed from a single dimension as was the trend previously amongst pastors. The pastors who took part in Kruger's (2012) study held a holistic view of a human being and what they explained to be mental illness. Furthermore, the participants perceived mental illness to be a complex and vastly occurring phenomenon affecting a person's whole being, the religious/ spiritual.

Kruger's (2012) findings were replicated by other researchers. For example, Payne and Hays (2016) discovered that the attitudes and perceptions the clergy (pastors) held toward mental illness fell along a continuum or spectrum of belief, with views that ranged from strictly spiritual in nature to those that incorporated medical and psychological perspectives. To be specific, Payne and Hays' (2016) study results demonstrated diverse opinions regarding the etiologic factors of mental illness and

available response options to those suffering from mental problems. Likewise, Mabitsela (2003) found in her study that Pentecostal pastors believed that a human being is believed to function as a system with interconnected spiritual, physical, and psychological subsystems. Thus, the participants in Mabitsela's (2003) study described psychological distress (mental illness) as a negative experience affecting the whole being, including religious/spiritual, physical and psychological areas.

Moreover, Mabitsela's (2003) study revealed that among Pentecostal pastors, psychological distress (mental illness) is understood to impair a person's ability to function effectively as behaviour; communication and moods are negatively affected and this was noticed through a person's interaction in social relationships. Thus, mental illness was described and defined beyond a single dimension but within a multi-dimensional context.

Regarding the conceptualisation of mental illness by the clergy (pastors) in Harare, Zimbabwe, Murambidzi's (2016) study also highlighted that mental illness is broadly perceived to be, "a multi-factorial phenomenon attributed to both supernatural and natural causes". In Murambidzi's (2016) study the most common supernatural representation of mental illness was the influence of malevolent spirits while psychosocial and biological representations dominated the natural representations of mental illness. It also appeared from Murambidzi's (2016) study that there is a common tendency to spiritualise mental illness by the clergy (pastors) as they described their clients' presentations and their subsequent response. This is not surprising. Other studies have also found that most Pentecostal pastors uphold a multi-factorial explanation of mental illness which is mainly dominated by the spiritual previously. For example, Harris' (2018) study established that pastors held a holistic understanding of mental health and illness by describing the combination of emotional, spiritual, mental, and physical health as influencing one's mental state. Furthermore, in a study conducted by Sullivan and his colleagues in 2013, it emerged that the clergy's (pastors') views of mental illness could take several approaches, for example, 1) religious/spiritual problem, religious/spiritual solution; 2) mental problem, religious/spiritual solution; and 3) mental illness, religious/spiritual and mental solution.

2.8 Mental illness is a religious/spiritual illness

One of the most common beliefs that Pentecostal pastors across countries and cultures have of mental illness is that mental illness is a religious/spiritual phenomenon. For example, Hardwick (2013) noted that Pentecostal Christians' complex view of mental health disorders entails a dimension often left unconsidered by the public, as well as other Christian faith traditions, namely: the spiritual. In agreement, Uwannah (2015) found that Pentecostal Christians perceive mental health problems to be religious/spiritual problems which cause them to underutilise mental health services. Almanza (2017) also established that amongst Pentecostal pastors, there exist some extreme tendencies such as maintaining that mental health patients should not seek clinical treatment but rather wage religious/spiritual battle. In concert, White (2016) reports that African American clergy (pastors) and the Black church rely more on faith and prayer as the main source for addressing mental health issues. Similarly, in his study, Asamoah (2016) noted that Pentecostal/Charismatics lean more towards a diabolical conceptualisation and Explanatory Model of mental illness than biomedical or psychosocial perspectives (Asamoah, 2016).

According to Asamoah (2016), Pentecostals' theological ontology and epistemology posit that, mental disorders are fruits of a curse driven by diabolical manipulations of the non-material component of humankind by a malign and wicked disembodied personality (demons). Similarly, Gaffeney (2016) also observed that generally, amongst the Pentecostals, there is a deep theologically based belief that mental illness is traceable to supernatural causes, most notably demonic (negative/evil spirit) possession. When exploring dominant understandings of the causes of mental disorders in their study, Ae-Ngibise et al (2010) discovered that there was a great deal of consensus among the participants that mental illness in the general community tends to be understood as a 'religious/spiritual illness' and attributed to 'juju', 'supernatural powers' and 'evil spirits'.

Such views were also recorded by Jackson (2017) who established that Pentecostal pastors view mental illness to be caused by divine supernatural sources which are beyond human's comprehension. Jackson's (2017) study was aimed at understanding

the perceptions of Black Pentecostal pastors towards mental health and collaborating with mental health counsellors. Specifically, the study Jackson (2017) indicated that pastors seemed to mention the term demonic, demon possession, or key Biblical moments where mental instability occurred, and religious/spiritual relief or deliverance was needed. Likewise, in their study Leavey et al (2016) observed that Pentecostal pastors view mental illness as a method by which demonic (negative/evil) spirits can possess an individual because of living a sinful life characterised by alcohol or drugs.

Harris (2018) noted that pastors who endorse the religious/spiritual problem, religious/spiritual solution were sceptical about the existence of mental illness. They view both mental and emotional problems primarily as religious/spiritual concerns. In South Africa, for example, a study by Mabitsela (2003), revealed that although Pentecostal pastors' definitions of psychological distress shared common features with several of Diagnostic Statistical Manual-Fourth Version (DSM-IV) diagnoses, they did not see psychological distress as an illness requiring medical treatment but religious/spiritual intervention. Mabitsela's (2003) study established that the Pentecostal pastors' explanations of psychological distress (mental illness) were based on their religious/spiritual worldview. Mabitsela (2003) thus argued that a worldview gives reason to the confusion in differentiating psychological distress and spiritual problems that Pentecostal pastors seem to experience. According to Mabitsela (2003), this seems to be largely due to the blurred dividing line between religious/spiritual problems and psychological problems. Moreover, Mabitsela (2003) indicates that the dividing line between religious/spiritual and psychological problems is further blurred by the belief held by Pentecostal pastors that psychological problems have their basis in the existence of underlying religious/spiritual problems. Thus, what may be called a 'psychological distress' is sometimes perceived as a religious/spiritual problem from the Pentecostal Christian frame of reference as noted by Mabitsela (2003).

2.9 Mental Illness is demon possession

Pentecostal pastors perceive mental health and illness as existed for years, beginning in biblical times, which manifested itself in the form of demon possession (Jackson,

2017). The beliefs in demonic possession and other supernatural causes of mental illness which are contentious among secular medical practitioners remain prevalent in many ethno-religious communities (Leavey, 2010). As noted by Asamoah (2016), Pentecostal/Charismatic cosmology conceives that a sufferer from mental illness must be possessed or influenced by demons and should be treated by the expulsion of those demons for the victim to be free. Specifically, amongst the Pentecostal pastors, any form of illness is attached to issues of demonic attacks (Mashau, 2013) and the demons seem to attack individuals differently. For instance, those who are not born again, are believed to be possessed by demons which cause them to do evil things or suffer from mental illness while those who are born again are believed to be demon oppressed than demon possessed. According to Gaffeney (2016), a sufferer from demons may refer to the one who's suffering in whatever form-recurrent divorce, persistent unemployment, and failure in business, poverty, incurable diseases, frequent indulgence in sexual immorality, medically incurable mental illness etc. are perceived to be tied to demonic manipulation and control. Thus, demon possession is perceived as mental illness or as a source of mental illness.

In psychology and psychiatry, all the above may be viewed as a symptom or symptoms of an existing mental illness, most likely of a personality disorder. Specifically, as noted by Grossklaus (2015, p.119), to a Western psychologist, the symptoms of spirit/demon possession may point to a specific mental illness, while in many other societies these symptoms are taken as evidence of the influence of some spiritual entity. Thus, someone may have a diagnosable personality disorder that would probably affect their cognition, interpersonal and occupational functioning, their emotional expression, and behaviour leading to the above-mentioned symptoms. As observed by Leavey et al (2016), amongst evangelical and Pentecostal pastors, the use of alcohol and drugs suggests that either a demonic force has gripped a person, or that addiction may lead to vulnerability to demonic attack. Thus, Grossklaus (2015, p.126) remarks that, amongst pastors, there seems to be a leaning more towards Biblical interpretations rather than a focus on the actual, biological, psychological, and social conditions that may give rise to the symptoms presented by a patient who will then be diagnosed as being possessed by a spirit (demons).

In concert, Asamoah (2016) alludes that amongst Pentecostal pastors, it is normally believed that sinful behaviour or a breach of a spiritual order paves the way for the demons to harass the victim. As a result, the victim comes under a curse and the condition that the person suffers from is a fruit of the curse and the demon polices that curse by afflicting and tormenting the person (Asamoah, 2016). The entry to an individual by demons or spirits may be facilitated through mental and physical illness, demonic category, and manner of transmission usually undifferentiated (Leavey, 2010). According to Leavey (2010), Pentecostal pastors itemise demons of lies, hatred, lust, greed, homosexuality, schizophrenia, and depression and split personality and so on. Thus, there are specific demons responsible for specific conditions and behaviours.

Taking the above findings into account, it seems uneasy for pastors to distinguish between demon or spirit possession and mental illness (Grossklaus, 2015). Grossklaus (2015, p.119) states that, "the distinction between mental illness and spirit possession in the literature has not been clearly delineated, given that the symptoms of the two experiences are so similar." Therefore, this may be detrimental to the mental health of congregants who might have been genetically predisposed to a mental illness. Thus, in lieu of seeking psychotherapy or psychotropic drug intervention, only deliverance may be employed (Uwannah, 2015). On the one hand, it is possible that Pentecostal pastors may ignore or pay less attention to other crucial aspects of their clients, or they may hesitate to refer to secular professionals (Harris, 2018). Equally so, MHCPs may miss the diagnosis of "spirit" possession since they are also not knowledgeable or trained in that area (Grossklaus, 2015). This may then suggest the need for an exchange or sharing of knowledge between the two professions for efficient treatment, care, and management of their clients (Greyvenstein, 2018).

2.10 Mental illness is madness/craziness

Literature reveals that Pentecostal pastors believe that mental illness is madness/craziness. Specifically, in African countries like Ghana, mental illness is perceived to be madness, symbolising that Pentecostal pastors' conceptualisation of

mental illness is limited to psychotic disorders (Kpobi & Swartz, 2018a). Kpobi and Swartz (2018a) further mention that other forms of mental illness such as depression and anxiety are not regarded as mental illness but have the potential to become mental illness if not managed. However, the pastors' description and explanation of what madness is, mimic the symptoms of what MHCPs would define or describe as psychosis.

In the study by Kpobi and Swartz (2018a) which explored the beliefs of charismatic/neo-Pentecostal faith healers (pastors) about mental disorders and the treatments that they employed to treat such disorders, all the participants agreed that the behaviours displayed by people with mental disorders suggest a malfunction in their brains and used the term 'madness' to describe what they considered as mental illness. In other words, the Pentecostal pastors viewed people with mental illness as those who are mad. Kpobi and Swartz (2018a) specifically observed that the pastors' explanations for what constituted mental illness pertained to descriptions of psychotic behaviour (Kpobi & Swartz, 2018a). Thus, the pastors' perception of mental illness was limited only to psychotic disorders or behaviours.

According to Kpobi and Swartz (2018a), Pentecostal pastors also perceived that those mental disorders resulted in what they considered strange behaviours. Kpobi and Swartz (2018a) observed that other mental illnesses such as personality disorders, depression, and anxiety were viewed as mental illnesses of lesser severity or not at all. Similarly, Uwannah (2015) discovered that pastors viewed mental health conditions as a spectrum of disorders ranging from less severe conditions such as depression to more severe conditions such as schizophrenia.

Mental disorders such as anxiety and depression are viewed differently from psychotic disorders by Pentecostal pastors (Kpobi & Swartz, 2018a). Based on the above findings, it could be said that Pentecostal pastors have their own way of classifying or categorising mental illness based on its symptom presentation or level of severity just like MHCPs rely on tools such as the DSM and ICD codes for such. For the present study, understanding how Pentecostal pastors describe or define and/or categorise mental illness will aid the development of an understanding between psychological definitions of mental illness and demon (spirit) possession from the pastors'

perspectives (Grossklaus, 2015). And as stated before, psychological guidelines for the diagnosis of mental disorders, such as ICD and DSM, are unknown in theology and thus better information would also help pastors (Grossklaus, 2015).

2.11 Mental illness is a psychological problem

Mental illness is also described as a psychological problem by Pentecostal pastors. For example, a study carried out by Mabitsela in 2003 which explored Pentecostal pastors' perception of psychological distress (mental illness), it emerged that pastors share common views about psychological distress with the medical, interpersonal, and cognitive schools of thought. Furthermore, the pastors interviewed by Mabitsela (2003) regarded psychological distress (mental illness) as impairment in the social and occupational life spheres. However, it should be noted that, although the pastors' perception of psychological distress (mental illness) was like Western ways, the pastors indicated that psychological distress is an illness requiring religious/spiritual intervention. The results of Mabitsela (2003) were replicated elsewhere. For example, Sullivan et al (2013) found that some clergy (pastors) view mental illness as a psychological problem but requiring a religious/spiritual solution and they defined psychological distress as a disturbance that occurs due to stressors, and affect the behaviour, mood, cognitive functioning, and religious/spiritual wellbeing.

2.12 Pentecostal pastors' knowledge of mental illness

Mental illness is a topic that is often neglected and shunned in the Black American community (Wilkins, 2019). Wilkins (2019) indicates that a review of the literature on mental illness yielded several potential reasons why communication about mental illness appears to be absent within the Black American community. The main contributors are stigma, lack of knowledge, mistrust, and preference for nonmedical coping mechanisms (Wilkins, 2019). In other studies, it emerges that Pentecostal pastors preach sermons suggesting that long term depression is a weakness and promote the notion, "Saints don't cry" and are dispassionate about the use of

psychotropic medication and the use of psychiatrists (Payne, 2008). Generally, amongst pastors, mental illness is something that many people do not acknowledge, cope with, or include as part of their overall health (White, 2016). For example, one of the participants in White's (2016, p.82) study had this to say, "African American clergy (pastors) and leadership do not formally address many issues in the church because for generations the Black community has been taught to have faith, pray, and trust God".

The participants taking part in White's (2016) study believed that admitting to the issue of mental health was basically equivalent to admitting to not having faith, not praying enough, and/or not trusting God. Thus, the mental health issue was somewhat exacerbated because the pressure to live up to great faith and religious/spiritual belief superseded the need to be honest and transparent with mental health struggles. Participants from White (2016)'s study shared how African American clergy (pastors) either ignored the issue of mental illness or identified it as a demon or trick of the enemy. As such, amongst Pentecostal pastors, addressing or confronting the issue of mental illness head-on was not the typical approach (White, 2016). Moreover, White (2016)'s study also revealed that pastors who shared their feelings and concerns about addressing mental health concerns with professionally trained individuals faced an uphill battle that often ended with them leaving the church, because they did not subscribe to the archaic practices of the denomination.

Harris (2018) also observed that the clergy members (pastors) acknowledged that both themselves and patient parishioners often deny mental health problems or avoid discussing mental health problems within the church. Moreover, they described the fear of being viewed and judged as less spiritual or weak, and noted that vulnerability is stigmatising (Harris, 2018). From these findings made by Harris (2018) and White (2016) it can thus be said that there could be a high prevalence of undiagnosed cases of mental illness in the church. The reasons could be due to the pastors' lack of knowledge of or training in mental health issues, or fear of stigma or being judged as faithless or religiously/spiritually weak. As such, mental illness may be under diagnosed or be perceived as spirit possession which seems to more acceptable by the church and be dealt with through faith in God and prayer (Grossklaus, 2015). For

psychology, this could be an opportunity to conduct awareness campaigns to churches.

2.13 *Pentecostal pastors' perceptions of what causes mental illnesses*

Research indicates that pastors across denominations generally hold different opinions regarding the causes of mental illness (Leavey, 2008:2010). Pastors' theological beliefs, cultural background, socio-economic status, political context, or geographic location can influence their perceptions of the etiological factors of mental illness (Bartlett, 2017). Bartlett (2017) observed that Pentecostal pastors in Uganda, for example, religious/spiritual beliefs were often applied to perceptions of mental illness where evil spirits and witchcraft are seen as causes of mental illness and prayer is an acceptable method of treatment of mental illness. Payne and Hays (2016) found in their study that Pentecostal pastors hold diverse opinions regarding the etiologic of mental illness and available response options to those suffering from mental problems. Generally, it seems that in the Christian community it is common practise to attribute mental illnesses to supernatural forces such as evil spirits, demons, and curses and sin (Almanza, 2017).

2.13.1 *Mental illness has multiple causes*

Many studies show that Pentecostal pastors attribute mental illnesses to different sources. There is a consensus that there are many factors, both external and internal, that influence mental illness (Harris, 2018) although the spiritual aetiology is dominant. For example, participants who took part in Harris' (2018) study posited a holistic understanding of mental health and illness by describing the combination of emotional, spiritual, mental, and physical health as influencing one's mental state. Similarly, a study conducted by Yendork et al (2019) in Ghana amongst Neo-Prophetic (Pentecostal) churches, the perceived causes of mental illness were related to lifestyle issues, spiritual factors, trauma, biological factors, and multiples causes. Thus, there was no single factor which was perceived as the sole cause of mental illness. Mental illness was viewed as emanating from a plethora of sources. In the study by Yendork et al (2019) one of the major themes that emerged from participants' account was the belief that mental illness is caused by a combination of many factors.

In another study carried out by Stanford and Philpott (2011), Pentecostal pastors reported that biological factors (inherited genes and chemical imbalances in the brain) as most important causes of mental illness and that biomedical therapy was the most effective treatment for it. Interestingly in that study, Stanford and Philpott (2011) found that among evangelical and Pentecostal clergy (pastors), alcohol and drug use suggested that either a demonic force has gripped a person, or that addiction may lead to vulnerability to demonic attack. Generally, Pentecostal pastors tend to believe that mental illness is a method by which demonic spirits can possess the individual, and the gate is often opened by a sinful lifestyle involving alcohol or drug) (Leavey et al., 2016).

2.13.2 Religious/*Spiritual factors of mental illness*

Although there is limited research regarding Pentecostal pastors' beliefs regarding causes of mental illnesses, few emerging studies around Pentecostals and mental illness in Africa have elicited that Pentecostal pastors hold a religious/spiritual worldview which greatly contributes to their understanding of mental illness (Kamanga et al., 2019). Moreover, Pentecostal Christians arguably emphasise the importance of spiritual influences on causal factors and treatment (healing) of both mental and physical issues (Uwannah, 2015). Thus, the Pentecostal pastors' beliefs about causation are predominantly supernatural in nature although they also acknowledge that there are natural causes which can cause mental illness (Murambidzi, 2016). Asamoah et al (2014) also observed that Pentecostal pastors tend to lean more towards a diabolical (negative/evil spiritual) model of mental health and illness than a biomedical perspective. Asamoah et al (2014) conducted their study in Ghana. In that study, though Pentecostal pastors acknowledged other factors as sources of mental illness, the dominant ones were supernatural explanations.

It is evident from the literature that when pastors rely on spiritual explanations as causes of mental illness, they also rely solely on religious/spiritual solutions for healing (Asamoah et al., 2014). Asamoah et al further indicate that the determination of the cause of the problem defined the role the clergy (pastors) can play in the healing process. Thus, if the problem was diagnosed to be non-spiritual, the case might be referred to other secular-based treatments or for professional attention (Asamoah et al., 2014). Similarly, in South Africa Mabitsela (2003)'s study established that

Pentecostal pastors use a more religious/spiritual framework which incorporates spiritual and transcendent beliefs as an important component of their worldview.

Consistent with Mabitsela's (2003)'s findings, Kamanga et al (2019)'s study found that on the religious/spiritual end of the continuum, a person may have mental illness because of possession by evil spirits commonly termed *ziwanda*. The possession by evil spirits is associated with a person who breaks cultural norms and may be affected by evils spirits as a punishment or a curse (Kamanga et al., 2019). The findings by Kamanga et al (2019) are common and in keeping with other researchers' findings in Africa. For example, from Yendork et al (2019)'s study, it appeared that Pentecostal pastors perceive mental illness to result from spiritual causes.

The participants in Yendork et al (2019)'s study perceived that mental illness could be caused by curses, weak spirituality, and evil machinations by the witches, evil spirits, and demons. Pentecostal pastors believe that spiritual factors can cause mental illness through a curse resulting from envy in the workplace while curses were also perceived to emanate from witches in one's family who envied their perceived future success (Yendork et al., 2019). In this context a curse could be placed on an individual which would make him/her become addicted to drugs, and consequently to become 'mad'. In addition to these, curses or karmic punishment could result in mental illness for individuals whose behaviour was judged as immoral (Yendork et al., 2019). The results of Yendork et al (2019)'s study resonated with what Murambidzi (2016 found indicating that pastors attribute mental illness to supernatural influence of either benevolent or malevolent spirits that were believed to exert their influence over the individual. Specifically, the from the malevolent perspective, mental illness is as a a manifestation of evil spirits while from the benevolent perspective it could be as a result of sin or a failed relationship with God. From Murambidzi' (2016)'s study, it also emerged that the clergy (pastors) attribute mental illness to spiritual attacks and possession by some malevolent spirits, 'demons' that 'occupy the person's mind' thus resulting in mental illness. To be more specific, Pentecostal pastors' views of what causes it are dominated by their spiritual beliefs as listed below:

2.13.3 *Demons as causes of mental illness*

Pentecostal pastors attribute mental illness to spiritual attacks and possession by some malevolent spirits, 'demons' that 'occupy the person's mind' thus resulting in mental illness. Likewise, Kamanga et al (2019) found that many pastors contend that mental illness has a supernatural cause hence patients can be healed through faith healing prayers and traditional medicine. This belief in supernatural causes of mental illness or illness in general is very rife amongst Pentecostal pastors globally. For example, Leavey et al (2010) observed in the USA that amongst Pentecostal pastors, there was a deep theologically based belief that mental illness is traceable to supernatural causes as mentioned before, most notably demonic possession (negative/ evil spirit). Grossklaus (2015, p.55) states that: "Demons are subordinate to Satan, for they are his angels" (Ephesians 2:2; and Mark 3:20). They are not harmless. Above all they cause conditions of illness (Luke 13:11-16: the woman had a spirit of infirmity-Satan had bound her, cf Acts 10:38; and 2 Corinthians 12:7); but not all illnesses can be ascribed to demons. Participants taking part in Grossklaus' (2015) study asserted that people who are possessed by demons appeared in the gospels as people whose personality had been blanked out by evil spirits, and those speak through them citing Mark Chapter 5 verse 5 as an example.

Grossklaus (2015, p.89) further mentions that:

> "It is thus assumed that people, including Christians, can be under the influence of demonic powers and that these burdened or possessed people need deliverance. This deliverance ministry normally takes place using commanding prayer and the laying on of hands, often in conjunction with fasting. The statements in the New Testament are referred to and various needs, problems, psychic-social disorders as well as physical illnesses are attributed to demonic powers"

While in the in the Western world, mainstream Christian and Jewish groups generally consider natural factors as primary causal elements in mental illness and mental health interventions, Pentecostal believers on the other hand emphasize the role of the supernatural in causation and healing of mental and physical disorders (Asamoah et al., 2016). Mental illnesses are considered as originating from demonic possession, and effective interventions are thought to require expulsion of the underlying demons

by means of deliverance (exorcism) (Leavey, 2010). Consequently, believing of many of these people to be spiritually afflicted or possessed, Pentecostals have declared a major interest in engagement; possibly with the demonic rather than the patient (Leavey, 2008).

Other studies which were conducted in the UK and USA respectively have also extensively established that Pentecostal pastors claim that while mental illness may have genuine natural causes, psychiatrists are unable to detect the presence of demonic influences (Jackson, 2017; Leavey, 2008:2010). The participants in Leavey (2008)'s study argued that Pentecostal pastors believed that psychiatrists would not be able to detect demonic presence when mental illness has a spiritual origin. Likewise, Asamoah (2016) observed on the Pentecostal/Charismatic platform that mental illnesses, including autism, depression, reactive attachment disorder, bipolar disorders and schizophrenia are etiologically traced to diabolical personalities who indwell their victim's body. Asamoah et al (2014) as well noticed that the demons, disembodied wicked beings, are seen as agents of Satan who can operate in material bodies, and are thus paralleled to the Holy Spirit, which can also enter a body and cause behaviours like speaking in tongues. Thus, illness and misfortune are understood to be a result of evil spirits intruding into a person's spirit and body (Grossklaus, 2015). This view of mental illness by the Pentecostal pastors is in keeping with the African Worldviews and the proposed theory for this study the BPSS model.

2.13.4 *Psycho-social factors of mental illness*
Although religious/spiritual causes dominate Pentecostal pastors' perception of the causes of mental illness, they also acknowledge that mental illness can be caused by psycho-social factors. For example, when exploring Pentecostal perspectives on causes and cures of depression in their study, Trice and Bjorck (2006) found that depression (mental illness) was attributed to natural causes such as difficult life events. Thus, life events happening around an individual psychologically and socially can be detrimental to a person's mental health. Likewise, when examining pastors' attitudes and opinions that the clergy members (pastors) hold toward mental and emotional problems, Payne and Hays (2016) found that what the clergy (pastors) viewed as the causes of disorders such as Post Traumatic Stress Disorder (PTSD) or

depression (mental illness), there were some of the clergy (pastors) who made statements falling on the far end of the religious/spiritual side of the continuum. Specifically, the pastors argued that the cause of PTSD is not demonic oppression. Instead, they felt that PTSD and depression occurred due to a person's life circumstances, handling disappointments or adversities, going through something specifically traumatic, or even due to avoiding issues when they arise and refraining from discussing them.

Although the above previous studies provide insight into understanding Pentecostal pastors' understanding of the causes of mental illness, they cannot be generalised to all mental illnesses. They specifically investigated two categories of mental illness, thus Trauma and Stressor related disorders and Depressive disorders. This might have limited the pastors' understanding of other categories of mental illness. Moreover, most participants in the study by Payne and Hays (2016) were Americans, while only a few were from Africa.

In a study conducted by Kruger (2012), in Polokwane, South Africa, it emerged that the religious/spiritual leaders (pastors) identified organic causes, learned behaviour and traumatic incidents/stressful life events as some of the most likely causes of the onset of a mental illness. Kruger (2012) observed that psychologically, mental illness was perceived to be because of learned behaviour. Some participants also mentioned that mental illness seems to originate from some type of learning obtained from others, mainly from parents. Thus, as explained by the social learning theory, mental illness can result from the observed behaviours of others or through modelling. Kruger (2012)'s study, also established that pastors attributed mental illness to trauma and stressful life events. The participants in Kruger's (2012) study specifically held the view that traumatic experiences and stressful life events do have an impact on the development of mental illnesses.

Similarly, the results of a study conducted by Kamanga et al (2019) indicated that the participants identified the following as psycho-social causes of mental illness: Loss of beloved one or loss of property leading disappointment leading to stress, extreme anger, anxiety, depression, problems in life, life challenges such as loss of relatives or property, conflict between two individuals. In a study that was conducted by

Murambidzi in 2016, pastors also reported the following as psycho-social sources of mental illness, namely: poverty, financial challenges, and stressful life events such as violence, abuse and trauma. The study also revealed that when one is subjected to stressful life experiences, the person may fail to withstand the pressure, then consequently become emotionally overwhelmed and eventually break down (Murambidzi, 2016).

2.13.5 *Biological causes of mental illness*

Previous studies indicate that Pentecostal pastors acknowledge that mental illness has a biological base. For example, in Kruger (2012)'s study, pastors identified organic causes such as biological or medical reasons to be the main cause of mental illnesses. Specifically, in Kruger's (2012) study, most participants mentioned chemical imbalance as the organic cause of mental illness. However, it should be noted that the participants taking part in Kruger (2012)'s study were predominantly Afrikaans speaking from affluent Pentecostal churches. In Kamanga et al (2019)'s study, participants cited inheritance; head injuries; illnesses to the brain (e.g., cerebral Malaria and meningitis); and drug abuse (e.g., chamba, cocaine, LSD, alcohol, etc.). Similarly, a study by Leavey et al (2016), it emerged that pastors attribute mental illness to biomedical factors such as brain chemistry imbalance, brain damage and organic problems related to alcohol and drug use. The biological view of mental illness by Pentecostal pastors is significant especially important because it strays from the original Pentecostal belief that mental illness is caused by religious/spiritual factors alone (Harris, 2018). As such, acknowledging that those who are mentally ill may have chemical imbalances in the brain may increase the likelihood that they will receive and pursue help by MHCPs, as well as accept psychotropic medications that can change the neurochemistry of the brain (Harris, 2018).

Other studies, especially in Africa, have revealed that Pentecostal pastors also acknowledge that the abuse of psycho-active substances emerged as the most common representation of biological factors. For example, Murambidzi (2016) observed that the frequency with which psychoactive substances were mentioned possibly suggested that most participants were either aware of the long-term impact of psychoactive substance abuse or had come across several people who had substance abuse related problems. Similarly, some of the participants who took part

in Kpobi and Sawrtz's (2018c) study stated that Traumatic Brain Injuries resulting from car accidents and substance abuse could also cause such behaviour. Others believed that such conditions could be genetic and running through families (Kpobi & Swartz, 2018c).

Important to note however from these previous studies is that participants believed, despite admissions, that there were instances when spiritual means could be used to orchestrate road traffic accidents which would then result in brain injury (Kpobi & Swartz, 2018c). Although Pentecostal pastors mainly perceive mental illness through a spiritual lens, Pentecostal pastors also perceive mental illness to be caused by biological causes/ forces. Thus, Pentecostal pastors can be said to view the causes of mental illness form a BPSS perspective though the dominant dimension is the religious/spiritual.

2.14 Pentecostals pastors' perceptions on the diagnosis of mental Illness

More often, pastors appear to diagnose mental illness through religious/spiritual means and provide their clients with spiritual explanations and treatments for their predicaments (Ae-Ngibise et al., 2010). In the contrast, Leavey (2010) indicates that the clergy (pastors) are seldom blind to the canopy that religion/spirituality provides to people with emotional or psychological problems. Thus, they are often able to distinguish between genuine religion/spirituality and over-value religion/spirituality, possibly pathological, zeal (Leavey, 2010). However, Murambidzi (2016) discovered that most of the clergy (pastors) in his study had no prior mental health education and training and as such, could not confidently assert that they were able to identify and address the mental health needs of their congregants. Similarly, Pentecostal pastors interviewed by Mabitsela (2003) confessed lack of concrete knowledge of recognizing or dealing with psychological problems. Likewise, in his study Park (2015) established that the clergy (pastors) were not trained in mental health and that additional training and education would be beneficial to assist people with mental health problems. As a result, findings of the study by Park (2015) highlighted the importance of providing mental health training and education to the pastors and increasing collaboration among the pastors and MHCPs to strengthen the referral process.

Jackson (2017) also observed that Pentecostal pastors recognise their limitations, such as lacking knowledge regarding symptomology, aetiology, severe pathology, DSM diagnosing, and effective treatment planning where both meaningful methods and evidence-based practices are used. Thus, Black Pentecostal Pastors were willing to collaborate to not only become educated on mental health, but to have qualified and competent counselling professionals assist with providing adequate mental health care that will enable their parishioners in overcoming the mental health barriers that have them bound (Jackson, 2017). To concur, in a study conducted by Kpobi and Swartz (2018c), it appeared that the mental health literacy of the practitioners was relatively low thus, presenting some concern about misdiagnosis and treatment. In that study, although many of the participants indicated that depression and PTSD were normal reactions to stressors, these conditions presented risks of harmful behaviour such as suicide, if left untreated (Kpobi & Swartz, 2018c). From their findings, Kpobi and Swartz (2018c) recommended that the mental health knowledge of Traditional Alternative Medicine (TAM) practitioners (pastors) was important to assess to avoid potential negative outcomes for patients arising from misdiagnoses or delayed interventions. Other studies identified that pastors felt that they are often put in the position of making heroic efforts with inadequate training and few resources (See, Mabitsela, 2003).

Other studies indicate that Pentecostal pastors dismiss the diagnoses of a significant large number of mental health disorders. For example, Matthew and Stanford (2003) observed that there is lack of support for the use of prescribed medications for depression and anxiety. Accordingly, it is this researcher's view that this poses an opportunity whereby MHCPs and Pentecostal pastors might collaborate with one another in addressing the mental health needs of congregants and community members. Different from the findings above, the clergy (pastors) interviewed by Vander Waal, Hernandez and Sandman (2012) believed they could recognise a person with a serious mental health challenge. In Ghana, for example, Pentecostal pastors argued that they possess the spiritual ability to diagnose the problem, be it psychological, physical, or religion/spirituality (Asamoah et al., 2014).

The results of Asamoah et al (2014)'s study were replicated by Kpobi and Swartz (2018a) who studied Neo-Charismatic/Pentecostal pastors in Ghana. Kpobi and

Swartz (2018a) focused on Pentecostal pastors and their conceptualisations of mental illness. The study by Kpobi and Swartz (2018a) revealed that while Pentecostal pastors were interested in the religious/spiritual aspect of their clients, MHCPs were less likely to do so. Thus, Pentecostal pastors addressed mental health problems/illnesses as a religious/spiritual problem which required prayer, fasting, deliverance or exorcism to heal. Leavey (2008) established amongst Pentecostal pastors in the USA that psychiatrists were unable to discern the presence of the demonic (evil negative spiritual influences) in their patients. From all the above, it can be deduced that although Pentecostal pastors do not make use of the ICD as it emerged from Kamanga et al (2019)'s study, mental illness is diagnosed based on violations of certain cultural or social norms. In support, Kamanga et al (2019) also observed that the interviewees relied on deviation of behaviour from the culturally accepted to something that does not conform to the person's cultural background to describe and identify mental illness.

2.14.1 *Pentecostal pastors' recognition of mental Illness*

Kamanga et al (2019) established that pastors agreed that deviation from one's cultural behaviours is the main indicator that someone is getting mentally ill. In other words, unlike MHCPs who rely on the DSM-5 and ICD-10 code to reach to a diagnosis, in Africa, cultural norms seem to play a role in the diagnosis of what can be said to be a mental illness. Kamanga et al (2019)'s study established that there should be notable changes such as physical, psychological, and socio-cultural for someone to be diagnosed with mental illness. To be specific, Kamanga et al (2019) noticed that physiological changes (expressions), psychological changes, socio-cultural, religious/spiritual behavioural change, unprovoked aggression, and violence, extreme anger, stress, depression, anxiety, witchcraft, curses, bizarre beliefs (delusions) and possession with demons (evil spirits) were concepts for mental illness and what caused it. Thus, Pentecostal pastors seem to use a spiritual method to detect and diagnose mental illness, though what they refer to as mental illness seems to describe only psychosis (Asamoah et al., 2014), meaning that, they may overlook the existence of less severe symptoms of mental illness which could be detected by trained MHCPs.

With regards to signs and symptoms of mental illnesses, pastors state that the symptom of a person who has a mental illness is basically seen by change in observing

one's cultural norms (Kamanga et al., 2019). The symptoms, as observed by Kamanga et al (2019) amongst the studied pastors included: walking naked, undressing in public, aggressive behaviour, isolating oneself from other members of the community, dressing in rugs, picking food from dustbins and any other behaviour that deviates from the norms of other members of the community. These symptoms fit exactly with symptoms of psychotic disorders DSM. Based on the above, it is imperative for MHCPs to understand the conceptualisation of religious/spiritual illnesses and respect that, whatever their position on the existence of religious/spiritual illnesses, for the client, spiritual illness is like any other illness (Laher, 2014). This is in line with what Grossklaus (2015) found in his study. Grossklaus (2015) found that the experience of spirit possession, for instance, is like physical and psychological states that indicate out-of-the ordinary experiences or altered states of consciousness.

In contrast to the above, data obtained from Mabitsela (2003) indicate that psychological distress (mental illness) is recognised mainly by signs of mood, behaviour and cognitive disturbance. Again, it involves a disturbance in expressed communication and interpersonal relationships (Mabitsela, 2003). Mabitsela (2003) further states that psychological distress (mental illness) is identified by disturbances in mood and affect, manifesting with depression, hopelessness, helplessness, discouragement, and a range of emotional problems. Eventually, Mabitsela (2003) observed that psychological distress brings about disturbance of behaviour in the affected person. Thus, there is a significant difference between behaviour prior and behaviour with the experience of psychological distress (mental illness) (Mabitsela, 2003).

In addition, social norms of behaviour and relating are violated (Mabitsela, 2003). Thus, the ability to function in a variety of relationships is impaired, manifesting with broken links in relations, including intimate family relations such as parent-child conflicts and marital disruption and disintegration of communal relations (Mabitsela, 2003). Besides affecting interpersonal relations, Mabitsela (2003) also observed that psychological distress (mental illness) affects the cognitive functioning such that attitude and perception of the affected person is negatively influenced, leading to a distorted outlook of the world and of the self, such as pessimism and low self-esteem. As observed by Mabitsela (2003), in extreme cases, severe disturbances in cognitive

functioning may occur, resulting in the affected person experiencing confusion, visual hallucinations, auditory hallucinations and delusions.

2.15 Pentecostal pastors' perception of the treatment and management of mental Illness

Pentecostal pastors are somehow involved in the management and treatment of congregants with mental illness. Specifically, Jackson (2017) indicates that the Black Pentecostal church is unique in their approach to how they combat mental health. The selected methods of Black Pentecostal pastors are based on their perception of mental health, which is derived from biblical teaching, training, and the Pentecostal doctrine (Jackson, 2017). Although there is much evidence indicating that before people with mental illness report to MHCPs, they consult with their pastors. However, not much is recorded empirically regarding Black Pentecostal pastors' perceptions on the treatment and management of mental illness and how they help their congregants with such problems in South Africa. Nevertheless, some previous studies indicate that how Christian pastors treat mental illness, is determined by what they perceive to be its cause (e.g., Asamoah, 2016; Kpobi & Swartz, 2018a; Jackson, 2017; Kamanga et al., 2019; Yendork et al., 2019). These studies have also focused on how Pentecostal pastors conceptualise mental illness and mental health issues as they seem to have a duty of spiritual care and guidance to them. As aforementioned, with regards to mental health services, Pentecostal pastors are the keenest of all faith-based groups to participate in the care (cure) of people considered by medical staff to be mentally ill (Leavey, 2010).

2.15.1 *Mental illness is treated spiritually*
Pentecostal pastors generally believe that they are endowed with special gifts of the Holy Spirit (Kpobi & Swartz, 2018a), which help them in executing what they call their 'kingdom mandate'. In essence, Asamoah (2016) states that the capacity for deliverance as a gift of the Holy Spirit, and one among several gifts, is said to have been received by the Apostles at the event celebrated as Pentecost. Based on their perceived gifting of healing and deliverance, many Pentecostal pastors, especially in Africa, have established what is termed, 'prayer camps'. In the camps, prayers, fasting

and deliverance services take place with the view of providing help to the congregants (Kpobi & Swartz, 2018a; Mashau, 2013). It seems that the concept of prayer camps is more common in African countries as compared to Pentecostal outside Africa. According to Kpobi and Swartz (2018a), in the prayer camps, miracles of healing for people with various ailments are performed by Pentecostal pastors. The prayer camps are often filled with patients and their caregivers seeking divine intervention for their illness (Kpobi & Swartz, 2018a).

Pentecostal pastors also exercise exorcisms to deliver those who are under demonic attacks and are possessed by demons and that those who are not cured as they are prayed for, are accused of lack of faith (Mashau, 2013). According to Mabitsela (2003), deliverance is a specific Pentecostal term to refer to an intervention that deals with human problems that have spiritual roots. Thus, Pentecostal pastors see deliverance as inclusive of prayer and exorcism of demonic spirits (Mabitsela, 2003). It is important to note that the term deliverance is sometimes used interchangeably with exorcism in the Pentecostal church. However, as noticed by Grossklaus (2015), exorcism is more practised in the Catholic Church, while deliverance is more common in the Pentecostal of 'free' churches. Grossklaus (2015) further mentions that in the Catholic Church, there is a prescription and guidelines documented on how and by whom the exorcism should be conducted. In other words, exorcism is conducted solely by the priest. Grossklaus (2015, p.44) states that "Exorcism is directed at the expulsion of demons or to the liberation from demonic possession through the spiritual authority which Jesus entrusted to his Church, which is exactly the intent of Pentecostal pastors when they conduct a deliverance session".

According to Grossklaus (2015, p.47):

> In Pentecostal churches, the supernatural aspect of Christian godliness is deliberately emphasised and encouraged. God's miracles are expected, supernatural gifts of the Spirit are practiced, and the deliverance of demonized people is seen as a commission from Jesus.

Grossklaus (2015) further states that, "illness, especially psychological (mental) illness, is a very different matter and treating it is the concern of medical science"; this

meaning that deliverance alone may not be efficient as an intervention for someone with a mental illness. Based on their perceived ability to heal mental illness spiritually some Pentecostal pastors seem to undermine Bio-Psycho-Social interventions. For example, Kamanga et al.'s (2019) study revealed that amongst Pentecostal pastors in Malawi, the pastors claimed that doctors do not have nor had little faith in God.

To concur, Kpobi and Swartz (2018a) observed that most Pentecostal pastors consider themselves to be operating at a higher level of efficacy than biomedical professionals and they consider their methods to produce more enduring results given their use of the gifts of the Holy Spirit, whom they consider as all-powerful. Hence, in that study by Kpobi and Swartz (2018a), Pentecostal pastors demand respect and reverence and expect their instructions to be followed. This perception by Pentecostal pastors may influence their congregants/patients to undermine or ignore the use of mental health services (Uwannah, 2015). Moreover, Pentecostal pastors holding such a view may trigger some anxiety or depression in their congregants or followers or they may not see the need to refer to or collaborate with MHCPs (White, 2018). Moreover, such pastors are more likely to rely solely on prayer, faith in God, miracles, exorcism, or some form of supernatural healing power to deliver (Mashau, 2013). Thus, the perspectives that Pentecostal pastors had on their spiritual ability and healing leads them to either refuse to collaborate with MHCPs or refer their congregants to them (Asamoah et al., 2014).

Pentecostals believe that God could heal any problem instantly, or in a gradual healing process that incorporates pastors and counsellors working together with the help of the Holy Spirit (Hardwick, 2013). In the contrast, in their official rhetoric, early Pentecostals condemned reliance on medicines, mental healing, or various other natural means of healing, especially for believers, focusing instead on deliverance from evil spirits and complete faith in God as keys to the healing process (Williams, 2008). In agreement, results of a study conducted by Kamanga et al (2019) revealed that Pentecostal pastors believed that there are two types of healing: physical healing and religious/spiritual healing. According to Kamanga et al (2019), the pastors believed that it is only God who can heal all types of illnesses both spiritually and physically and that hospitals are a creation of God and therefore prayers should come first when someone is mentally ill. Apparently, the above assertion means that even

though when Pentecostal pastors refer a congregant to the hospital and they be healed, the understanding or interpretation would be that the person was healed through God's power.

2.15.2 *Mental illness is treated spiritually and psychologically*

As much as Pentecostal pastors hold different views on what mental illness is and what causes it, they also hold differing views on how it should be treated and managed (Murambidzi, 2016). Furthermore, the Pentecostal pastors' healing methods are derived from Biblical scriptures and the Holy Spirit. Thus, Pentecostal pastors also have a different understanding of healing of a mentally ill person (Kamanga et al., 2019). For example, Roux (2019), mentions that for the Pentecostals, healing is more than just physical cure, as is commonly understood in the Western medical model. Again, Roux (2019) states that Pentecostal healing encompasses much more than just physical healing and extends to various other dimensions of the human person which include the cognitive, conative, affective, as well as physical, environmental, and spiritual dimensions. Specifically, Roux (2019) indicates that wholeness is for the 'whole person' and includes the cognitive, conative, and affective, physical and religious/spiritual anthropological dimensions. This view of healing by Pentecostal pastors seems to be in keeping with the proposed theory for the current study, the BPSS model. However, it should be noted that elsewhere some Pentecostal pastors are of the view that their methods work better than biomedical methods (Kpobi & Swartz, 2018a). This view of treatment and management of mental illness by Pentecostal pastors may instigate antagonism or divergence between MHCPs and Pentecostal pastors.

Many Pentecostal pastors acknowledge the place of biomedicine despite their assertion that their methods worked better than biomedical methods (Kpobi & Swartz, 2018a). They also perceive biomedicine to have greater recognition and respect in the national health discourse and, by extension, greater power, and legitimacy in the eyes of the government as compared to the former (Kpobi & Swartz, 2018a). Specifically, results of a study conducted by Harris (2018) indicate that amongst Pentecostal pastors, there are two schools of thought concerning the treatment of mental illness. Harris (2018) discovered that there are those who subscribe to the use of others by God for healing. Thus, on the one hand, there are some Pentecostal pastors who

believe that MHCPs and psychiatrists are used by God to heal through methods of consultation, therapy, and prescribing psychotropic medications; and, on the other hand, there are those who believe that they would rely completely on God for instant and complete and divine healing (Harris, 2018).

The latter group of Pentecostal pastors as noted by Harris (2018) view secular interventions as against the will of God, lacking in faith, or as a form of rebellion. Hardwick (2013) also notes that Pentecostal pastors perceive that mental illness should be treated by MHCPs with counselling and medication while pastors should provide concurrent spiritual care as a support. Thus, medication and psychotherapy should be sought to address biological and psychological symptoms while spiritual care should be employed to alleviate spiritual distress (Harris, 2018). As noted by Harris (2018), pastors believe that God can heal any problem instantly, or in a gradual healing process that incorporates the clergy (pastors) and counsellors working together with the help of the Holy Spirit. As such, with either school of thought, God is credited for the physical and mental healing of the congregant (Harris, 2018).

2.16 Pentecostal pastors' role in the management and treatment of mental Illness

Historically, churches served and still serve a crucial role in the mental health needs of its members (Leavey et al., 2016). However, available literature demonstrates that there is limited information on this topic, especially in the South African context (Greyvenstein, 2018). Many individuals with mental health problems seek out pastors for support. James et al (2014) also agree that individuals with mental disorders and their caregivers frequently consult the clergy (pastors) when mental symptoms cause distress. Empirically, it is also proven that clerics (pastors) are important sources of social support and provide services that range from spiritual guidance to formal counselling (Leavey et al., 2007). Thus, the fact that pastors play a significant role in the lives of their congregant members with mental health problems cannot be overlooked. Pastors are somehow role models and are influential to their congregants (Mabitsela, 2003). As such, exploring and understanding their perceived role in the

treatment and management of mental illness will provide insight to MHCPs for integration or collaboration purposes (Greyvenstein, 2018).

According to Heward-Mill et al (2018) faith leaders (pastors) can influence health behaviour not only on the individual level but also on a socio-cultural and environmental level. Likewise, Mabitsela (2003) indicates that pastors are very influential, and their attitudes were likely to rub off on their followers. Specifically, pastors exert such influence through several mediators such as scriptural influence, social influence and by serving as role models. Hence, it is not unusual for congregants and people in general to seek pastors' counsel when they experience mental health problems (Hewrad-Mills et al., 2018). In agreement, Rogers et al (2013) state that by the pastoral nature of their ministry, pastors are primed to seek and respond to people in distress. Thus, pastors act as guardians for the church, managing and protecting the church members and serve as mentors, guiding members through their pursuit of spiritual meaning and Biblical principles (Mabitsela, 2003).

2.16.1 *Praying and teaching God's word*

As stated earlier, it is important to note that in pastoral every-day life, overlaps do occur again and again, particularly when people show symptoms associated with demonic possession. According to Grossklaus (2015), both MHCPs and pastors work predominantly with people: The former in clinics and practices and the latter in churches and schools (religion lessons). Thus, it can often happen that in pastoral counselling, pastors are confronted with needs which perhaps MHCPs could better deal with (Grossklaus, 2015). Furthermore, Grossklaus (2015) indicates that church members often go and see their minister first and depending on their problems he can either help or he refers them to a psychologist. For if he suspects demonic possession then he will see himself more as a helper and less as a psychologist. Thus, in the process of helping their congregants, it seems that pastors are aware of having limited competence for dealing with their congregants' mental health problems (Smith, 2017).

Park (2015) also mentions that out of the many religion/spirituality practices, prayer appears to the most dominant Religious/spiritual intervention practice (i.e., attend Faith Based Organisation (FBO) (church), scripture reading, prayer, meditation, exorcism, confession, faith healing, other rituals, oil anointing, laying on hands, and

fasting) in which 89.5% of the clergy (pastors) reported to engaging in with mental health concerns. Similarly, in their study regarding pastors' roles, Young et al (2003) reported that the pastors described a tendency to pray and quote scripture in their sessions and to include some references to confession and faith healing. Thus, Pentecostal pastors perceive their role of providing prayers as one of their major roles in the treatment and management of people with mental illnesses (Kpobi & Swartz, 2018a). However, there seem to be no studies which have explored the efficiency of prayer in healing mental illnesses.

Pastors are also able to distinguish between cases where they believe they can help a parishioner with mental distress from those where a MHCP is needed (Smith, 2017) meaning that when they judge they can help, they use various strategies to counsel parishioners. As noted by Smith (2017), "the strategies that the Pentecostal pastors employ are generally based on the Bible and spiritual considerations, and they may reflect practical knowledge about how to engage people and encourage them to discuss their issues openly." Similarly, Owoeye (2012) observed that Pentecostals educate their congregations through sermons, Bible studies and seminars in their conventions and retreats, and they also counsel all their members, especially the young ones to abstain from reckless or frivolous sexual behaviour. From the study by Asamoah et al (2014), it also emerged that another role that Pentecostal pastors engage in is that of exorcism. This role, according to the pastors interviewed, concerns the expulsion of malign spiritual agents through specific religious/spiritual rituals and practices such as prayer and fasting as indicated in the voice below. Apart from exorcism/deliverance, Asamoah et al (2014) report that most participants indicated they play a role in the provision of social support as already mentioned.

2.16.2 *Biblical Counselling*
Empirical evidence indicates that pastors are also involved in extensive counselling services. As an illustration, Young et al (2003) discovered that pastors averaged more than six hours of counselling work weekly and often addressed serious problems like those seen by secular MHCPs, with whom they reported readily exchanging referrals. According to Young et al (2003), most of the pastors reported that they observed and addressed severe mental illness and substance abuse in their congregations and those they also counsel individuals outside their own denominations. Likewise, a

study conducted by Murambidzi (2016) indicates that confirmed that one important role of the church expressed by most participants was offering counselling and crisis support services to people experiencing various life problems.

In support, Asamoah et al (2014) discovered that Pentecostal pastors offer counselling services as a form of social support though the participants indicated that counselling services, they offered were not formal and professional counselling. The counselling services appeared to be more of advising; the provision of directions to patient and family members of patients with regards to how to handle the patient (Asamoah et al., 2014). Thus, it can be said that although pastors lack training of extensive knowledge in mental health, by virtue of their calling and position in society, they have a significant role to play in the lives of their congregants. When their roles are well clarified and understood by MHCPs who also see these congregants good working relations for the benefit of the affected can ensue.

In a study conducted by Rudolfsson and Milstein (2019), psychologists (MHCPs) mentioned that their profession did not allow them to take part in their patients' lives, as boundaries were important for psychotherapy to be successful and described a need to prioritise their work with the patient. Thus, pastors have more access to their church members as compared to psychologists (MHCPs). In Rudolfsson and Milstein's (2019) study it appeared that although acknowledging that psychologists (MHCPs) often had the competence to engage their patients more broadly, pastoral caregivers were described as more suitable by MHCPs to counsel church members. This is in line with the findings of Asamoah et al (2014) that Pentecostal pastors tend to view a human being as a tripartite being (mind, body soul/spirit). Thus, they investigate a person holistically based on their theology or spiritual/religious worldview (Asamoah et al., 2014). Based on the above, instead of only viewing themselves as religious/spiritual leaders, they self-identify as multitasked caregivers who also serve as teachers, counsellors, marriage therapists, parole officers, social workers, and conflict mediators (Frontus, 2015).

2.16.3 *Pentecostal pastors serve as sources of referral*

More often, when individuals experience emotional crisis and distress in life, usually they turn to their pastors for help. However, studies have revealed that they do not

have adequate training in dealing with mental health issues (Mabitsela, 2003). In a case whereby pastors perceived themselves as incapacitated to help their congregants, they would refer either internally or externally. Specifically, the above view was observed by Kruger, (2012) amongst Afrikaans speaking pastors in Polokwane who believed that the main role the church must play in the management of mental illness is more of providing a referral path to other health professionals that mentally ill individuals would not have been referred to. Specifically, Kruger (2012) noted that pastors played a role in the referral of their congregants to other pastors whom they perceived as more skilled and knowledgeable or to Mental Health Professionals. This finding by Kruger (2012) was echoed Smith (2017) who observed that the most prevalent approach mentioned by pastors was to either refer a person to a MHP at the outset or to do so if the mental health issue is serious or beyond the pastor's capability to deal with properly.

On the other hand, Frontus (2015) found that most of the clergy (pastors) believed that the direct provision or referral of mental health services for help-seekers was an integral part of their pastoral duties. Likewise, Vander Waal et al (2012) found that the Christian clergy (pastors) play an important role in identifying individuals with mental health and substance abuse disorders and providing education, support, and referrals to needed services. In agreement, participants taking part in Asamoah et al (2014)'s study observed that one main role Pentecostal pastors play in mental health care is identification of cause of mental illness. They indicated they have the (spiritual) ability to diagnose the problem be it psychological, physical, or religious/spiritual. This is in line with what Leavey (2010) found in his study. Leavey (2010) reported that Pentecostal pastors perceived their role as one of being able to detect the presence of demonic spirits, unlike psychiatrists who were not able to do so. Thus, they canvassed for collaboration. Collaboration is a necessity for the two professions.

As mentioned by Mabitsela (2003), the role of providing referral to other pastors or MHCPs seems to be invaluable for some Pentecostal pastors while on the one hand, some may feel powerless or as betraying the trust that their congregants have on them. For example, Pentecostal pastors interviewed by Mabitsela (2003) mentioned that they sometimes opt for referral with social problems that are beyond their understanding or cannot handle and they often collaborate with experts that are state

funded such as social workers and police. However, they seldom referred to psychologists. To be specific, the studied by Mabitsela (2003) cited the following reasons for not referring to MHCPs: Firstly, all professional psychological services are seen as very expensive for most of their members, secondly these Western-orientated mental health services are not recognised by most congregants. Thirdly, psychological service facilities are not readily available in the township. Moreover, Pentecostal pastors seem to accuse psychologists (MHCPs) of ignoring the spiritual side and only concentrating on the physical and psychological (Mabitsela, 2003).

2.16.4 *Pentecostal pastors serve as educators*

Another significant role that Pentecostal pastors seemed to play in the treatment and management of mental illness by Asamoah et al (2014) is providing mental health education. A good number of the participants indicated that churches are sites for mental health education in the country and they participate in this to provide some health education to members. Thus, the clergy (pastors) appeared to use the church setting to create opportunities through their programmes for life enhancement. Furthermore, Asamoah et al (2014) mentioned that another form of health education indicated was more of theological education with an overarching intention to facilitate faith-growth through increased scriptural knowledge. In the study by Asamoah et al. (2014), close to half of the participants indicated that religious/spiritual education existed where mentally distressed persons receive tutoring in the Bible from their pastors to facilitate faith-growth.

According to Asamoah et al (2014), the idea was that increased faith can be a panacea to ill-health and thus the overarching motive for teaching people how to grow in faith is goal-directed towards experiencing healing. Based on the above, one can mention that the tendency of members of more conservative religious/spiritual groups to rely on God and on ministers in times of distress suggests that ministerial (pastoral) support is a particularly viable option for Pentecostals (Chatters et al., 2011). As noted by Rudolfsson and Milstein (2019) pastoral caregivers talk about pastoral care as caring rather than curing and described the support in a religious/spiritual community as potentially healing, and as a prevention intervention. To confirm the above, MHCPs who took part in Rudolfsson and Milstein (2019)'s study agreed that pastoral

caregivers were freer to engage in their confidants' lives in a holistic way. Thus, they did not have problems with making referrals to them or collaborating with them.

2.16.5 *Pentecostal pastors provide social support*

Pentecostal pastors serve as carers to their congregants. For example, Asamoah et al (2014) noted that the social support services included the provision of certain basic needs of the patient, lack of which might be the source of the mental illness. Support was also provided in the form of emotional care, whereby the pastor would regularly organize hospital visitations with some members of the church to give hope to patients and families who are hurting one way or the other (Asamoah et al., 2014). According to Asamoah et al (2014), closely related to the emotional care was the provision of an environment that facilitated healing. Similarly, Murambidzi's (2016) study noted that pastors perceived the church as a fountain of emotional and psychological care and support to people experiencing various problems, including mental illness. Most notably, the church was perceived as having the capacity and resources (both human and material) to provide care and support to people with mental illnesses (Murambidzi, 2016). Moreover, some of the participants pointed out that the church has well established structures that support community health activities (Murambidzi, 2016).

Participants in Murambidzi (2016)'s study specifically reported having health departments in their churches, active community linkages through church-home groups, as well as close working relationship with the family structure which was regarded as the first level of care and support as noted by one of the respondents. Similarly, a study conducted by Rudolfsson and Milstein (2019) in Sweden revealed that pastoral caregivers described that many of the people they met had nowhere else to turn as they could neither get a public psychiatry appointment nor afford to see a private-practicing psychologist. Thus, people came to them because the pre-determined number of sessions offered in public psychiatry was not sufficient (Rudolfsson & Milstein, 2019). Generally, it seems that as compared to psychologists (MHCPs), pastors are trusted, are more accessible and maintain close relations with those they minister to by means of follow up. In addition, Mabitsela (2003) found that the Pentecostal church provides its members with a sense of belonging; members share religious and spiritual values and serves as a life skills centre that empowers the community by disseminating information through workshops, projects,

conferences, and preaching services that are usually organised by church leadership. Overall, Mabitsela's (2003) study discovered that the Pentecostal church is also concerned with the well-being of its members, whether social, physical, and spiritual.

2.17 Pentecostal pastors' perceptions regarding possible collaboration with MHCPs

Pentecostal pastors hold varying attitudes towards collaboration. While in the USA and UK Pentecostal pastors seem to be willing to collaborate with MHCPs, in some African countries, the position seems to be different. For example, Pentecostal pastors interviewed by Kpobi and Swartz (2018b) displayed a strong desire to be formally recognised for their work and abilities, suggesting that they perceived themselves as equally knowledgeable and skilled in mental health issues. Based on that understanding, many of them envisioned a system in which they worked alongside doctors to provide services to patients in hospitals (Kpobi & Swartz, 2018b). Kpobi and Swartz (2018b) also observed that even though Pentecostal pastors acknowledged the place of biomedicine, they asserted that their methods work better than biomedical methods.

According to Kpobi and Swartz (2018b), Pentecostal pastors emphasised the need for recognition and collaboration with the formal health system. The pastors perceived biomedicine to have greater recognition and respect in the national health discourse, and by extension, greater power and legitimacy in the eyes of the government (Kpobi & Swartz, 2018a). In other words, though the pastors proposed to be involved in the formal mental healthcare system, they were not opposed to referring patients to hospital when deemed necessary. Thus, Kpobi and Swartz (2018b) proposed that both pastors and MHCPs be considered equally powerful yet operating in parallel dimensions. As such, by partnering with pastors, mental health liaisons would gain both increased access to the congregation and enhanced legitimacy (Kpobi & Swartz, 2018b).

Kpobi and Swartz's (2018a: 2018b) findings were replicated. For example, a study conducted by Kamanga et al (2019) revealed that pastors believed that there is no trust between doctors (MHCPs) and pastors. The pastors were suspicious that

doctors (MHCPs) believe that pastors cannot understand the pathophysiology of illnesses and believed that doctors (pastors) have no or little faith in the power of God. One pastor who took part in Kamanga et al (2019)'s study specifically mentioned this: "Health professionals and pastors do not trust each other hence it is difficult to work together and refer patients to each other for more holistic care." Moreover, Kamanga et al (2019)'s study discovered that pastors believe that healthcare workers have little faith in God while healthcare workers believe that pastors do not understand the pathophysiology of illness. However, the pastors acknowledged that there was a need for themselves and MHCPs to collaborate.

Conversely, a study conducted by Kruger in 2012, church leaders (pastors) were of the view that their lack of knowledge about what services MHCPs render could cause distrust. Kruger (2012) mentions that pastors felt that some MHCPs might disregard the spiritual importance in counselling and might even influence their church members to become less religiously devout. Thus, they would resort to internal referral or refer to MHCPs of the same faith with theirs. To be specific, Pentecostal pastors are open to collaborate with secular counsellors in taking care of their congregants with mental illness. However, they need to collaborate with MHCPs who understand and value their theology and spirituality. In agreement, Kruger (2012) found that all the participants were in favour of collaborating with medical and psychological practitioners specifically because they understood that illness could be medical, psychological, and/or spiritual. In agreement, Ae-Ngibise et al (2010) state that despite the various barriers, and widespread scepticism that were revealed by faith healers (pastors) around possible collaboration, the interviews suggested some potential for collaboration.

For collaborations to be successful, Rogers et al (2013) indicate that they need to take place in the context of personal relationships. These relationships must be founded on mutual respect and grounded in the knowledge that each professional has something unique and valuable to offer (Rogers et al., 2013). Rogers et al (2013) indicate that collaborations thrive in the presence of shared values, especially common respect for religious/spiritual ideals, and are strangled by value conflicts on important issues. Thus, individuals who understand both cultural mindsets, psychological and religious/ spiritual, are best prepared for collaboration (Rogers et al., 2013). Besides,

as noted by Kruger (2012), MHCPs from the same faith are believed to be sharing similar values with the referring pastor.

Similarly, in a study by Hardwick (2013) Pentecostal pastors embraced collaboration with counsellors, with a preference for counsellors who believed in God. In their study amongst the Christian clergy (pastors) Vander Waal et al (2012) also found that most of the clergy (pastors) stated they would be likely to refer church members to a professional (preferably Christian) counsellor if they had a mental health or substance abuse disorder. However, it should be noted though that in the study by Hardwick (2013), the pastors indicated that it was not necessary for the Christian MHP to provide Christian counselling. They simply wanted someone who would not go against their Christian worldview and was not anti-God. Above all, Jackson (2017) found that Pentecostal pastors desired that within the collaborative process, the Pentecostal doctrine is respected and incorporated. The participants were of the view that it is through this type of collaboration where counsellors must be able to understand that Christ will have to remain at the centre of the services and treatment that is provided, and that healing will come through God within this process (Jackson, 2017).

2.17.1 *Factors affecting collaboration between pastors and MHCPs*

Many studies indicate that collaboration between pastors and MHCPs is affected by many various factors. Specifically, Leavey (2010) indicates that the calls for collaboration between mental health services (MHCPs) and pastors may be problematic particularly in the resolution of conflicting beliefs and therapeutic modalities. As mentioned by Rogers et al (2013), due to the historical rift between the clergy (pastors) and MHCPs, direct collaborations are uncommon despite the complementary expertise of the two professions. The difficult relationship between pastors and MHCPs is mainly caused by the differing approaches to mental health issues within the Christian denominations, pastors of all faith-based groups and secular service providers (Leavey, 2010). According to Rudolfsson and Milstein (2019), pastors talk about the need for knowledge within their own profession, within the other profession, and within the general population. Thus, it becomes difficult to build a solid or effective working relationship with pastors who have not specifically clarified their stance, especially on mental health issues. Hence, the present study

sought to explore and understand Pentecostal pastors' perspective on collaborating with MHCPs.

Apart from having an obscure stance towards collaborating with MHCPs, Mabitsela (2003)'s study revealed that Pentecostal pastors viewed MHCPs as practitioners who tend to ignore the religious/spiritual side and only concentrate on the physical and psychological. This view was later supported by Bulbia and Laher (2013) who remarked that Western definitions of and approaches to mental illness have been critiqued for their lack of incorporation of cultural and religious/spiritual elements. In essence, the pastor-MHP relationship is largely characterised by hidden conflict, mistrust, discontent, and lack of appreciation of the role and contribution of the counterpart profession (Murambidzi, 2016).

The difficulties with regards to collaboration between pastors and MHCPs has been largely attributed to lack of knowledge on both available community mental health services and the referral procedure, lack of discussion forums between the two divides, personal beliefs and attitudes, and economic reasons in some cases (Murambidzi et al., 2016). In addition, Sullivan et al (2013, p. 9-11) noted barriers for the tension and antagonism between pastors and MHCPs: (i) Lack of trust that the clergy/clinician collaboration can happen and (ii) Stigma undervalues the contribution of clergy (pastors) and mental health clinicians.

Ae-Ngibise et al (2010) also noted that MHCPs express scepticism about possible collaboration as it was seen that the 'system has not been well developed since faith healer (pastors) and traditional healers "just went about and doing their own things and nobody checks them" Thus, many MHCPs stated that if they formed alliances with traditional and faith healers(pastors) they could be seen to be 'condoning such practices' and 'encouraging such abuses (Ae-Ngibise et al., 2010). These findings from previous studies indicate the fact that there is a need for training for both Pentecostal pastors and MHCPs. MHCPs need to learn from pastors and vice versa. Specifically, as noted by Sullivan et al (2013), mental health providers (MHCPs) identified a need for additional training for both how to discuss spiritual issues and access potential spiritual resources during a clinical encounter and for understanding any legal or ethical limitations to the extent of this discussion.

2.18 Pentecostal pastors' referral process

Other studies exploring pastors' views regarding collaboration discovered that pastors advocate for faith-based treatments to be included and preferred treatment by like-minded Christian professionals before secular MHCPs (See, Kruger, 2012). Likewise, Stanford and Philpott (2011) found that Baptist senior pastors were likely to refer their congregants to MHCPs they knew to be a Christian. According to Stanford and Philpott (2011), the predominant factor related to referral appears to be knowledge of the MHP's faith which is consistent with previous research. Baptist pastors preferred Christian Licenced Professional Counsellors (LPCs) and Licenced Marriage and Family Counsellors (LMFTs) when making mental health referrals (Stanford & Philpot, 2011). Thus, the Baptist pastors preferred to refer their members to MHCPs that recognise the importance of biological and psychosocial influences in mental illness while providing a therapeutic environment that is supportive of faith (Stanford & Philpott, 2011).

Interestingly, other studies indicate that pastors prefer to refer people with mental health problems to other pastors, something coined, intra-referral. For instance, Ae-Ngibise et al (2010)'s study reveals that many of the traditional healers and faith healers (pastors) shared the sentiments that they would normally refer a patient to another healer when they found the condition very difficult to manage. According to Ae-Ngibise et al (2010), a few said they would refer the person to a more powerful healer to take over the treatment process. On the other hand, many participants in the study by Ace-Ngibise et al (2010) mentioned that they would combine R/S forces with another healer for the management of some patients, especially in more complex cases and some also stated that a deity may inform the healer (pastor) to refer the patient specifically to another deity because that deity has the cure for that disorder.

Research has also established that the more a pastor is educated in secular education or mental health, the more likely they are to make a referral to a MHCPs. For example, Park (2015) observed that the clergy (pastors) with graduate level education were more likely to engage in mental health referrals than those who received less education. The study by Park (2015) also revealed that the clergy (pastors) with non-regionally accredited certificate education were the least comfortable with mental

health referrals, made the least mental health referrals, and engaged in the fewest mental health services when compared to other education level and/or types of education.

Similarly, a study by Gaffeney (2016) revealed that Pentecostal pastors who had a secular educational background, believe in a pluralistic view of the causal factors, and have no problems collaborating with secular MHCPs. In concert, Rogers et al (2013) indicate that the clergy (pastors) are the religious/spiritual experts; most MHCPs are not well trained in R/S matters. Rogers et al (2013) further indicate that MHCPs are experts in mental disorders, a topic often perplexing to the clergy (pastors).

2.19 Concluding remarks

This chapter presented the overview of religion/spirituality. The confusion regarding the interchangeable use of the concepts religion and spirituality were clarified and the terms were thus referred to as a single concept in this study. Following that, the correlation between religion/spirituality and mental health was also presented with a specific focus on both the positive and negative effects of religion/spirituality. Subsequently, the integration of religion/spirituality into psychotherapy was also discussed. It emerged from the reviewed literature that calls for such are mounting high and the need is urgent, especially in Low- and Medium-Income Countries (LMICs) like South Africa where the rate of mental illnesses has risen and the number of MHCPs available is incongruent with the demand. The issue of the integration of religion/spirituality into psychotherapy was also discussed in the context of one of this study's objective which is to develop a collaborative intervention programme between Pentecostal pastors and MHCPs.

From the reviewed literature, it emerged that Pentecostal pastors hold a multifactorial view of what mental illness is. However, in most past studies, spiritual factors seemed to dominate Pentecostal pastors' understanding and attributions to the presence of mental illness. Their views are influenced by their Biblical interpretation (Theology) and the geographical and cultural context. Thus, a Pentecostal pastor's view of mental illness may be affected by where they practise their ministry in and how the Bible is interpreted in that area. Most previous studies were conducted in the United Kingdom

and United States of America. Thus, their results could not be generalised. Besides the studies conducted in the UK and USA, many other studies available looking at Pentecostal pastors were conducted in Ghana. However, those studies looked at a few Pentecostal pastors alongside other faith healers. The same applies to a study conducted by Murambidzi (2016) in Zimbabwe. The study had two groups of Pentecostals in namely, the New-Neo Pentecostals as well as the Pentecostal from African Indigenous churches. The latter churches practice Pentecostalism which syncretises with the theology of African Traditional Religion (ATR).

CHAPTER THREE
EXPLANATORY MODELS OF MENTAL ILLNESS

3.1 Introduction

There are multiple models of mental illness that inform professional and lay understanding (Harland et al., 2009). These models are referred to as 'Explanatory Models' (EMs). Explanatory Models are beliefs about the nature, the name, the cause, the expected course, and the desired treatment for an episode of illness (Mohr, 2011). Explanatory Models (EMs) refer to patients' causal attributions of illness and have been shown to affect treatment preference and outcome (Ghane et al., 2009). EMs are influenced by culture but vary largely among individuals of the same cultural background (Kuittinen et al., 2017). According Kuittinen et al (2017), causal attributions of mental health problems play a crucial role in shaping and differentiating illness experience in different sociocultural and ethnic groups. In addition to culture and social situations, demographic characteristics and lifespan events are also important determinants of health experience and explanation (Kuittinen et al., 2017). The theory and practice of clinical psychology is often regarded as an alternative to the biomedical paradigm (Deacon, 2013). Clinical psychology's adoption of biomedical outcome research methodology has not been without its disadvantages (Deacon, 2013).

3.2 The Biomedical model of mental illness

The biomedical model posits that mental disorders are brain diseases and emphasizes pharmacological treatment to target presumed biological abnormalities (Deacon, 2013). The central tenet of the biomedical model is that psychological problems are literal diseases of the brain (Deacon, 2013). For three decades, the use of psychiatric medications has sharply increased, and mental disorders have become commonly regarded as brain diseases caused by chemical imbalances that are corrected with disease-specific drugs (Deacon, 2013). The biomedical model provides the medicalised model of illness that often results in the negative connotations and creates a stigmatised view of mental illness (Maurya, 2009). Thus, the biomedical model

reduces a human being to a single component explaining pathology. As a result, Lebowitz and Woo-kyoung (2014) argue that biological accounts of psychopathology can exacerbate perceptions of patients as abnormal, distinct from the rest of the population, meriting social exclusion, and even less than fully human. In concert, the (Sovereign Health of California [SOVCAL], 2015) indicates that like a lock and key, the biomedical model seeks to find a solution that fits the respective problem than other possible causal factors and eventually solutions. For many decades, mental disorders have increasingly been understood biologically. Specifically, the biomedical paradigm has profoundly affected clinical psychology via the adoption of drug trial methodology in psychotherapy research (Deacon, 2013).

Deacon (2013) indicates that the neglected Bio-Psycho-Social (BPS) model represents an appealing alternative to the biomedical approach, and an honest and public dialogue about the validity and utility of the biomedical paradigm. Thus, in 1977, George Engel responded by adding two dimensions (i.e., psychological, and social factors) to the limited biomedical approach to make it a more holistic approach to understanding mental illness. The BPS model was formed on the basis that existing biomedical and psychosocial frameworks that form the conceptual basis of medicine today were insufficient to address the needs of the medically complex and environmentally challenged populations of patients often cared for by physical medicine and rehabilitation specialists (Stineman & Strein, 2010).

Despite the widespread faith in the potential of neuroscience to revolutionize mental health practice, the biomedical model era has been characterized by a broad lack of clinical innovation and poor mental health outcomes (Deacon, 2013). As such, the sole use of biomedical perspectives in the evaluation of response to complex diseases needed to be replaced with a broad-based approach and understanding of coping strategies across cultures (Johnson et al., 2012). Besides the biomedical factors, psychological and socio-cultural factors also play important role in explaining mental illness (Maurya, 2009).

3.3 Psychological models of mental illness

Psychologists explain behaviours differently from pastors and theologians. To illustrate the above, Grossklaus (2015, p. 25) states that psychology does not assume the existence of a devil, demons etc., as theology does, but rather attempts to classify these phenomena in a different way. Each psychological model takes a stance on the nature of behaviour (general psychology), (psychopathology), and on how abnormality can be prevented or corrected or both (intervention) (Peterson, 2010). Thus, Psychologists focus attention on individual factors that produce abnormal thoughts, feelings, and behaviours (Peterson, 2010). As such, psychological theories attempt to avoid pathologizing and look to understandings of 'normal' human processes to explain abnormal behaviours, such as psychosis (Kinderman, 2005).

Unlike the Biomedical models, psychological models of mental disorder address different sorts of mechanisms than exclusively biomedical theories, but also strive to encompass more than the mere mechanics of any individual system and to look at interactions and interrelationships (Kinderman, 2005). For instance, the Cognitive-behaviourist explanations of mental illness for example understands the presence of abnormalities to arise when individuals are placed in highly unusual situations or have unusual ways of thinking (Interventions encourage adaptive habits and teach individuals to perceive the world more accurately and to solve problems more efficiently (Peterson, 2010).

According to Levin (2010) the cognitive-behavioural model of abnormal behaviour posits that religious/spiritual impulse is expressed through myriad behaviours, emotions, motivations, beliefs, attitudes, thoughts, values, experiences, and relationships. As such, the resulting cognitive-behavioural model of abnormality also views people as information processing systems, attempting to predict and understand events in the world with the goal of maximizing pleasure and minimizing pain (Peterson, 2010). Overall, he Cognitive-behavioural model explains that people's problems are not intrinsically different from their normal behaviour; rather, all actions are produced by the same processes of learning and thinking (Peterson, 2010).

On the one hand, the psychodynamic or psychoanalytic model on abnormality originated in Sigmund Freud's influential theorising. At its core, this model implies that people are closed energy systems (Peterson, 2010). These theories in general assume that people's problems result from inner conflicts that overwhelm their defences. The psychoanalytic model, which also assumes that people are, closed energy systems motivated by a variety of drives. Thus, abnormality can be understood developmentally. So, early childhood events affect adult functioning (Peterson, 2010). Another important aspect of the psychoanalytic model is that it takes a developmental approach to abnormality, stressing events, and occurrences early in life that affect adult functioning (Peterson, 2010. For example, Freud argued that the behavioural styles that children develop early in life become the ingredients of their adult personalities (Peterson, 2010). Thus, according to this model of abnormal behaviour or mental illness, psychopathology is linked with an individual's past developmental experiences not to religious/spiritual factors as pastors may allude. According to the psychodynamic model, the experiences unconsciously haunt and influence or motivate an individual's abnormal behaviour (Peterson, 2010).

The Humanistic, Existential and Phenomenological Psychologists conversely are not much concerned with traditional diagnosis (Peterson, 2010). Although they recognize that people have problems, their view of them is quite different than the one inherent in traditional diagnosis (Peterson, 2010). According to Peterson (2010), the Humanistic model posits that problems ensue when people experience a discrepancy between their sense of who they are and the way the world treats them. Thus, sometimes the world is to blame, in the sense of creating circumstances that lead them to doubt their own choices. Thus, humanists view psychopathology as developing from the fact that sometimes people make poor choices by not declaring to themselves their true intentions. In other words, problems are derailments along the way to self-actualization (Peterson, 2010). Peterson (2010) further indicates that people have a central fear, according to many theorists in this tradition, and this fear is one of nonexistence – death. All the above psychological models are represented within the Bio psychosocial model of mental illness; hence they shall not be broadly discussed.

3.4 The Bio-Psycho-Social (BPS) model of mental Illness

The term "Bio-Psycho-Social model" is associated with the name of George Engel, the internist, psychiatrist, and psychoanalyst (Anczewska et al., 2013). According to Anczewska et al (2013), George Engel's background in medicine and psychoanalysis inclined him to look for cross-links among illness, personal development, and life situation. The BPS model is aptly named because of its three essential components: biological, psychological, and social ideologies (SOVCAL, 2015). As noted by Wade and Halligan (2017), the BPS model emerged from dissatisfaction with the biomedical model of illness, which remains the dominant healthcare model. The BPS is based on the notion of multiple simultaneous causes of mental disorder while the psychological model of mental illness suggests that disruption or dysfunction of mental processes is a final common pathway in the development of mental illness (Kinderman, 2005). The model also includes the wide spectrum of psychological conditions and the vast variety of social elements like cultural and economic backgrounds (SOVCAL, 2015).

3.4.1 *Core ideas of the BPS model*

This BPS model implies that many etiological factors could be necessary but that none by themselves would be sufficient conditions for the development of a psychiatric disorder (Paris, 1993). According to Paris (1993), the etiological influences on any disorder may function as risk factors or protective factors. The factors could include biological vulnerability, the psychological impact of life experiences, and the influence of the social environment (Paris, 1993). Thus, compared to the biomedical model, the BPS recognises factors that were overlooked in psychiatry-psychological and social factors. Specifically, the BPS model that considers all relevant determinants of health and disease and that supports the integration of biological, psychological and social factors in the assessment, prevention and treatment of diseases (Havelka, Lucanin & Lucanin, 2009). Havelka et al. (2009) further indicate that the BPS does not diminish the significance of biological factors but extends a rather narrow approach. The BPS model also emphasises illness and how you live with, or respond to, symptoms or a disease, in contrast to the biomedical disease model, which primarily focuses on disruption of bodily systems by underlying physiological, anatomical, or pathological processes.

3.4.2 *Psychopathology as explained by the BPS Model*

The BPS model posits that although someone can be mentally healthy at some point in their life, they can still experience mental illness if their biopsychosocial balance is disturbed (Cardoso, 2013). Cardoso (2013) further states that based on the BPS model, interactions between people's genetic makeup (biology), mental health and personality (psychology), and sociocultural environment (social world) contribute to their experience of health or illness. According to Cardoso (2013), the biological influences on mental health and mental illness are varied, and include genetics, infections, physical trauma, nutrition, hormones, and toxins. In the process, the psychological component looks for potential psychological explanations for a health problem, such as lack of self-control, emotional turmoil, or negative thinking, while social and cultural factors are conceptualized as a particular set of stressful events (being laid off, for example) that can differentially impact mental health depending on the individual and his or her social context (Cardoso, 2013). Thus, according to the BPS model, each one of these factors (Bio-Psycho-Social) is not sufficient to create health or mental illness, but the interaction between them determines the course of one's development (Cardoso, 2013). In concert, Anczewska et al. (2013) mention that psychosocial difficulties arise from the interaction of the psychological and the social factors. Hence, they are not direct consequences of the health condition alone but are outcomes of the interaction between the health condition and contextual factors (Anczewska et al., 2013).

3.5 The African worldview on mental Illness

The African worldview of mental ill health currently encompasses a wide spectrum-from ancestors, folk belief, and witchcraft, to modern medical science (Chalk, 2006; Mkhize, 2003). The origins of the African worldview were found in traditional Africa before the emergence of European influences (Thabede, 2008). As such, the traditional African believes in the trustworthiness of the ancestors as strongly as the Christian believes in the trustworthiness of the Bible (Chalk, 2006). In a similar tone, Waldron (2010) indicates that the traditional African worldview is premised on the interrelationship between the living and the non-living, natural, and supernatural

elements and the material and the immaterial. Thus, the African worldview differs in many ways from the dominant Western perspective that focuses more on natural elements of a human being.

3.5.1 *Psychopathology as explained by the African worldview*

Whereas in the Western thought, supernatural causes are not considered to be plausible explanations for phenomena, in the African thought, supernatural causes play an important role in explaining phenomena (Thabede, 2008). In other words, the African worldview is founded upon metaphysical elements such as religious/spiritual beliefs and/or culture. In agreement, Ayuya et al (2015) indicate that matters pertaining to the life of Africans are interconnected to God, nature, and other relations (living or dead). Specifically, the African worldview postulates that psychopathology results when disharmony exists between people and supernatural powers. For instance, this implies that an individual member of a family may suffer because of disharmony between the family or community and the ancestors (Ayuya et al., 2015). Likewise, Naidu and Ramlall (2016) state that in the African worldview, the natural and supernatural elements are inextricably interwoven, and health is not seen merely as a biological matter, but one bonding the human body and the soul in total harmony.

Unlike the Euro-Western conceptualisation of illness, which is perceived to have originated in a genetic, biological or some other internal source, indigenous or folk conceptions of illness are more likely to consider how factors external to the individual (e.g., punishment by an angry spirit, witch or ghost) contribute to illness (Waldron, 2010). Thus, in many of African societies, illness is often perceived as 'culture-bound' because the explanations given for various illnesses are based on personal understandings of health and illness that reflect the symbolic structure of specific cultures and societies, as well as local histories, and environments (Waldron, 2010).

Psychopathology in the African worldviews is also perceived as the occurrence of a breach in the normal routine of an individual's existence, changing the victim's inner and outer equilibrium from peace and harmony to illness and distress (Nwoye, 2015). Thus, the disharmony is understood to not only affect an individual, but the individual's family and/or larger community (Nwoye, 2015). Moreover, in most traditional African cultures, it is believed that it is disturbed social relations such as incest; that create

disequilibria expressed in the form of physical or mental problems cause illness (Ayuya et al., 2015; Kamanga et al., 2019). Specifically, as noticed by Ayuya et al (2015), a disturbed relationship with one's God (macro-cosmos), conflict with one's relations, nucleus and extended family members (micro-cosmos) and problems with ancestors (meso-cosmos) contribute to the individual's unhealthy status (physical or mental). Thus, in the African worldview, the explanation for the illness is communal either involving an individual, a couple in a community or a family (in the case of ritual) within a community (Washington, 2010).

3.5.2 *Treatment of mental illness from the African worldview*

While the Western perspective relies heavily on 'talking therapy' with the aim of empowering the client, the African traditional perspective takes the responsibility for resolving the problem away from the client by performing (supernatural) rituals and by sometimes, including others in treatment (extended family members, alive and deceased) (Naidu & Ramlall, 2016). When it comes to healing in the African worldviews, Ross (2010) states that affected individuals are healed not only by herbs and other natural products but also by communicating with the ancestors, who in turn communicate with the Supreme Being. This is usually done in the form of performing certain rituals. As noted by Washington (2010), failure to perform a ritual or rituals may lead to psychopathology. Africans prefer to use treatments that recognize their ways of thinking and their value system (Naidu & Ramlall, 2016). To ascertain this, when people were asked about their reasons for consulting traditional healers, their common response was dissatisfaction with treatment received from, or negative experiences with, Western allopathic medical practitioners (Ross, 2010).

According to Ross (2010), other common themes have been the holistic focus of traditional healing; the healers' close association with cultural, religious and spiritual beliefs and practices; and the fact that such healers speak their language, spend time with them and provide explanations for their health conditions. Given the above, in most African nations, people haunted by illness, seek treatment from allopathic medical practitioners, African traditional healers and faith healers (pastors) (Mabvurira et al (2015). The African traditional approach to healing is aimed at social cohesion and therefore the focus on 'who caused the problem' should be aimed at bringing about reconciliation rather than revenge to deal with the element of cycle of enmity

(Ramlall & Naidoo, 2016).   Thus, African traditional healing involves a holistic integration of mental and spiritual guidance, herbs, nutrition, and physical therapy, and is linked to African cosmology. As such, indigenous healers (pastors) more fully elaborate on spiritual models, suggesting that spirituality plays a more significant role in understanding and resolving mental health problems (Waldron, 2010).

3.6 Theoretical Framework: The Bio-Psycho-Social-Spiritual model (BPSS)

3.6.1 *Introduction*

A theoretical framework serves as a foundation for any study (Makgahlela, 2016). This chapter presents the Bio-Psycho-Social-Spiritual (BPSS) or the Extended Bio-Psycho-Social model as a framework for the present study outlining its core beliefs, providing empirical evidence for the use of the model both clinically and in research. The present study chose the BPSS model as a framework that generally guided and oriented the attainment of the study objectives. Below, the model's origin, core ideas, and theoretical underpinnings, including the implications for the present study are discussed.

3.6.2 *Origin of the BPSS Model (Also known as Extended Bio-Psycho-Social Model)*

The current study adopted the BPSS model as the theoretical framework to understand Pentecostal pastors' conceptualisation of mental illness. The model is an extension to the widely used and existing Bio-Psycho-Social model coined by George Engel in 1977 (Hefti, 2011). The BPSS model is a modern humanistic and holistic view of the human being in health sciences (Saad, de-Medeiros & Mosini, 2017). For this study, the model was chosen because it integrates religion/spirituality as a fourth dimension (Hefti, 2011) to interpret, assess, diagnose, and treat mental illness. Moreover, the BPSS model provides a holistic and integrative framework and is a useful tool to understand how religious/spiritual influence mental as well as physical health (Hefti, 2011). According to Sulmasy (2002), genuinely holistic health care must address the totality of the patient's relational existence-physical, psychological, social,

and spiritual. Thus, the BPSS model involves a more positive view by suggesting that individuals should not only be seen just in terms of their pathologies, but rather also in terms of their strengths and weaknesses as well (Sulmasy, 2002).

3.6.3 *Core ideas of the BPSS*

The BPSS model of mental illness acknowledges the importance of biological, psychological, social, and spiritual factors as determinants of psychopathology (Shonin & Gordon, 2013). Thus, the BPSS model represents a much more acceptable and inclusive model of understanding mental illness. As noted by Winarski (1997), the BPSS model acknowledges that all persons have many aspects and that these aspects all interact. In other words, all the domains and aspects of a human being are interdependent and when one is affected, all are likely to be affected (Winarski, 1997). It is therefore this researcher's view that the BPSS model provides the relevant and most appropriate lenses for both pastors and MHCPs to understand the origin and manifestation of mental illnesses, as well as how they can be treated. In addition, the BPSS model could also be the most appropriate framework that both pastors and MHCPs implement to develop a comprehensive and all-inclusive intervention programme for their clients who consult with both as already mentioned. In support of the above, Sulmasy (2002, p.32) states that "illness disrupts all of the dimensions of relationships that constitute the patient as a human person, and therefore only a BPSS model can provide a foundation for treating patients holistically".

The BPSS model also provides a platform for whole-person care (Sulmasy, 2002). This is echoed by Puchalski (2013) who indicates that whole-person care is premised on the core values of altruism and service to others, recognizing that clinical care is a vocation and not just a job, which places emphasis on the care of the whole person and describes suffering as psychosocial religious/spiritual as well as physical. As such, this multidimensional approach to the understanding of spirituality and psychopathology requires a multidisciplinary paradigm (Cox & Verhagen, 2011). As mentioned by Lee, Zahn and Baumann (2014), in the domain of mental health and care, it is supposed to be a professional standard to consider patients' various dimensions of mental life as well as behaviour and to reflect them in the therapeutic process. Hefti (2011) agrees that the Bio-Psycho-Social-Spiritual model illustrates that a holistic approach in mental health must integrate pharmacotherapeutic,

psychotherapeutic, socio-therapeutic, and religious/spiritual elements. The other significant aspect of the BPSS model is that it encompasses spirituality, which was a missing element form the dominant BPS model (Monteiro, 2015).

The BPSS model is not a "dualism" in which a "soul" accidentally inhabits a body (Sulmasy, 2002). Rather, in the model, the biological, the psychological, the social, and the spiritual are only distinct dimensions of the person, and no one aspect can be disaggregated from the whole (Sulmasy, 2002). According to Sulmasy (2002), each aspect can be affected differently by a person's history and illness, and each aspect can interact and affect other aspects of the person. Given the above, it is evident that illness can disrupt the integration of one's life and provoke a spiritual crisis around meaning, purpose, and connectedness (Puchalski, 2013). Thus, illness disturbs more than relationships inside the human organism (Sulmasy, 2002). Sulmasy (2002) further mentions that illness disrupts families and workplaces and shatters pre-existing patterns of coping. This then raises questions about one's relationship with the transcendent. Specifically, Sulmasy (2002) indicates that when a person is mentally ill, there are disruptions or disturbances in more than one relationship of the individual's life.

3.6.4 *Clinical application of the BPSS model*
Regarding spiritual/religious support for in-patients, a contemporary orientation of the hospital experience model must encompass the religious/spiritual dimension (Saad et al., 2017). According to Saad et al (2017), in order not to hurt sensibilities or be invasive, the ideal situation is to check with the patient, on admission, whether he/she wants a religious/spiritual visit. If so, the patient's name goes into a list that is provided to the clergyman (pastors), who then makes the religious/spiritual visit only for them, avoiding an inopportune intrusion (Saad et al., 2017). The BPSS model thus provides pastors and MHCPs with a platform to explore all the patient's attributions of mental illness. This means the biological, psychological, social, and spiritual. In agreement, Puchalski (2013) remarks that religion/spirituality is dynamic in the patient's understanding of illness, and it may affect coping (both patients and care- givers), healthcare outcomes, and healthcare decision making.

With the above in mind, this researcher is of the opinion that the BPSS model somehow provides us with an opportunity to tap into all the domains affecting human behaviour as they interact with one another without anyone dominating the others. For example, the lens that the BPSS model provides to understand mental illness incorporates and values the unique roles and expertise of MDT members, including pastors. At the same time, the BPSS model corrects the reductionist approach to understanding human behaviour as other previous medical and psychological theories posited. As mentioned by Sulmasy (2002, p.24), "a genuinely holistic health care must address the totality of the patient's relational existence-physical, psychological, social, and spiritual".

3.6.5 *Treatment of mental Illness as explained by the BPSS model*

The BPSS proposes that religious/spiritual faith healers or preachers (pastors) may be used in specialized cases in near-death situations, or terminal cancer cases, chronic pain syndromes, or severe depression to find alleviation for the suffering patients (Bailoor, 2017). Likewise, Monteiro (2015) indicates that to contextualise mental health services in Africa, the BPS model should include a focus on socio-cultural-spiritual dimensions of conceptualising and treating mental illness. Monteiro (2015) asserts that doing so, would represent the unique cultural EMs for understanding mental illness in Africa.

In Africa and Eastern countries as mentioned before in Chapter 2, illness is mainly understood and conceptualised within a religious/spiritual and cultural context. According to Sulmasy (2002), ancient peoples readily understood sickness as a disturbance in relationships. Because these peoples had a keen sense of the relationship between human beings and the cosmos, the task of the shaman was to heal by restoring the relationship between the sick person and the cosmos (Sulmasy, 2002). Thus, healing was a religious/spiritual act which consisted in the restoration of right relationships between people and their gods (Sulmasy, 2002). Although Sulmasy (2002) acknowledged that contemporary scientific healing also consists of the restoration of right relationships, he argued that scientific healing understood this as limited to the restoration of the homeostatic relationships of the patient as an individual organism. Thus, sincerely, and profoundly applying this new view of the human being

(the Bio-Psycho-Social-Spiritual) would bring remarkable transformations to the concepts of health, disease, treatments, and cure (Saad et al., 2017).

The use of the BPSS model is also consistent with the current evidenced-based practice protocols in the treatment of depression and anxiety (Prest & Robinson, 2006). According to Prest and Robinson (2006), it provides professionals and families with a structure that can be used to collaboratively develop a comprehensive assessment and treatment program focused on the variability and complexity of these conditions. Prest and Robinson (2006) further mention that using the BPSS approach, therapists and clients work together to address the reciprocal relationships among the illness, the individual, physical health, the family, social and cultural factors, and spirituality and religious practices. Prest and Robinson (2006) argue that most people are not used to dissecting their lives in this manner.

3.6.6 The *BPSS on collaboration*

As noted by Winarski (1997), based on that common acceptance of the model, practitioners of diverse views can sit together, view a patient from many angles, and blend their different views into a biopsychosocial/spiritual treatment plan. Thus, in the process, the entire patient is acknowledged, and different team members' competencies to deal with the different aspects are validated (Winiarski, 1997). Generally, as emphasised by Winiarski (1997), the BPSS model assists us in incorporating knowledge from other disciplines. Winiarski (1997) further mentions that the blending of knowledge within a system as just described also must occur within each practitioner. Thus, the BPSS model provides a platform for various professionals to share and exchange knowledge, work in collaboration and above all displays their expertise for the common good of the patient. Moreover, the multidimensional approach of the BPSS model resonates with current thinking and intervention models such as the Task Shifting and Collaborative models which posit the scaling up of mental health services through the recognition and involvement of other non-specialist mental health providers (Murambidzi, 2016).

3.6.7 *Research application of the BPSS model*

Besides its marked significance and growth clinically and academically, there is currently growing evidence supporting the use of the BPSS model in research. For

example, Murambidzi (2016) used the same model in his study and offered him to explore the pastor's biological, social, psychological, and spiritual perspectives on mental illness as potential informal mental health providers in Zimbabwe. In that study, by Murambidzi (2016) the BPSS model was found to be a useful tool to explore and understand the pastors' understandings, responses, and perceived contributions towards people with mental illnesses.

Mental illness was broadly conceptualised as a multi-factorial phenomenon attributed to both supernatural and natural causes. The most common supernatural representation of mental illness was the influence of malevolent spirits while psychosocial and biological representations dominated the natural representations of mental illness (Murambidzi, 2016). The BPSS model provided a broader platform for the recognition of other factors other than bio-psycho-social factors which can cause mental illness. For example, Murambidzi (2016) also established that the tendency to spiritualise mental illness was common among participants' descriptions of their clients' presentations and their subsequent response.

Besides the fact that spiritual factors dominated the pastors' causal factors of mental illness, they also attributed mental illness to a number of causes, including biological, psychological, environmental and social factors, which was consistent with both the BPSS model and previous studies conducted among pastors in LMICs (Murambidzi, 2016). As stated before, in many LMICs, many people prefer to consult with pastors when experiencing mental health problems because they are believed to share the same cultural and spiritual beliefs, they are accessible and less expensive as compared to psychologists. Besides, it is extensively noted in literature that the ratio of psychologists and psychiatrists in LMICs in not proportional to the number of the burden of mental illness thus, presenting a large treatment gap.

3.7 Concluding remarks

The researcher in the present study considers the BPSS model as a useful theoretical lens to explore and understand how Pentecostal pastors perceive mental illness in terms of its diagnosis, causal factors and management or treatment. The model fits

well into the interpretive paradigm since religion/spirituality cannot easily be investigated through the positivist lens of psychological science. As such, the BPSS model is the most suitable framework for this study since it is aimed at exploring the perception and treatment of mental illness by Pentecostal pastors. This study was a response to challenges met by the researcher with religious/spiritual clients in MDT ward rounds as previously mentioned. Many are times, clients are subjected only to the Bio-Psycho-Social model, whereas the religious/spiritual domain is left unattended to or regarded as part of the illness.

RESEARCH METHODOLOGY

4.1 Introduction

This chapter discusses the methodology utilised to complete the doctoral project. The research study used the qualitative approach to explore the perceptions and treatment of mental illnesses by Pentecostal pastors ministering to congregants with mental illnesses with the view of developing an intervention programme. The research methods used to recruit research subjects and collect data are summarized below. This exploratory study was designed to gather qualitative information from pastors who serve as frontline mental health workers to their congregants experiencing mental health problems. The objective was to explore how pastors respond to such congregants and their perceptions of those with mental illnesses. Furthermore, this study aimed to find what could better inform the integration of religion/spirituality into psychotherapy in the form of developing an intervention programme of partnerships between pastors and MHCPs.

This chapter includes a discussion of the methods the researcher utilised for the study and is organised in the following sections: (4.1) Introduction; (4.2) Research approach (4.3) Research design (4.4); Research paradigm (4.5); Study setting; (4.6) Population and sampling (4.7); Data collection (4.8) Data analysis; (4.9) Quality criteria; (4.10) Ethical considerations; (4.11) Concluding remarks.

4.2 Research Approach

This study was undertaken under the qualitative research methodology. Qualitative research seeks to understand a given research problem or topic from the perspectives of the local population it involves (Mack et al., 2005). The choice of qualitative research methodology for the present study, is the based on the fact that, firstly, it takes account of complexity by incorporating the real-world context; secondly, it can take different perspectives on board; thirdly, studies behaviour in natural settings or uses people's accounts as data with usually no manipulation of variables; and fourthly, it focuses on reports of experience or on data that cannot be adequately expressed numerically and

on description and interpretation and might lead to development of new concepts or theory, or to an evaluation of an organisational process (Hannock et al., 2007, p.4).

Qualitative research is especially also effective in obtaining culturally specific information about the values, opinions, behaviours, and social contexts of populations (Mack et al., 2005). The present researcher had sought to obtain quality information from the participants' perspective to gain a better understanding of their worldview; as such this method of research was preferred based on its nature, especially guided by the aims, objective, and the research question. As noted by Mack et al. (2005), the strength of qualitative research is its ability to provide complex textual descriptions of how people experience a given research issue and provides information about the 'human' side of an issue – that is, the often-contradictory behaviours, beliefs, opinions, emotions, and relationships of individuals.

To explore and understand the phenomenon being studied, this normally translates into gathering deep information and perceptions through inductive, qualitative methods such as interviews; vignettes; discussions and participant observation; and representing it from the perspective of the research participant(s). In view of the above, it was essential for this researcher to adopt a qualitative design and to ask open-ended questions, so as to have a deeper understanding of the perceptions of mental illness by the participants.

4.3 Research design

This research was undertaken under an explorative research design. An explorative research design is often used to generate new ideas and to increase the researcher's knowledge and to enable the researcher to familiarise himself with the problem or concept to be studied (Manerikaar & Manerikaar, 2014). According to van Wyk (2012), an exploratory research design is most useful and appropriate for a project seeking to address a subject about which a high level of uncertainty and little research on it exists. The exploratory research design was thus found appropriate since the researcher in the present study seeks to explore and describe how Pentecostal pastors perceive and treat mental illness. Their subjective perceptions formed the core data of the study; hence it needed the method that would deal with the topic in an exploratory

nature. As noted by Thanh and Thanh (2015), there is a high connection between interpretive paradigm and qualitative methodology. By means of in-depth semi-structured interviews, the researcher became part of the research as a meaning maker interacting with the participants in their churches.

4.4. Research paradigm

4.4.1 *Interpretivist/Constructivist paradigm*

A paradigm is a basic belief system and theoretical framework with assumptions about ontology, epistemology, methodology and methods (Rehman & Alharthi, 2016). According to Rehman and Alharthi (2016), a paradigm forms our way of understanding the reality of the world and studying it. This study followed the interpretivist/constructivist paradigm. The interpretivist/constructivist paradigm has roots in the philosophical traditions of the hermeneutics and phenomenology and sociologist Max Weber is generally accredited with being the central influence (Chowdhury, 2014). As noted by Chowdhury (2014), the interpretivist/constructivist paradigm is a school of thought of cultural study through human actions which was founded by Franz Boas in his modern anthropological conception. Boas viewed culture as an integrated system of symbols, ideas and values that should be studied as a working system, an organic whole where he observed people's mental content as being judgement minded in relation to individuals (Chowdhury, 2014). Thus, the interpretivist/constructivist paradigm tries to 'get into the head of the subjects being studied' so to speak, and to understand and interpret what the subject is thinking or the meaning s/he is making of the context (Kivunja & Kuyini, 2017).

According to interpretivists/constructivists, external reality cannot be directly accessible to observers without being contaminated by their worldviews, concepts, backgrounds etc (Rehman & Alharthi, 2016). Thus, reality is socially constructed (Kivunja & Kuyini, 2017; and Pham, 2018). As such, interpretivism rejects the notion that a single, verifiable reality exists independent of our senses (Rehman & Alharthi, 2016).

The goal of interpretive methodology is to understand social phenomena in their context (Rehman & Alharthi, 2016). In the process, every effort is made to try to understand the viewpoint of the subject being observed, rather than the viewpoint of

the observer (Rehaman & Altharthi, 2016) since this paradigm asserts that truth and reality are created, not discovered. Theoretically, it is also understood that interpretive paradigm allows researchers to view the world through the perceptions and experiences of the participants (Thahn & Thahn, 2015). Specifically, the interpretivist/constructivist paradigm assumes a subjectivist epistemology, a relativist ontology, a naturalist methodology, and a balanced axiology (Pham, 2018), which is why it is referred to sometimes as the constructivist paradigm. According to Pham (2018) interpretivists adapt a relativist ontology in which a single phenomenon may have multiple interpretations rather than a truth that can be determined by a process of measurement. In other words, the assumption of a subjective epistemology means that the researcher makes meaning of their data through their own thinking and cognitive processing of data informed by their interaction with participants (Pham, 2018).

Within the interpretivist/constructivist paradigm, the approach to analysing generated data is inductive, i.e., the researcher tries to discover patterns in the data that are collapsed under broad themes to understand a phenomenon and generate theory (Rehman & Alharthi, 2016). Rehman and Alharthi (2016) indicate that this is the polar opposite of the deductive approach, in which researchers start off by identifying patterns and themes before starting the data collection process; once data are collected, researchers would search through the data for words, statements and events that are instances of the pre-identified patterns and themes.

The interpretivist/constructivist paradigm, theory does not precede research but follows it so that it is grounded on the data generated by the research act (Kivunja & Kuyini, 2017). This then presents a balanced axiology that assumes that the outcome of the research will reflect the values of the researcher, trying to present a balanced report of the findings (Rehman & Alharthi, 2016). As aforementioned, the goal of interpretive research is not to discover universal, context and value free knowledge and truth but to try to understand the interpretations of individuals about the social phenomena they interact with (Rehman & Alharthi, 2016). As such, in seeking the answers for research, the investigator who follows interpretive paradigm uses those experiences to construct and interpret his understanding from gathered data (Than & Than, 2015).

One of the advantages of the interpretivist paradigm is that with the diversifying views to investigate phenomena, interpretivist researchers can not only describe objects, human or events, but also deeply understand them in social context (Pham, 2018). Thus, valuable data collected provide researchers with better insights for further action later (Pham, 2018). However, Pham (2018) mentions that the interpretivist/ constructivist paradigm may be limited in that its research outcomes are unquestionably affected by the researcher's own interpretation, own belief system, ways of thinking or cultural preference which causes to many biases. Secondly, as noted by Pham (2018), the interpretivist paradigm does not address the political and ideological impact on knowledge and social reality.

Furthermore, Pham (2018) indicates that interpretivism is also criticised for its ontological view which tends to be subjective rather than objective. Having observed the character of the interpretivist and in line with the nature of this study (qualitative), this research adopted an interpretivist/constructivist approach. An interpretivist/ constructivist paradigm tries to see the world from the participants' perspective and considers the participant's perceptions of the world (Photongsunan, 2010). As noted by Brooke (2013), there are many realities in the world and the research considers the human situation, behaviours and experiences that construct realities which are inherently subjective. Thus, it will be an error to assume that since Pentecostal pastors globally share the same theological beliefs or doctrine, they hold the same understanding regarding mental illness and how it should be treated.

In accordance with the interpretivist/constructivist paradigm, this researcher is of the view that it is people who give meaning to their social world, and that it is humans who construct that social world (Photongsunan, 2010). In this study, thus the researcher seeks to understand the world through the perceptions and experiences of participants. It is only through the participants' meaning making and construction of their reality that one can understand their perception of mental illness. The explanation and description that they may give of mental illness and how it should be treated is unique and should not be universalised. They socially construct their own understanding and, as a group, may be influenced by different understandings of mental illness as compared to that of MHCPs. Specifically, their socio-cultural

background, theological beliefs, and training, and thus may view a particular event in a different manner compared to civilians.

4.5 Study setting

This study was conducted in Polokwane, Limpopo Province. Polokwane, situated on the Great North Road, is the capital city of the Limpopo Province (South African Cities Network [SACN], 2012). According to the SACN (2012), the proximity of Polokwane to the neighbouring countries of Botswana, Zimbabwe, Mozambique and Swaziland makes it a major economic centre for the area. The Polokwane local municipality comprises a total area of approximately 377 578.99 hectare and is in the central part of the Limpopo Province (SACN, 2012). Despite being predominantly rural in nature, the Polokwane Municipality, located within the Capricorn District Municipality, is both the economic hub and administrative capital of the Limpopo province.

According to the City of Polokwane, (2016), the Black population in the city is approximately 94% of the municipal residents. The White population accounts for almost 5% and the coloureds and Indians just over 1% of municipal residency. Culturally and ethnically diverse, the cultural mix of the city is a fascinating one (City of Polokwane, 2016). In addition, six of the official South African languages can be heard in the streets, namely, Sepedi, XiTsonga, TshiVenda, Isindebele, English and Afrikaans. Polokwane was chosen as the most suitable field for this research because of its ethnic diversity and geographical location.

Figure 1: Map of Polokwane

4.6 Population and sampling

Participants for the present study were selected through purposive sampling. According to Gaganpree (2017), purposive sampling, also known as judgmental, selective, or subjective sampling, reflects a group of sampling techniques that rely on the judgement of the researcher when it comes to selecting the units (e.g., people, case/organisations, events, pieces of data) that are to be studied. Purposive sampling is most effective when one needs to study a certain cultural domain with knowledge experts within (Tongco, 2007). The target population for the present study were Pentecostal pastors of Black/African ethnicity currently residing in Polokwane and pastoring a Pentecostal church within Polokwane. There is a notable emergence of Pentecostal churches within and around the city of Polokwane. Thus, the sample size consisted of pastors within and around a 30km radius around Polokwane.

4.6.1 Characteristics of study participants

Purposive sampling was selected for the present study because it allowed the selection of participants with some defining characteristic such as being a church leader or pastor of Black/African ancestry to a Pentecostal (Classical and New/Neo-Pentecostal) congregation in Polokwane with ages ranging from 19-55 years. The participants who took part in this study were Black/Africans residing in Polokwane and pastoring specifically classical and neo-Pentecostal churches within a 30km radius of the City of Polokwane and upholding Classical/Neo-Pentecostal beliefs as discussed in Chapter 2. Although the participants were Black/African origin, most of the participants preferred to be interviewed in English. Specifically, 12 participants in this study were of Pedi origin, while four were of Tsonga origin, two were Ndebele and one was of Venda origin. However, only six participants preferred to be interviewed in Sepedi.

It is this researcher's observation that speaking or preaching in English is common in the Pentecostal or Charismatic church even in rural areas. Pentecostal pastors from White and Afrikaans speaking churches, from Indigenous Pentecostal churches (i.e., ZCC and Zion Apostolic Churches), Coloureds and Indians were excluded from this

study. Furthermore, church Elders and Deacons were excluded since in the Pentecostal church, they are not regarded as pastors until they are ordained as such. Thus, individuals who participated in this study met the inclusion criteria discussed above. Initially, the researcher proposed to interview 25 participants, but data collection was stopped at participant 19 whereby there were no longer new themes emerging from the participants' responses.

4.6.2 Sampling procedure

In the present study, the researcher approached the leaders of the Limpopo Pastors' Fraternal and the Polokwane United Pastors respectively and had two separate meetings to share with them the purpose and objective of this study. The leaders of the fraternal then announced in their monthly meetings about the study and indicated that those who were interested should participate when the researcher contacts them. The two leaders informed the pastors about the study and were encouraged to voluntarily participant and were informed of no monetary gains from the study. Following that, a list of Pentecostal pastors was obtained from the two leaders. From the list, a convenient sample of pastors was selected based on their availability and willingness to participant in the study when approached by the researcher. The researcher telephonically set an appointment with the selected pastor to be interviewed and briefly related the nature and purpose of the study. The pastors were interviewed at a place most convenient to them, in this case at their church buildings and offices. The participants were conveniently selected regardless of years' experience, size of congregation, educational qualifications, gender, or socio-economic status of the church to ensure that there was variety with respect to key factors in this study. Since the study was exploratory in nature, the issue of whether a pastor had prior experience with mental illness or not was not considered either as an exclusion or inclusion criteria.

Within a research area, different participants can have different opinion regarding a phenomenon (Photongsunan, 2010). Pentecostal churches are usually led by noticeably young pastors as compared to their counterparts in the mainline churches

(Catholics, Anglicans, and Lutherans). In this study, data were collected until a point of saturation was reached. Initially, a total of 25 pastors were interviewed. However, data collection was stopped at participant 19 since saturation was reached (Fusch & Ness, 2015). There were no longer different themes from the data that was available. Thus, only data from 19 participants were analysed since it contained a thick description of the phenomenon studied. Thus, sampling was discontinued when no new theme emerged in the interviews. Following that, data analysis was started.

4.7 Data collection

Jackson (2017) defines data collection as a process which is embedded in the research design and serves as an integral role in the expansion of new knowledge as well as the attaining of a deeper understanding of the world in which we are a part of. According to Jackson (2017), data collection encompasses an array of strategies and methods, whether it is for quantitative research or interpretative research. In this study, data were gathered using semi-structured in-depth interviews (See Appendix 1a, for English version and Appendix 1b, for Sepedi version). The interviews were conducted in English and Sepedi depending on the participant's preference. The majority of participants in this study were Sepedi speaking. Participants from other ethnic groups such as TshiVenda and XiTsonga were interviewed in English.

A total of nineteen participants were interviewed. Thirteen of the participants were interviewed in English as their preferred language while six were interviewed in Sepedi. Each interview took approximately 45-60 or less minutes based on the researcher's probing or the participant's experience, or knowledge of the phenomena studied. Face-to-face interviews were conducted in a non-directive style. A semi-structured Interview Guide (Appendix B) was compiled consisting of open-ended questions which were used to elicit the participant's beliefs, perceptions, and experiences about mental illnesses. The interview schedule was developed based on the purpose of the study and informed by related issues reported in the literature on mental health and religion/spirituality. The Interview Guide included items on the following areas: demographic data, prior mental health training, experiences with people living with a mental illness, perception of mental illness, causal attributions,

recognition of mental illness, perceived treatment and management of mental illnesses, perceived role in the treatment of mental illnesses, views on collaboration with MHCPs and preferences when collaborating.

Semi-structured interviews provide a flexible manner in deducing information and allows for a large information to be obtained. Again, when using semi-structured interviews, the advantage is that interviewer can clarify difficult questions, as well as to further explore issues and to probe as the situation requires. In this study, participants were contacted before the interview and the aim and objectives of the study were discussed with the participants. Appendix C provides the Interview Guide used in the study. All the interviews were audio recorded with the permission of the respondents. The interview protocols were assigned separate identification codes, in line with the recommendation by Smith and Firth (2011). After data were collected, the principal researcher transcribed and cleaned it. The Sepedi interviews were first transcribed in vernacular by the researcher and later were translated to English by an experienced translator. Most of the participants in the study, though they were Sepedi speaking, preferred to be interviewed in English.

4.8 Data analysis

Data analysis is a step in the research process that is interconnected with the data collection process (Jackson, 2017). In this study, data derived through the semi-structured individual interviews are analysed through Thematic Analysis (TA). Thematic Analysis is a method for identifying, analysing, and reporting patterns (themes) within data. It minimally organises and describes your data in (rich) detail. However, frequently it goes further than this, and interprets various aspects of the research topic" (Braun & Clarke, 2006, pp.79). This method of data analysis is good for qualitative research in that it can draw interpretations that are consistent with the data that are collected. According to Braun and Clark (2011), TA is flexible and can be used across a range of research questions, theoretical frameworks, types of data, large and small data sets. Accordingly, as noted by Thahn and Thahn (2015) in

seeking answers for research, the investigator uses the participants' experiences to construct and interpret his understandings from gathered data.

Based on the nature of this research, the research question, the research methodology, epistemology and theoretical framework of this study, this researcher has opted for this analysis method because it also provides an opportunity for giving a rich and a detailed yet complex account of data. Again, Thematic Analysis is capable to detect and identify, e.g., factors or variables that influence any issue generated by the participants. As such, this researcher opted to analyse data using this widely used qualitative analytic method within psychology (Braun & Clark, 2006, p.77).

In this study, data analysis commenced with transcribing and cleaning of the data. The audio-taped interviews were transcribed by the researcher and in the process, listening to each interview, typing out each word from verbatim. For validity checking some of the participants were telephonically contacted to verify what they had said during the interviews. After the initial transcriptions, the transcripts were reviewed by an independent reviewer. The six Sepedi interviews were first transcribed in vernacular language by research assistants and were then translated to English by an experienced language translator and senior lecturer. Subsequently, the interviews were analysed through Thematic Analysis, which is a method for identifying, analysing, and reporting patterns (themes) within data. In the process, the researcher adopted the following steps of inductive data analysis as adopted from Braun and Clark (2006):

- **Familiarising yourself with your data**: In this step, this researcher becomes fully immersed and actively engaged in the data, firstly by transcribing the interactions and then reading (and re-reading) the transcripts and/or listening to the recordings, searching for meanings and patterns. At this stage, initial ideas and potential coding schemes were noted down on the margins of the transcripts. In this stage, the researcher also began to transcribe audio-taped participant interviews into written form to conduct a Thematic Analysis. After reading and familiarising himself with the data, this researcher then began to generate initial codes by making a list of ideas about what is in the data and what is interesting about them.

- **Generating initial codes**: Coding refers to the process of organising data into chunks that are alike, i.e., that share properties for analysis. Once familiar with the data, the researcher then starts identifying preliminary codes, which are the features of the data that appeared interesting and meaningful. These codes are more numerous and specific than themes but provide an indication of the context of the conversation. The codes were then organised into basic themes, which were assimilated into broader or abstract themes.

- **Searching for themes**: The third step in the process is the start of the interpretive analysis of the collated codes. Relevant data extracts were sorted (combined or separated) according to overarching themes. The researcher's thought process alluded to the relationship between codes, subthemes, and themes. In this stage, the researcher systematically assembled, coded themes and subthemes into basic themes.

- **Reviewing themes**: A deeper review of identified themes followed where the researcher decided whether to combine, refine, separate, or discard initial themes. In this phase, the researcher combined and refined initial themes and developed subthemes from the data. As expected, data within themes should cohere together meaningfully, while there should be clear and identifiable distinctions between themes. This was done over two phases, where the themes were checked in relation to the coded extracts (phase1), and then for the overall data set (phase 2).

- **Defining and naming themes**: This step involves 'refining and defining' the themes and potential subthemes within the data. On-going analysis is required to further enhance the identified themes. The researcher provided theme names and clear working definitions that provided a summary. At this stage, unified story of the data emerged from the themes.

- **Producing the report**: Finally, the researcher needs to transform his/her analysis into an interpretable piece of writing by using vivid and compelling extract examples that relate to the themes, research question, and literature. The researcher in the present study summarised the principal themes, analytic

narrative, and data extracts. The principal themes were also contextualised in relation to the research questions, objectives and existing literature integrated and interpreted in a narrative report. All psychological meanings derived from all emerging themes and subthemes were consolidated and presented in the report.

4.9 Quality criteria

• **Trustworthiness**: This refers to the researcher's ability to demonstrate that the evidence for the results reported is sound and when the argument made based on the results is strong (Lester, 1999). In this study, the researcher was to be as open and receptive as possible to the participants' reported experiences. To display trustworthiness in this study, the researcher independently reviewed of transcripts and themes and reflexivity to enhance the trustworthiness of the research findings.

Trustworthiness in the current study is framed on the Lincoln and Guba (1985) four criteria of credibility, dependability, conformability, and transferability. A brief illustration on how the above four processes were applied to determine trustworthiness in this study is outlined below:

• **Credibility**: This refers to the value and believability of the findings (Lincoln & Guba, 1985). To elicit credible information and convincing results, purposive sampling was used to select participants with the capacity to provide credible data relevant to the phenomenon under investigation. Participants who took part in the present study were recommended and made available through two pastors' fraternal LMF and PUP. Moreover, some of the participants were already known to the researcher, who had encountered with them at various prayer gatherings in the City of Polokwane and the researcher verified and confirmed their credentials. Although some of the pastors new the research, they did not know the researcher as a clinical psychologist. Thus, the researcher always kept the precepts guiding the profession of psychology in South Africa, the Health Professions Council of South Africa throughout the study (HPCSA).

• **Dependability**: Refers to the ability of the researcher to account for the constant changing conditions of the phenomenon studied, for the interaction with study participants and for the entire research process carried out with an emergent design (Lincoln & Guba, 1985). In this study, the researcher ensured that there is consistency in data collection, systematic data analysis and the reflexive diary documenting the research process. The researcher met with most of the participants in this study in their church offices and a few at their homes. Furthermore, the researcher was consistent in his way of introducing himself to the participants, which brought about ease and calm to participants who had though the researcher been a journalist or from the Commission for the Promotion and Protection of the Rights of Cultural, Religious and Linguistic Communities (CRL) to investigate how their ran their churches as it had been happening with other Pentecostal churches. To ease the participants, the researcher highlighted that besides being a psychologist, he was also a Pentecostal pastor based in Polokwane, with good intentions, by clearly stating the aim and the objectives of the study. Subsequently, the participants were calmer and more eager to participate as they now regarded the researcher as one of their own.

• **Transferability**: Transferability in qualitative research refers to the degree to which the results of qualitative research can be generalised or transferred to other contexts or settings (Lincoln & Guba, 1985). In the present study, transferability was achieved through a detailed (thick description) of phenomena and by also evaluating the extent to which the conclusions drawn are transferable to other times, settings, situations, and people (Lincoln & Guba, 1985).

4.10. Ethical considerations

4.10.1 *Permission for the study*

For the purposes of this study, permission was sought and obtained from University of Limpopo's Turfloop Research Ethics Committee (TREC) prior the commencement of the study. Permission was granted on the 20/02/2019 and the project number as TREC/02/2019 (See Appendix 5). The researcher also approached the Limpopo Pastors' Fraternal for permission to interview their affiliates (See, Appendix 4). The researcher was then sent a data base of the LPF and PUP affiliated pastors.

4.10.2 *Informed consent*

Research participants are entitled to full information regarding the reasons, aims and purpose of an investigation (Christensen, Jonson & Turner, 2014). When contacting the potential participants for this study, the researcher fully identified himself with the study participants and the participants were briefed about the nature and purpose of the study. The participants who accepted to participate in this study were requested to sign a Consent Form to ensure that they agreed to participate in the study (see Appendix 2(a) for Informed consent – English version and Appendix 2(b) for Informed consent – Sepedi version). Furthermore, prospective participants were informed that participating in this study is voluntary and they could withdraw from the study at any time they wished to during data collection. The researcher also openly discussed with the participants the potential benefits and risks associated with participating in the study and that there were no monetary gains for participating in the study. In addition, the participants were also informed of how data from the study would be used.

4.10.3 *Confidentiality and privacy*

Coffelt (2017) defines confidentiality as separating or modifying any personal, identifying information provided by the participants from the data. Thus, the researcher has the responsibility to protect the participant from harm by altering any identifying personal information that may be revealed during the interview. The issue of confidentiality and dissemination of information was discussed with the participants before the interviews are conducted. Further, participants were assured that their names and identities will remain anonymous and confidential throughout the research process. In this study, the researchers did not mention names of the participants or the names of their churches or location. Instead, Code names were used. Furthermore, all audio tapes and recordings were destroyed after the analysis of results was concluded. Research data was always stored on a password protected computer which was kept in the researcher's office. To ensure privacy in this study, the participants were interviewed privately in their church offices and homes. Thus, the participant was not interviewed in a group setting.

4.10.4 *Debriefing for participants*

The researcher was aware that the research could lead to discomfort and some emotional reactions by some participants. In an event where any of the above

happens, affected participants were to be referred for debriefing to psychologists in the local hospitals. The researcher was aware that the research could pose very minimum risks to participants, that is, discussions in the interview could make some participants feel uncomfortable or upset. Participants were therefore advised to bring to the researcher's attention any feelings of discomfort and to choose which questions they feel comfortable to answer as well as their right to stop the interview at any point. In addition, the researcher would debrief participants who report being distressed by the interview process. However, besides some occasional emotional comments on past experiences with mentally ill persons, neither overt nor covert emotional distresses were registered and none of the participants opted to end the interview due to the increasing distress.

4.11 Concluding Remarks

This chapter has explained and described the guiding methodology and the research design which was followed in the research project. Approaching this study qualitatively has aided in that the researcher has obtained a better understanding of participants' subjective opinions and some, their lived experiences. The researcher used semi-structured and open-ended questions to ensure that the research descriptions reflect the participants' perceptions about mental illness. It was also important for the researcher to assure the participants that anonymity, confidentiality and not any harm would be done to them. This was upheld during the entire study.

CHAPTER FIVE

FINDINGS

5.1 Introduction

In this chapter, findings of the present study are presented. The study sought to find out how Pentecostal pastors understood mental illness and how it should be treated as well as their views regarding collaborating with MHCPs. As outlined in the previous chapter, the researcher followed the eight steps of data analysis elucidated by Braun and Clark (2006) to transform the data. In this chapter, the presentation of the results will only be limited to steps 5 and 6 (namely, defining and naming themes from coded data and reporting the findings). In Part A, the data are reviewed with a view to understanding the relationships and patterns within the themes. In Part B, a psychological description and interpretation is given. Based on these psychological descriptions, the researcher then proposes an intervention programme guiding the collaboration of Pentecostal pastors and MHCPs that is presented in Chapter 7.

Firstly, the profile of the participants is introduced (**See, Table 1**), followed by a thematic exposition from the transcripts obtained from the participants. The following psychological themes and subthemes are presented, namely: 1). Notions of mental illnesses by Pentecostal pastors; 2). Diagnosis and Recognition of Mental illness 3) Causes of mental illnesses; and 4), The treatment and management of mental illnesses; 5); Participants' perceived roles; 6). Participants' views regarding referral and collaborating with MHCPs. Subthemes are also presented subsequently after the major themes (**See, Table 2**). The chapter concludes by presenting the psychological meaning of the findings and concluding remarks. As some of the data were collected in Sepedi, some of the phrases which might be difficult to understand when translated into English were explained where necessary.

5.2 Demographic profile of participants

A total of nineteen (19) Pentecostal pastors participated in the study. Sixteen (16) of the participants were male, while only 3 were females. This was indicative of the gender inequality in the profession. They were between twenty-seven and fifty-five

years of age. The participants mainly referred to themselves as pastors, prophets, or apostles irrespective of their qualifications or religious/spiritual denominations. The participants in the study had an array of educational qualifications. Only one of the participants had no tertiary qualifications and was still studying towards his Diploma in Theology. Fourteen of the participants had obtained a Diploma in Theology and five of the participants had obtained a Bachelor's degree in Theology, one an Honours degree in Theology while one of the participants had post-graduate qualifications, including masters, but not in Theology. Eighteen of the participants were from New Pentecostal churches; while only one was from a national church denomination referred to in this study as Classical/mission Pentecostal. The demographic details of the participants are presented in the table below:

Table 1: Demographic Profile of participants

Participants	Gender	Age	Title	Theological Training	Qualification
Participant 1	Male	35	Apostle	No	Master of Business Administration
Participant 2	Male	43	Pastor	Yes	Diploma in Theology
Participant 3	Male	32	Pastor	Yes	Bachelor of Arts in Theology
Participant 4	Male	39	Pastor	Yes	Bachelor of Arts in Theology
Participant 5	Male	31	Prophet	No	Diploma in Marketing
Participant 6	Male	55	Pastor	Yes	Honours Degree in Theology
Participant 7	Male	51	Pastor	Yes	3 Year Diploma in Theology
Participant 8	Female	46	Pastor	Yes	Diploma in Practical Ministry
Participant 9	Male	35	Apostle	Yes	Msc Agricultural Science, Diploma in Theology

Participant 10	Female	52	Pastor	Yes	Bachelor of Arts in Theology
Participant 11	Male	47	Pastor	Yes	Diploma in Theology
Participant 12	Male	53	Pastor	Yes	Bachelor of Education
Participant 13	Male	29	Prophet	Yes	Diploma in Theology
Participant 14	Female	31	Pastor	No	Bachelor of Laws
Participant 15	Male	33	Pastor	No	BCom Degree
Participant 16	Male	38	Apostle	Yes	Diploma in Theology
Participant 17	Male	49	Bishop	Yes	Bachelor of Arts in Theology
Participant 18	Male	54	Bishop	Yes	Bachelor of Theology
Participant 19	Male	50	Apostle	No	Bachelor of Education

PART A: RELATIONSHIPS AND PATTERNS WITHIN EMERGING THEMES

Table 2: Emerging themes and subthemes from the data

Theme Number	Main Theme	Subtheme
1	Participants' notions of mental illness **(5.3)**	**5.3.1** Mental illness is a religious/spiritual problem
		5.3.2 Mental illness is madness/craziness
		5.3.3. Mental illness is a psychological problem
		5.3.4 Mental illness is abnormal or strange behaviour
		5.3.5 Mental illness is demon possession
2	Diagnosis and recognition of mental illnesses (**5.4**)	**5.4.1** Only MHCPs should diagnose mental illness
		5.4.2. Both pastors and MHCPs should diagnose mental illness
		5.4.3 Only pastors should diagnose mental illness
		5.4. 4 Recognition of mental illness
		5.4.1.1 Strange/abnormal behaviour
		5.4.1.2 Taking off clothes
		5.4.1.3 Talking to self
		5.4.1.4 Roaming around

		5.4.1.5 Forgetfulness
		5.4.1.6 Seeing things and hearing voices
3	Causes of Mental illnesses **(5.5)**	**5.5.1** Mental illness is caused by evil spirits and witchcraft
		5.5.2 Mental illness is caused by generational/family curses
		5.5.3 Mental illness is caused by demon possession or demon attacks
		5.5.4 Mental illness attributed to psycho-social factors
		5.5.5 Mental illness is caused by biological factors
4	Treatment and management of mental illnesses **(5.6)**	**5.6.1** Both Mental Health Professionals and pastors should treat mental illnesses collaboratively
		5.6.2 Mental Health Professionals should treat mental illnesses caused by Bio-psycho-social factors only
		5.6.3 Only Pastors should treat all mental illnesses
5	Pastors' perceived roles **(5.7)**	**5.7.1** Providing support
		5.7.2 Counselling, Motivating and Teaching
		5.7.3 Praying/Fasting/Deliverance
		5.7.4 Referral & Follow up
6	5.8 Participants views on referring to and collaborating with Mental Health Professionals	**5.8.1** Preferences in collaborating/referring
		5.8.2 Factors affecting referral to Mental Health Professionals

5.3 Theme 1: Participants' notions of mental illness

5.3.1. *Mental Illness is understood to be a religious/spiritual problem that cannot be cured by natural means*

The following extracts demonstrate these views:

"So, as spiritual people we do say, hey, this is a curse, a spiritual thing, it is witchcraft, it can be like that."

(Participant 5)

"It's a spiritual attack, depression, a lot of things can just happen, and people end up in that condition."

(Participant 8)

"*If I realise that this person has got for example, 'spirits' as we call them and I realise that I cannot help the person myself, there will be a pastor there or somebody I know, this person used to pray for such people and they got delivered."*

*(*Participant 12)

"*They are just giving them the pills just to make them feel better, but they are not healed why, because it is a spirit. If it were something that needed a psychologist who can talk to that person and begin to counsel him, it would be treated. Whether they give those pills or what some of them they are just giving them injections to neutralise their strength. Because it is a spiritual thing. We Christians believe that every challenge or every abnormality that is happening to a human being, there is a certain spirit that is following that person. In the Bible, there is an example of a person who had palsy. And when Jesus came, he would rebuke that spirit.*

Meaning that any form of sickness that a person encounters, it has come spiritually."

(Participant 13)

"*According to our understanding, since that is a spiritual problem, when someone is mad, we can bring them to you medical professionals and give the person medication and inject the person, and just find that they are not helping. You may even examine and find that you cannot detect anything, because the issue will not be in the physical, but in the spiritual. And spiritual things cannot be treated by an injection. It needs to be fixed in its own spiritual way.*"

(Participant 17)

All the above extracts, all indicate that the participants regard themselves as spiritual people. As such, their description and explanation of mental illness is spiritually inclined. It also appears from the above extracts that, since mental illness is perceived to be a spiritual problem, psychological or medical methods of healing cannot address it, but only religious/spiritual methods should be used. This view of mental illnesses by the participants was mainly based on Mark Chapter 5 verse 1-20, a scripture in the Bible. They explained that the man's behaviour and characteristics in the story fitted exactly into their 'picture' of what they would consider to be mental illness and how it should be treated and managed. This is indicative of how uneasy it can be for the participants to diagnose or differentiate between mental illness and a religious/spiritual problem.

Participants who uphold the view that mental illness is a spirit or a spiritual problem may influence their congregants not to seek psychological help, delay treatment or even abandon medical treatment if they were already started or employ only spiritual ways to help the congregant. At most, they may even dismiss the diagnosis. Furthermore, based on this view of mental illness, referral to MHCPs may be impossible. Again, the explanations of mental illness given by the participants above could suggest that mental illness does not exist, but spiritual problems are common. This could also mean that the other dimensions of well-being such as emotional,

cognitive, social, and biological may be overlooked, thus creating an imbalance in a person's life. This is illustrated by these extracts:

"I think it is issues of denial to say it is not a mental problem that makes us not to really deal with it as such."

(Participant 2)

"But most of them, especially the ones affecting learners and students at the universities most of that happens during examination time, I have observed such cases. But those ones I say it is a demonic attack, it is a spiritual thing."

(Participant 13)

The extracts above may suggest that learners who experience exam related stress or adjustment problems during exam times, may be viewed as attacked by demons and not be referred to MHCPs for psychotherapy. The central belief that emerges from all the participants quoted above is that the participants' beliefs in Biblical scriptures and the Holy Spirit shape their world view, they rely on to understand view and interpret phenomena. So, looking at mental illness any other way other than relying on scripture and the Holy Spirit may be viewed as stifling or undermining the power of the Holy Spirit. Based on that, Pentecostal pastors may exalt their approach and methods and underutilise psychological intervention. MHCPs may be viewed as 'secular' and not understanding spiritual things. As such, for efficiency or what is referred to as cultural competency, it calls for the psychologist to understand more of the Pentecostal culture (i.e., their theology, their values, meaning making, ideologies and etc.).

In this study, the participants also understood mental illness based on the context where it takes place. In other words, if it is in church, it may only be viewed as a spiritual problem and when outside church, other causes maybe considered. And besides being Pentecostal pastors, the participants seem to be aware of their cultural background as well as their race, which influenced their perception of mental illnesses. This means that, besides being influenced by their theological beliefs, participants in this study were also influenced by their African ancestry. This is supported by the extracts below:

"If it happens in a church set up, it's not something that we look at as a mental problem but as a spiritual problem. So, we deal with it spiritually, and then you find that the issue of praying and casting until this person normalises again. More like exorcism."

(Participant 2)

"I *am an African. I know that some mental illnesses might be caused by witchcraft. You may be attacked by the spirit of witchcraft."*

(Participant 11)

"We Africans believe that there is what we call witchcraft that exists."

(Participant 13)

5.3.2 *Mental illness is madness/craziness*

The participants in this study also understood mental illness as madness/craziness, though there was no clear-cut distinction between the two concepts. This view of mental illness is illustrated by the following extracts:

"Initially, what comes to my mind when I hear about mental illness (pauses a bit) is… a person that is being crazy. From the school of thought that I come from, we identify mental illness as a person that is crazy. In a Black community or Black society, if they say anyone is affected mentally, we automatically or we grew up knowing that, if something has to do with your mental or psychology, you are mad."

(Participant 4)

"When you read in the Bible, the Bible states that Jesus finds a sick person in the cemetery. This sick person was called a mad person. From that, you begin to understand that when the Bible describes a person with mental illness, it says it is a mad person."

(Participant 17)

It emerges from the above excerpts that what medical and MHCPs would refer to as psychosis or mania, is referred to as madness or craziness. While what MHCPs refer to as mood, anxiety, or adjustment and trauma related disorders is referred to as mental illness by some participants. Some of the participants would begin by using the word madness, but later withdraw or apologise citing that it is derogatory. But when asked to describe symptoms of madness, they appeared to be like what MHCPs would consider as psychosis. This is illustrated by the following extracts:

"But then, your level of madness may not be like that of people you see or meet on the streets eating on dustbins, this and that…."

(Participant 4)

"It starts as stress, then depression. Then, when the illness is more severe, I understand that one of them will be that, it is madness/craziness or losing your mind."

(Participant 15)

"There is madness/craziness and mental illness. Those two are different. Mental illness is depression, stress, and others. Craziness on the other hand, is more severe and cannot be treated by your modern medical methods, because it is spiritual in nature."

(Participant 17)

Based on the above extracts, it seems that the participants in this study understood mental illness to be progressive from a milder form to a more severe form. It appears that the more severe form of mental illness is then referred to as madness.

"But it was not as severe as I said had happened with the family members. Like I said, it manifests in different forms."

(Participant 2)

"Because, like I said in the beginning, in warfare, we say the highest level of disability is when a person is mad or is crazy."

(Participant 4)

"According to my understanding, it will start as stress. But as I see it, stress will be the initial stage. And when it becomes intense, it comes to what we call in English, 'depression' but I do not know. Maybe in Sepedi, it will be severe depression (kgatello e kgolo ya monagano). But let me just say severe depression. So, it will start as depression, severe depression. I think those are some of the mental illnesses."

(Participant 15)

It was also understood by the participants in this study that what they perceived to be lesser forms of mental illness, would be treated, and managed psychologically as compared to what viewed as craziness/madness. Again, when what is perceived to be mental illness by the participants is of a milder form or type, it seems that the participants were comfortable mentioning and accepting as compared to more severe mental illnesses, which this researcher has already mentioned as understood to be madness. The extract below illustrates this understanding:

"Mental illness is different from madness/craziness in this fashion: When someone is mentally ill, it could be that they had unresolved problems or have problems and having no one to talk to. Maybe it could be the fact that the person is shy, he is ashamed because of the seriousness and sensitivity of the problem they are having. And when someone is suffering from mental illness, not madness, they can be treated."

(Participant 17)

From the extracts above, it emerges that the participants in this study do not have a common definition of what mental illness is. At the same time, mental illness is viewed as madness/craziness and vice versa. However, there seems to be a common understanding from the participants that madness is viewed as the highest form of disability what MHCPs would refer to as psychosis. This may mean that the participants' understanding of mental illnesses is limited to psychosis. The view that is ascribed to mental illness is influenced by the theology of the participants and the context in which the behaviour associated with mental illnesses is observed. Unlike for MHCPs who rely on the ICD-10 Code and the DSM to categorise and classify

mental illnesses, participants in this study, describe mental illnesses based on what is perceived to cause them and the context in which they take place.

This is illustrated by the extract below:

"In our ministry or in the warfare, we do not just say that this is a psychological problem. We try to look for the cause. So, when we discovered the cause, we realised that it was a spiritual problem."

*(***Participant 4)**

This may imply that mental illness may be missed and not clearly recognised by the participants, since it may manifest in spiritual ways as viewed by the participant above. The participants who only rely on the Biblical and cultural explanations of mental illnesses tend to ignore or undermine natural causes that can affect the other dimensions of a human being. This may mean that a congregant experiencing psychological symptoms may be stigmatised or perceived as being spiritually weak. This may also suggest that participants above, lack training and knowledge of mental health issues and may benefit from such training.

5.3.3 *Mental illness is a psychological problem*

Some of the participants in this study understood mental illness to be psychological. This understanding of mental illness is illustrated by the extracts below:

"I know mental illness to be a psychological problem that sometimes needs psychological intervention and that might be temporary. It is not something that will be there forever if well treated and well understood. That's what I understand that even the causes may differ."

(Participant 10)

"A human being is a "triune being". It is a spirit, living in a body and has a soul. So, when we speak of the soul, we speak of the mind, the emotions, we speak of the feelings. And many times, when a person gets attacked, he or she may be attacked in or more of those areas, the mind, the emotions, or the feelings."

One of the participants in this study also viewed mental illness as a medical condition. This is what the participant said:

"Look. I think with the exposure that I have; I am a person who believes that mental illness can be a medical condition and I also believe that if someone can seek medical attention, they can be able to find help."

(Participant 3)

Based on the above illustrations it can suggest that besides being perceived as a spiritual problem, mental illness is also regarded as a psychological problem affecting all people and is not permanent. This is how Participant 4 put it:

"We are the ones who come and pray for these people though they are given medication and then we start speaking hope to them. And we start telling them about you know what…. This thing is not a permanent thing."

(Participant 4)

Based on all the above statements by the participants, it appears that they recognise that there is not only one factor according to these participants which cause mental illness. The other factors are regarded as important. If one of the factors is affected, psychopathology may result. Thus, according to both Participants 10 and 11, a person may be affected or attacked in one of the three areas (body, soul, spirit) and develop a mental illness.

This view of mental illnesses by the participants may help to ease the unwillingness to refer their congregants to MHCPs. The views of the participants above differ from those who viewed mental illness solely as a spiritual problem, thus seeking only a spiritual solution. According to the extracts above, the condition of mental illness manifests with psychological/ or medical symptoms. As such, assistance from a psychologist and/or doctor may help in alleviating the symptom. This could be indicating a paradigm shift taken by theology to be more integrated with psychology.

5.3.4 *Mental illness is understood to be abnormal behaviour*

It emerged from some of the participants in this study that mental illness can manifest as abnormal behaviour.

As some of the participants put it:

"To us is an irrational behaviour where people behave not according to the way they are supposed to behave. It is abnormal."

(Participant 7)

"*Mental illness is when someone is not normal or functioning well properly in the mind."*

(Participant 18)

The above extracts illustrate that mental illness is viewed as an illness that affects the mind of a person and as a result, the person behaves abnormally or irrationally. As a result, people begin to change in many ways. Some of the behaviours which are associated with the view of mental illnesses by the above participants is supported by the following extracts:

"What we have seen with one of our family members, she out of nowhere began to be violent, break things in the house and shouting. The voice would change and stuff something like that…. How she got helped…. was through medical intervention…."

(Participant 2)

"But you can tell than this person is not himself. If they were in their normal state of mind, he would not be behaving the way he is. The person acts violently towards parents or anyone who is trying to help them out."

(Participant 3)

"Their behaviour traits tell most of the time. Especially if you spend much time with them, they do not behave like a normal person. Sometimes they get lost in the middle of a conversation. And they do certain things that a

normal human being will not do, especially if it is in a gathering of people"
Because as a spiritual leader, one of the things that help us to help people
is, checking behaviours. *We work with behaviours.* *We interpret*
behaviours in a different way from a normal person."

(Participant 4)

"*But this one is our "normal" church members. You find that they go at the*
back (in church) and they start disrupting. They become unruly and you
cannot even control them."

(Participant 7)

"*I think, as for me, you can just see it from the outlook that this person is*
not normal. *A normal person and a person who is not normal are two*
different people because if a person is normal, they have good sense. *He*
knows what he is doing. *He knows everything.* *But if a person is insane,*
he can even walk naked. *He cannot even see that he is naked.* *He can*
even start beating people and not even know that he is beating people.
So, a mental person sometimes, he does things which are opposite to what
is supposed to be done mostly."

(Participant 8)

"The problems with mental illness can be seen when someone is unable
to live the way a normal person is supposed to live."

(Participant 16)

Based on the above statements, it does appear that participants recognise the existence of different forms of mental illness according to the symptoms that are displayed. Furthermore, the extracts above, seem to suggest that mental illness is associated with behaviours which are out of touch with reality as understood by the participants. Psychologically, most of the behaviours described above, are what one would refer to as mental illness-psychosis to be specific. It seems that the participants are limited in their understanding of what mental illness is. At one moment, it appears

that they refer to mental illness as madness. While at another moment, it appears that madness is regarded as a spiritual problem, not a mental illness.

Mental health related problems such as anxiety, depression and trauma are viewed as less severe forms of mental illness. Generally, it appears that in Pentecostal circles, mental illness is viewed as abnormal behaviour disrupting or deviating from even spiritual norms. However, it seems difficult for participants to distinguish between abnormal behaviour because of demon possession and spiritual attack and abnormal behaviour because of an existing mental illness.

5.3.5 *Mental illness is demon possession*

It has also emerged from this study that some of the participants regard mental illness to be demon possession. The following extracts illustrate this understanding of mental illness:

> "*But it's unfortunate because I think generally, the church has looked at it as demon possession and what we do is to cast out the devil.*"
>
> **(Participant 2)**

> "*When Jesus went to the Gadenes and he found a man which the Bible says used to live in the tombs, he was possessed with demons called legion. They tried to tame him, but they could not. At some stage they would tie him with chains and some ropes. He would break them and…people were afraid of him. So, if you look at that, when Jesus found the man, he realised that the man was possessed with demons. But probably when people looked at him, not from a spiritual perspective they would say, "He is mentally ill." So that is why you find that in most cases we would rather prefer to pray before we even refer, so as to deal with it in the way of praying…because we take it that, this is just a spirit entering a personality.*"
>
> **(Participant 3)**

One of the participants attempted to distinguish demon possession from mental illness this way:

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"I think there is a difference between a possessed person and mentally disturbed person. A mentally disturbed person can take time to recover others can take short time. But if a person is possessed, they can be delivered there and there and be free. But a mental person, it can take time sometimes, but sometimes it can take easy."

*(***Participant 8)***

Similarly, another participant indicated that they would need to be extra careful before giving an outright answer as to whether someone had mental illness or was demon possessed. This is what he said:

"When I hear that, I don't take it as an outright answer that people who are regarded as mentally ill are all really affected mentally. Because there are some effects that cause them, especially to us who are Pentecostals wherein if you observe certain behaviours of a person, you might quickly say this person is possessed and you may say that, "Here i have to exorcize some type of demons. But before you go there, my understanding is that before you label a person as mentally ill, you have to observe certain things such like the attitude, socio-economic background of a person, maybe the different affiliations of what this person has done or even sometimes you check the background of this person."

(Participant 6)

The above extracts suggest that mental illness is described and understood to be demon possession. However, it seems to be difficult for the participants above to clearly distinguish or draw a line between demon possession and mental illnesses. As such, before a conclusion is made about the sufferer, participants would resort to prayer. Besides prayer, as portrayed above by Participant 6, a thorough assessment or interview will have to be conducted to verify and confirm whether the congregant is demon possessed or had a mental problem.

This may suggest that although the participants may not recognise mental illnesses the same way MHCPs do or have a standardized tool to diagnose mental illnesses, they seem to have their own methods of assessment. This finding is important since

it can provide an opportunity for Pentecostal pastors to work hand in hand with MHCPs, whereby MHCPs would share their knowledge or use their skill and vice versa.

5.4 Theme 2: The diagnosis and recognition of mental Illness

5.4.1 Only MHCPs should diagnose mental illness

Regarding diagnosis of mental illnesses, most participants in this study acknowledged that they did not have the skill and knowledge to diagnose mental illness. They acknowledged that it was not readily an easy thing for them to do. Those who viewed themselves as not being able to diagnose mental illness then emphasized the importance of referring to or collaborating with MHCPs. Generally, there were conflicting views regarding how and by who should mental illness be recognised. The participants who believed that it was not their expertise to diagnose mental illness said this:

> *"Look, the question of recommendations or assessment that can lead us to make recommendations to a person to seek professional help, first, we acknowledge that we are not professionals and are not properly equipped to make assessment to that level."*
>
> **(Participant 3)**

> "*According to me the medical experts…. must diagnose mental illness. (Laughter). I just observe. I suspect, but to put a stamp to say, this is that condition, I don't think it's my place."*
>
> **(Participant 10)**

> "*Generally, I know it is the psychiatrist who does that. I do not know any other person who does that…. And in the church, if there is a case, it is the pastor who gives direction.*"
>
> **(Participant 12)**

The above extracts indicate that most of the participants in this study felt that they were not well equipped or trained to diagnose mental illnesses like MHCPs. As such, they would not hesitate to refer their congregants suspected to be having mental illnesses to MHCPs and would be more open for collaboration.   This finding is surprising since participants are known to be having "spiritual" gifts or powers endowed within them by the Holy Spirit to aid them know people's problems before hand and be able to interpret and treat them. The above participants may be viewed by their colleagues as weak in faith, prayer less or spiritually immature. This again, brings us to the assertion that; Pentecostals differ in doctrine and generally in ministry, although they hold one central belief.

5.4.2 *Both pastors and MHCPs should diagnose mental illness*

Conversely, in this study, it also emerged that some participants strongly believed that both they and MHCPs should diagnose mental illnesses in their different ways. Signifying that, the diagnosis of mental illnesses should not be solely left to MHCPs. This is illustrated by the following extracts from participants:

"Obviously, psychological help also will be needed, because there are certain things that could not be spiritual which will need the help of academics. Which means both pastors and people who are dealing with mental issues can help each other."

(Participant 1)

"On the medical side, if they were able to bring in the spiritual people after they have interviewed them, or they have taken the room of counselling them, then they bring them spiritually, then spiritual leaders or church pray, and God reveals to them what is happening about this person, including what has been said there, and after the pastors or spiritual leaders have dealt with the person, he goes back to the medical science. Then medical science still approves that ok now this person is right according to their tests."

(Participant 4)

"To my belief, it is that..., even though I believe in prayer. I also believe that the knowledge that the psychologist has, even those practitioners who are dealing with the mind of a person has, it is also the gift of God, including hospitals themselves. So, I might not finalise my things. I will assess my thing to my own level and If I felt that now, this person needs a further attention wherein this person needs either to be referred the hospital or to find a psychologist."

(Participant 6)

"There are certain things that we can do and there are certain things that doctors can do. So, while we discover such, while we are busy praying for him and believing God that he can be healed, we refer them to the psychiatrist so that they can do the necessary check-up and assessment on the patient."

(Participant 7)

"I think both they can diagnose it. They can see that this person is disturbed. Especially doctors, they can see from their education. But pastors can discern from the Spirit of God how to deal with those people. Both can just see that this person is mentally disturbed. But doctors will deal with their medicine and everything. But for pastors it will be spiritual warfare. It is not just an easy thing. It is a spiritual war that has to be geared up by prayer and everything so that you can help the person."

(Participant 8)

"I think pastors, should also work with the Department of Health, especially when coming to such cases."

(Participant 13)

From the extracts above, it appears that it is not an easy thing for the participants to diagnose mental illness. As such, they perceive working hand in with MHCPs to complete the process of helping their congregants. As mentioned by one participant, the pastor is the one who gives direction (if it is in church), but they cannot conclude

the presence of mental illness. As indicated earlier that there seems to be difficulties amongst the participants in terms of differentiating between what is regarded as mental illness and madness, there is equally some difficulty in separating a spiritual problem from a mental health problem.

Generally, the above extracts reveal how it is also complex for MHCPs as well to detect mental illness from a highly religious/spiritual group such as Pentecostal Christians, since sometimes symptoms of mental illnesses may be overshadowed by those regarded as spiritual in nature. This therefore calls for an open dialogue or engagements between MHCPs and pastors to identify gaps that could have detrimental effects on their congregants given the fact that, before MHCPs are approached, the participants are first consulted. Moreover, this also raises an awareness to incorporate other worldviews into the teaching and practise of psychology.

5.4.3 *Only pastors should diagnose mental illness*

On a differing tone, some participants indicated that they are able to determine through spiritual means, such as discernment, prophecy, revelation and spiritual counselling/interviewing, whether a case is spiritually inclined or determined when it is purely an issue that MHCPs could diagnose and deal with. Here is what some of the participants said:

> "*We don't fight flesh and blood. We fight spiritual things. So, we do spiritual things more than physical. God helped me a lot to see things. When people say this problem is just a minor thing, however God sees it as a major thing.*"
>
> **(Participant 5)**

> "*Yes, you can by the Spirit of God. Through the Spirit of God, God can just reveal that this thing is a spirit from the family or it's a spirit…and, you know, there are some other people who will be doing something which can cause them to be ill.*"
>
> **(Participant 8)**

The above extracts by the participants may suggest that Pentecostal pastors are more preferred than MHCPs since they are regarded to know the problem beforehand. This is one of the spiritual gifts that is said to be endowed upon the participants by God, namely, the gift of prophecy or discernment. This view is also supported by this participant below:

> *"In Medical science when you have a problem, they don't diagnose the problem. They ask you, what is wrong with you. Then now, what you tell them is wrong, that is what they say is the problem. But on the spiritual part, we must pray and have the gift of discerning, to discern what is wrong. So, it is two different…worlds."*

(Participant 4)

Based on the extracts above, firstly, the weakness of medical science is illustrated, perhaps to portray the idea that the participants have their unique way of diagnosing a mental illness. Again, regarding the diagnosis of mental illness, it emerges that what would be considered in psychological terms as clinical presentation or clinical impression is spiritually determined, whereas for the psychologist it is determined by the information provided by the client and/or tests conducted. As such, the detection of a spiritual problem (mental illness) is said to be possible through the help of the Holy Spirit. However, it should be noted that there were contradictions amongst the participants.

There was no uniformity in terms of how the participants detected the presence of mental illnesses. Some participants indicated that they would firstly have a counselling session to gain more understanding of the problem just like MHCPs would do in clinical interview. And there are those who said they would pray, 'For God to reveal' or use their spiritual gift of prophecy and discernment to 'detect and interpret the problem'. One of the participants said this:

> *"Well, the issue of revelation is that sometimes when you interview a person, or sit with the person or do a one-on-one, you may not have an answer as you speak. But as you continue, the Spirit of the Lord, may reveal certain things based on the answers that the person is bringing. And*

you might tend to… explain to this person, something that this person will be surprised what is happening. The Spirit of the Lord allows you to have a Word of knowledge and to deal about those things. I know that the MHCPs and whatever, will be following a pattern which have been pre-prepared (laughter) so, we don't follow that."

(Participant 6)

5.4.4 Recognition of mental Illness

Data obtained from this study indicate that most of the participants were able to identify some behaviour related to mental illnesses though it was not an easy thing to do, more especially if it occurred during church service. However, it appears that most of the times, it was not a simple exercise for them to clearly differentiate between the symptoms of mental illness and spiritual possession. On the one hand, other participants indicated that they were able to simply observe their behaviour during church services, counselling/interview sessions and generally, based on their interaction with other people. The following extracts illustrate this finding:

"*We personally had an experience like that in the middle of a service. I do not know whether it was charged up by the atmosphere, the environment itself where people will start manifesting (clicking sound). So, like I am saying, if it happens in a church set up, it's not something that we look at it as a mental problem but as a spiritual problem.*"

(Participant 2)

"*And they do certain things that a normal human being will not do, especially let us say if it's in a gathering of people. You understand. So, those are some of the things that we check in because as a spiritual leader, one of the things that help us to help people is, checking behaviours. We work with behaviours. We interpret behaviours in a different way from a normal person.*"

(Participant 4)

"*In the beginning, when they jump, you may not recognise that. But as you engage them in prayers and in counselling, after the incidence, then you realise that, this is not the Holy Spirit. It is something abnormal. When it*

starts, you may not really identify. But in the process as you are engaging them, when you are praying for them, asking them questions, you find out that they don't really respond the way you want them to respond."

(Participant 7)

"At the end you, find that now their actions and their behaviour become somehow wherein if you did not sit down with this person and try to counsel this person and understand what is happening, you may not come up with a correct conclusion of what is going through the mind of that person."

*(***Participant 6)**

"I think, as for me, you can just see it from the outlook that this person is not normal. You can see the behaviour. The way people do. If a person is mentally disturbed, you can easily see that this person is mentally disturbed person."

(Participant 8)

All the extracts above, suggest that most participants in this study have engaged with or encountered with people experiencing mental illness. However, it seems that they often experience challenges regarding the distinction between mental illness and spirit possession. In this regard, respondents found it difficult to delineate naturally occurring mental illness from spiritual possession. But, with the passing of time after prayers, one-on-one sessions, or further observation, they seem to have a breakthrough using their own tools. In the event whereby the feel uncertain or overwhelmed, that is where they will either refer externally or internally.

Several signs and symptoms that characterise mental illness were identified and described by the participants. In this section, the different signs and symptoms as perceived by the participants are presented as follows:

5.4.1.1 *Behaving strangely and violently*

According to the participants, behaving strangely, being violent towards others and doing things that do not make sense are some of the common indicators of mental illness. This is reflected in the following statements:

"You find that a person prays…. But the way he prays, he begins to speak things which you cannot even understand yourself. It cannot be other tongues! (Voice louder and nodding head). No, you find that he is speaking another language you cannot understand yourself. Maybe it could be that there has been a spiritual attack or so."

(Participant 1)

"*Look! It is a sad one because you just see this individual that you know to be this type of a person behaving in a strange way that you do not understand. You know. Uhm It alters their behaviour. It changes how they look at things also."*

(Participant 2)

"*Look, the person will be acting violently towards parents or anyone who is trying to help them out. They will act violently; they will not want to listen to anyone and even their physical appearance somehow will change."*

(Participant 3)

"I mean, we have a lot of cases of mental health where you find people just behave in an irrational way, jumping around, screaming, falling just all that."

(Participant 7)

From the above extracts, it is evident that deviant behaviour is reflecting in actions like behaving irrationally, being violent, jumping around and not making sense hence considered as mental illness. However, it also appears that it is not easy for most of the participants to distinguish between the signs and symptoms of mental illness from spiritual attack and vice versa. The signs and symptoms that most Pentecostal pastors perceived to be those mental illness was like those MHCPs considered to be mental illness or a mental health problem. In particular, the most dominant signs and symptoms were related to the Biblical event in Mark Chapter 5.

5.4.1.2 *Undressing in public*

The participants in this study indicated that some of the signs and symptoms of mental illness are reflected when the person affected takes off clothes in public. This is shown by the following statements:

> *"But if a person is insane, he can even walk naked. He cannot even see that he is naked."*
>
> **(Participant 8)**

> *"Sometimes, you find that this person is naked, not wearing anything, his manhood being visible. Such things, a normal person cannot do."*
>
> **(Participant 16)**

The above extracts depict a picture which confirms that the participants in this study view taking off the clothes in public as a sign and symptom of mental illness. Taking off clothes was also associated with behaviours such as untidiness.

5.4.1.3 *Talking to Self and Laughing Alone*

Participants indicated that behaviour such as talking to self and laughing alone and being irrelevant during a conversation as common indicators of mental illness. This is reflected in the following statements:

> *"Normally there are pictures that you see nobody sees according to our views….and sometimes, a person would just speak alone."*
>
> **(Participant 1)**

> *"In fact, he just started making noise in the church. He wasn't shouting, he just started making noise and speaking alone at the back."*
>
> **(Participant 7)**

> *"The signs of mental illness, can include talking alone or not talking at all."*
>
> **(Participant 11)**

"Usually, the person will be talking alone, laughing alone, not making sense and off ramping when you communicate with him."

(Participant 16)

5.4.1.4 *Roaming around*

Participants in this study indicated that behaviours such as roaming around, shouting and hoarding are reflective of the presence of a mental illness in an individual's live. This is illustrated by the following statement:

"*For example, there is a certain young man around……He roams around to and from down the tar road. He will go down to that village…....come back to this village, just making fruitless up and downs in a day" Such things, a normal person cannot do.*"

(Participant 16)

5.4.1.5 *Seeing things and hearing voices*

"Normally there are pictures that you see that nobody sees.   And when they are sleeping, they would hear sounds, they would hear people calling them, so it is really disturbing that you find people in that kind of a situation in the church circles."

(Participant 1)

5.4.1.6 *Easily forgetting things*

Participants indicated that they would identify someone with a mental illness when the person consistently or continuously forgets things most of the time. This is reflected in the following extracts:

"Thirdly you will find that this person just tells you, "You know what, I have forgotten things while you have just spoken to him to do something (forgetfulness). Even in the ministry you give people instructions to do things, all the sudden and you find that it is not done. When you ask them, they say, "Ï have forgotten". So, you would see that this is really a mental challenge because if I tell you something in 5 minutes ago and when I come back after 10 minutes you say you have forgotten to do it."

*(***Participant 1)**

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"Someone with mental illness could be somebody who easily forgets what he has learnt, maybe by birth, he can't be able to use the mind as he should. So, a think those kinds of people are left behind in the academic area…."

(Participant 9)

The statements above reflect the fact that forgetfulness is viewed by participants as one of the symptoms of an existing mental illness. It also appears from the above extracts that forgetfulness is because of a mental challenge eventually leading the sufferer to even make slow academic progress. Although it is not clear which mental illness the participants may be referring to specifically, in psychological terms and based on the DSM, it appears that the symptoms could possibly be reflecting Intellectual disability. In their description of the signs and symptoms of mental illness, there seemed to be a consensus amongst the participants. In other words, although they mostly described mental illness from various perspectives, in terms of its manifestation, there was a great convergence. When the participants described the symptoms and behaviours associated with the mental health issues, they were congruent with the participants' descriptions of the issues though the symptoms seemed to be mainly representing psychosis. This could mean that mental illnesses with a more affective presentation may not be easy to detect and treat for the participants.

Although most of the respondents could not name the specific mental disorders, descriptions of the symptoms seem to suggest the following mental conditions, schizophrenia, substance related disorders, acute or Post-Traumatic Stress Disorders, intellectual disability, and major depressive disorder with psychotic features. While the participants above were able to identify the above as symptoms of mental illness, it also appears that the same behaviours were associated with madness based on their description of mental illness. This finding insinuates that MHCPs need to consider looking at clients' problems outside the confines of the DSM-5 and the ICD-10. This can be achieved either through an integral or collaborative approach or considering culturally/spiritually inclined classifications of mental illness and interventions.

5.5 Theme 3: Causes of mental illness

All the participants in this study attributed mental illness to multiple causes. However, religious/spiritual attributions of mental illness were emphasised as the main causes. Although other factors were considered, they were said to be spiritually influenced. All the participants acknowledged other causes to the mental health disorders, including biological components, social components, and psychological factors. The participants realized that there could be multiple causes, depending on the issue and the individual, and most of the time there was more than one contributing factor to mental illness. This is reflected by the statement below:

> "*I think for various people, there different causes. I have met different cases as a person. I have met people that were raped. I have met people who lost their family members, in one accident, where the mother, father and siblings die and they are left alone. I have met people where the child realises later that the family there are staying with, are not their biological parents.*"

> **(Participant 14)**

However, the most prevailing causes of mental illness according to Pentecostal pastors in the present study were spiritually inclined forces, i.e., (demonic attacks, curses, witchcraft, and evil spirits).

5.5.1 *Mental illness is caused by evil spirits and witchcraft*

Most of the participants perceived mental illness to be a direct result of witchcraft or evil spirits. They indicated that people would be bewitched for various reasons like to stop them from progressing in various aspects of life or obtaining their inheritance.

This understanding is reflected in the following statements:

> "*Like I said in the beginning…It might be…. Witchcraft. I would say its witchcraft. Mostly it is witchcraft. I can even give a testimony.*" *So, when we discovered the cause, we realised that it was a spiritual problem that*

some other family members wanted this young man to be crazy so that he does not get his inheritance."

(Participant 4)

"Some of them are bewitched. Some of them you find that now really, they are bewitched, which we get the story from family members. That is how they brought them. They said this one has been bewitched."

(Participant 7)

"I am an African. I know that some might be caused by witchcraft. You may be attacked by the spirit of witchcraft."

(Participant 11)

"We Africans believe that there is what we call witchcraft that exists. So, it might be that it is demonic and also we can say that it is witchcraft, maybe they have cast a spell upon that person and that person begins to react in a funny way."

(Participant 13)

"It is highly impossible that you can take your own life because of unemployment of being overwhelmed at work. So, it is a clear indication that Satan uses that situation to attack you. It happened to me, but I got help from another pastor."

(Participant 15)

"But it also shows what brings about madness in the life of a person. Madness is a spiritual illness, not mental illness. It is a spiritual illness, which is brought about by evil spirits in a person. If you hear it, it says, "Evil spirits "coming to him, cutting himself with sharp stones, and doing all sorts of abnormal things. Firstly, he lived in the graveyard. Secondly, cutting himself with things. So, the Bible shows that there is madness, which is brought by evil spirits. But now, as African people, you might have realised that I am not white. We know that it is not only that madness

is brought by evil spirits. Evil spirits are also influenced by another spirit, which is the spirit of witchcraft. Witchcraft is also spiritual."

(Participant 17)

The extracts above bear evidence that participants in this study understand that mental illness or madness as they refer to it is brought about by supernatural forces such as evil spirits or witchcraft. Participants indicated that an individual can be bewitched for several reasons. Sometimes it can be because of jealous or hatred or revenge or demonstrating power or strength ill. Such a belief that the participants have about mental illness could either contribute to the developments of mental illness or complicate the treatment of an existing mental health problem.

The bearer or suffer of a mental illness may trust their pastor who is apparently more accessible, trusted, and closer to the congregant as compared to the MHCPs. Again, the methods that MHCPs use to treat mental illness may be rendered ineffective or irrelevant when a case is perceived to be because of evil spirits or witchcraft. It appears that the treatment of mental illness is symptom based rather than problem based. As such, when symptoms subside, it can be interpreted as if the illness has been cured.

5.5.2 *Mental illness results from generational curses*

Other participants in this study perceived mental illness as a generational or family curse. Specifically, the participants were of the view that mental illness was a curse running within the family brought about by various reasons. This is highlighted by the following statements:

"With medical science, if you just know that one person in the family once had this, you become cool that I am not starting with this, in this family. It is a family thing. But with us as Pentecostals, we do not have that thing that, "It's a family thing". It is a generational curse. We need to uproot it from the roots completely…."

(Participant 4)

"We realised this thing is running in the family, so as spiritual people we do say, hey, this is a curse, a spiritual thing, it is witchcraft, it can be like

that. It does happen. We believe that. Because we say, "We don't fight flesh and blood "We fight spiritual things" "So, mental illness for me it is like there is a curse that is released from the Kingdom of Darkness. I believe so. Every person who is born was born to be a normal person. We were not born to be ill or have any Chronic, any kind of chronic. But God wants us to have good health. So, what I understand about mental illness that this thing is a curse that is running from generations to generations."

(Participant 5)

Based on the extracts above, it could be suggested that mental illness is conceived as something that can affect an individual because of a curse or a spell which was cast on the entire family. This might not be viewed in a similar way by the Western-trained MHCPs who may see the explanation of the cause of mental illness as genetically inclined or as heredity. In the process, they suffer; especially the younger generation may experience emotional distress because of inheriting the curse from their family line.

5.5.3 *Mental illness is caused by demon possession and demonic attacks*

Other participants in addition to the above-mentioned causes alluded that mental illness was as a result of demonic possession and/or demonic attacks which they described as the entrance of a demon in the life of someone to cause emotional or spiritual distress, failure, sickness and etc. This is reflected by the following statements:

"….. And of course, demon possession somehow. So that is why you find that in most cases we would rather prefer to pray before we even refer, is to deal with it in the way of praying…because we take it that, this is just a spirit entering a personality. And we have seen a few delivered through that and now you find that suddenly this person is fine without any medical intervention or anything like that…."

(Participant 2)

"When Jesus went to the Gadenes and found a man which the Bible says a used to live in the tombs. He was possessed with demons called legion. And they tried to tame him but they could not. At some stage they will take

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him with chains and some ropes. He would break them and…people were afraid of him. Uhm. So, if you look at that, when Jesus found the man, he realised that the man was possessed with demons. But probably when people looked at him, not from a spiritually perspective they would say, "He is mentally ill."

(Participant 3)

"*Well, if it is a spiritual matter, we hear of demon possession, that one is possessed with spirits. Yeah, that is what we hear.*"

(Participant 12)

"*But I have concluded that a mental problem, even though it may be demonic, the devil will always use a tool, you understand to launch that attack. Whether it is substance abuse or, whether it is stress.*"

(Participant 13)

Apart from demonic possession, other participants indicated that mental illness can be caused by *demonic attacks*, which is to be oppressed by a demon. This is what some participants mentioned:

"*According to me what I have seen, I can say that most of the people who have this problem, it is a **demonic attack.** Unless someone was injured on the head and something shifts.*"

*(***Participant 13***)*

"*And then they start to manifest, manifest demons. These very demons, you find that it is not necessarily mental illness, but these demons are blocking them somehow, for the future, for their careers whatever.*"

(Participant 19)

From the above extracts it can be deduced that individuals manifesting signs and symptoms of mental illness are said to either be demon possessed or demon attacked. Participants indicated that demon possession is when a foreign spirit or personality

enters the mind of a person and begin to control and influence them. Eventually, the presence of the demon in the mind of the affected will manifests through the behaviours that participants recognise as mental illness. On the other hand, demonic attacks are described by the participants as invisible spiritual forces which remain outside the body or mind of a person but from time to time causing them spiritually or mentally related problems yet remaining in their place of abode. It also appears as indicated by the participants that its demonic possession is more associated with vulnerable individuals, especially those who are not born again, while demonic attacks usually affect those who are already born again. As such, deliverance, exorcism, prayer, and fasting are likely to be used methods of intervention.

5.5.4 *Mental illness is a result of sin or living a sinful Life*

Other participants in the present study have attributed the presence of mental illness/health problems to sin, and to be specific, 'unconfessed sin'. This is illustrated by the following statements:

> "*Mental illness can also be caused by like I said for example, if you do something wrong and that you discover that, the thing I have done is wrong and you meditate upon it, it ends up damaging your mind*" Especially like *if you kill somebody that is a sin. If you do something bad pastor, you can meditate upon it that. This thing I have done, I have done an extra mile which is bad. That thing recurs in your mind.*"

(**Participant 8**)

> "*Sometimes when a person had done something, not wanting to confess, that thing will oppresses him, eating him up. Sometimes because of the status or position of being afraid that if I confess* **my sin***, people will perceive me somehow. As a result, the person will remain with that secret deep within and it troubles him. That is why sometimes you will just hear a person saying, "I have killed someone, I have killed someone, talking to self" Eventually; the person may be affected mentally.*"

(**Participant 16**)

"If someone has not fully surrendered all to the salvation of the Lord could be the one which might have caused that woman to have mental illness. This is because; the Spirit of God is not free to dwell in her while as she continued doing those things which do not please God. That is what I know, which I have encountered in my ministry."

(Participant 18)

The above extracts seem to denote that if a person lives a sinful life, whereby they continue to sin and not confess their sins to God or anyone in the church, the sin may remain in them, leading to emotional distress and ultimately mental illness. This understanding of this causal factor of mental illness holds some similar understanding of mental illness by the Psychodynamic view especially. For instance, according to the Psychodynamic view of mental illness, when people supress their thoughts and feelings, they become prone to develop psychopathology later in their lives.

The behaviours portrayed in the extracts above, by the participants above can be equated to what is referred in psychology as a defence mechanism. Furthermore, based on what the participants above have mentioned, the presence or onset of mental illness may be exacerbated by the status or position of the affected in the church, leading to delayed or missed psychological intervention. As such, this may call for the church to provide a channel whereby people can express their feelings freely and openly without fear of being judged or perceived as spiritually weak. For psychology it may mean providing psycho-education on how harbouring or suppress emotion may affect a person's behaviour.

5.5.5 *Mental illness is caused by biological factors*

Besides the spiritual factors which the participants noted as causal factors of mental illnesses, participants also attributed mental health problems to biological factors such as substance abuse, Traumatic Brain Injuries and heredity. This is reflected in the statement below:

"And the last one was with a young man who went to smoke some substance which we still don't know what it was. But then it has been going on for some time until it got to a point where he started."

"The other one it was use of drugs. We also had an experience with that-The use of drugs (laughs). Although you only pick it up later that someone is actually on drugs when they are now fine and you are forcing them, but not violently so, but by at least putting them in a corner to say, "tell me what's going on"? Is there any substance that you are taking that could be contributing to this condition? And eventually they do admit, and they will tell you that look, "I am addicted to this kind of drug. And it is starting to take over."

(Participant 3)

"*Some of them it is because of substance abuse. I remember last time; we had a brother from a very well to do family because I thought it was abuse. But he was from a well to do family. But when I asked the parents, they said no, he is taking a lot of substances. Like drugs and dagga. It was the parents who told us that.*"

(**Participant 7**)

"*Of course, some they can be caused by abuse of substances, an overdose of nyaope or marijuana or whatever, all those kinds of things that people are smoking. Usually, they can also affect the brain.*"

(Participant 13)

Besides the abuse of substances, some participants in this study attributed the presence of mental illness to heredity and Traumatic Brain Injuries. This is illustrated by the following statements:

"It is also possible that someone can be born with a mental illness from the onset."

(Participant 9)

"Some mental illnesses can be as a result of heredity or family genes."

(Participant 10)

"Sometimes, a mental illness can result because someone has been diagnosed with a brain tumour for example."

(Participant 12)

When a child can fall many times and be injured on the head, that can affect their brain/ and cause them mental illness."

(Participant 19)

From the above extracts, it is evident that mental illness is complex and multifaceted in nature. Generally, most participants concerted that there are many causal factors that influence mental illness. These factors could either be internal or external. As we have seen from the extracts above, some of the participants had a multidimensional understanding of mental health and illness. This was demonstrated by their perception of what mental health/illness was by describing it as a combination of emotional, spiritual, mental, and physical health as influencing one's mental state.

The extracts above also depict a picture that mental illness is understood by the participants to emanate from the abuse of substances. It appears that the participants only begin to realise after having observed some strange behaviours from their congregants or being told by the caregivers of the affected individual. The continued use and abuse of drugs as indicated by the participants could affect the individual cognitively, emotionally, and behaviourally. Although participants display some sense of awareness to the dangers of drug abuse, it seems that they have some limitations in terms of specific drugs of abuse's presentation and causes of drug abuse (especially in a church setting) and perhaps how they can help the affected. With this limited knowledge, the participants may resort to spiritual methods to deal with the problem.

However, one participant said this:

"However, when we realise that the situation is beyond what we can understand and even after praying/when we pray we realise that there seem to be no…improvement or no change or little change for that matter, then we make recommendations. But I can confirm that almost 99.9

percent of the people that we pray for, even when they look fine, we still make the recommendation and say, "Look just to verify that everything is well with you, just go and consult, see a psychologist, psychiatrist, a doctor or professional that can be able to best help you."

(Participant 2)

Based on the statement above, it is likely that when mental illness is perceived to have been caused by substances, participants are open to further engage with MHCPs for the further management of the congregant though they will have prayed for the person. This may be indicative of the fact that participants in this study are open and willing to collaborate with Mental Health Professionals in the care and treatment of the affected.

5.5.6 *Psycho-social factors*

Other causal factors such as psychological past life experiences, stress, divorce, loss, poverty, trauma, depression) and other life/environmental circumstances, relational problems and family conflicts as causal factors of mental illness emerged from the participants in this study. However, it is important to indicate that, though these factors were recognised as natural, other participants regarded them as spiritually orchestrated. Here is what the participants said to indicate the above:

"From my perspective as a pastor, I should think that, there a lot of things. Others they go through abuse in families. And others have seen horrible things in their lives which leaves them affected mentally."

(Participant 1)

"You find that somebody has just gone through a divorce or a painful experience…And loss of a loved one, things like that. So, then people can see that…. this person is…. You know just Depression as it is……. then we will do some small counselling and telling them how much God would love them. You know we commit to praying for them, just giving them normal support without any medical intervention."

(Participant 2)

"First we realised that stress and should I say trauma? When a person was under a lot of stress. Because after praying for people and then you sit down with them later when they are in a position to converse with you normally, then you ask what is happening, you check their background, then you realize that there is so many things that was happening or that is happening in their lives that is putting in a lot of pressure or a lot of stress on them and depression that somehow affects them. Some of them, the evidence was clear. You find that maybe that it's a young lady who has just lost a husband."

(Participant 3)

"I think you know, family issues, depression can come and can also affect the lives of people. You know they say people end up having depression and say, "I want to commit suicide". Those things can damage even your mind. There are a lot of things in life that happens that even people start losing their minds."

(Participant 5)

"Of course, some of these things that may affect, you will find that it's how a person are has been raised up. What I have discovered in church, there are so many people who grew up without knowing their real fathers. And then, when they grew up, they started to behave somehow. And sometimes it is the traumatic stage which this person might have gone through. Because all these things may affect this person, wherein some of them are so depressed in such a way that now it may affect their behaviour."

(Participant 6)

"Previous abusive experiences and relationships that a person might have had in the past can take part in damaging his/her mind."

(Participant 16)

"When relationships end unexpectedly, when there has been loss of employment and divorce, people can have mental illness."

From the above explanations of the causes of mental illness by participants, it can be construed that participant are also aware of many other factors which could contribute to the development of mental illnesses. Besides perceiving mental illness only as a religious/spiritual problem requiring a spiritual or divine intervention, participants seem to acknowledge that mental illness can result as a combination of emotional, spiritual, mental, and physical health as influencing one's mental state.

This perception of mental illness by Pentecostal pastors, could easily allow them to pursue a collaborative/integrative approach, consisting of MHCPs to manage and care for their congregants. Besides the psychological factors highlighted by the participants in this study as causes of mental illness, participants also perceived mental illnesses to be resulting from social and environmental factors. This is reflected in the following statements:

"But then, the second part, it might be the influences around you or that the environment that you are in creates such. Like today, well we are talking about some people who are abusing substances because of influences around and environmental influences around them. Then you find that the brain is being affected. When the brain is being affected, the people have a mental illness/condition."

(Participant 4)

"So, if the environment is ok, is normal and encouraging, it is possible that a person can be right. Because I have always had a problem whereby you find that someone goes to court with an abuser, it can be parents who are abusing this child, or children who are abusing parents or a spouse who is being abused by the partner. So, as they come back from the court, they go back to the same "abusive" environment. So, you see that ultimately, this person will lose his mind."

(Participant 11)

"Lack of education, poverty and unemployment can also lead someone to be mentally ill. When a person lives in the right environment and can afford a meal every day in their lives, they are likely to develop symptoms of mental illness that the one who cannot."

(Participant 16)

5.6 Theme 4: Treatment and management of mental illness

Data provided by the participants indicate that they describe various approaches to treatment and management of mental illnesses. The participants' treatment and management approaches that were consistently referred to could be described as aspects of Pentecostal pastors' treatment and management of mental illnesses. These included prayers, the use of scriptures for guidance, teaching, counselling, and motivation. Within these approaches, some participants believed that MHCPs are also used by God to heal through methods of consultation, therapy, and prescribing psychotropic medications. On the one hand, those who described mental illness as a spiritual problem only indicated that it needed divine intervention to treat, not medical methods. The following statements by the participants, reflect their views on the treatment and management approaches:

"Some of the things are spiritual, but we also need medication. We do not really run away from medication. After we pray for them, we know God gave doctors wisdom. There are certain things that we can do and there are certain things that doctors can do. So, while we discover such, while we are busy praying for him and believing God that he can be healed, we refer them to the psychiatrist so that they can do the necessary check-up and assessment on the patient."

(Participant 7)

"When it comes to treatment, there is not only a one-way approach. I believe as I have said that a human being is a triune being. I believe that

there are situations that are medical and that can be treated medically. A person can also go for counselling. And I also understand that a person can be prayed for. So, if it is something that came through stress, I think even though we are going to pray for this person, we need to give the person counselling so that they can be able to understand the situation, pray for this person, and understand the situation and then they admit. Remember that normally when a person is stressed, it is when he is in denial and cannot accept. So, after counselling, when a person is now well in a balanced state, understanding and accepting that there are certain situations that you cannot be able to change yourself, then you allow God to heal you. But at the same time, we can also after praying for the person and realise that there are no changes, you find that there is a mental damage that was done that needs medical attention."

(Participant 11)

Based on the above extracts, participants believe that mental illness can be treated both ways-by pastors and by MHCPs. Again, it appears that the treatment and management of a mental health problem by pastors, is based on what they perceive to be its cause. Overall, three approaches emanated from the data regarding the participants' views on how mental illnesses should be treated and managed namely: (i) Both pastors and MHCPs should treat and manage mental illness; (ii) MHCPs should only treat mental health problems caused by bio-psycho-social factors; and (iii) Only pastors can treat and manage mental health problems divinely

5.6.1 *Both MHCPs and pastors should treat and manage mental illness*

Most participants in this study considered mental illness as a condition that can be treated through pastoral (religious/spiritual) and medical/psychological remedies and practices. This is reflected in the following statements:

"As ministers and pastors, God has given us grace and wisdom and spiritual insight to help people, I think it could be through teachings, mentorship programmes, follow ups on them…. "Obviously, psychological help will also be needed, because there are certain things that could not

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be spiritual which will need the help of academics. So, which means both pastors and people who are dealing with mental issues can help each other."

(Participant 1)

"I would not say one specific person should do that…like I said, it differs in levels. And…as pastors I think we can deal with, we can definitely deal with it…but at the same time we shouldn't be ignorant of those who have studied this extensively to understand…. because sometimes you will find that you pray long and this thing did not really need a long prayer. You pray with them and encourage them to go and do their tests and whatever. You encourage them to take their medication pray over that medication, because we believe that God has called people to work in the medical field. So, mental illness, I do not see why it should be different from any other. So, the approach could be the same."

(Participant 2)

"Medical attention is necessary. It is also viewed as being from God. They are considered as experts in their own right, of course with their expertise as a gift from God. However, medical attention should not replace or undermine spiritual attention and vice versa. "Yes, my view on medical attention…look, my view is that, God gave wisdom, for me, let me put it this way, God gave wisdom to different people, so they can explore what he has already created."

(Participant 3)

"We have people who do counselling in the church. I think even people who did psychology, they can do that. They can treat that. Pastors can do that. Everyone can, If God can give us the wisdom and knowledge to do that. In God there is everything man of God. I trust that God that can do anything. When he says, "Nothing is too hard for me" i think God can do anything. He gave yes doctors wisdom. He gave them to treat this illness. But also, to us spiritually, we can treat that spiritually. We can. Nothing is

impossible with God. We trust God beyond measure that he can do something-a miracle in someone's life."

(Participant 5)

"*It can be treated both ways. It can be treated in the hospital by doctors or also by prayer and fasting, it can be treated through prayer and fasting. You can get help. You can be healed through prayer and fasting. As I said, in our lives, we had several mental people who came into our lives. We prayed for them and they were delivered, and they were ok. And some of them they even went back to their workplaces working well through prayer.*"

(**Participant 8**)

"*I think it can be treated both spiritually and physically. Spiritually meaning, the pastors, servants of God, they should deal with certain mental cases, especially cases such that a person just went mad without using any substance or without being initiated or not having any stress and it is just a sudden attack. I think pastors, also they should work with the Department of Health, especially when coming to such cases, and some people should be given counselling, physically. I mean they should be medical counselling or proper help; they go to those channels. If those channels are not working, they try the other alternative which is spiritual and they begin to pray for them and they begin to cast that spirit out.*"

(Participant 13)

From the extracts above, the participants could be suggesting that they can work collaboratively with MHCPs to care for their congregants with mental health problems. There is no need for them to compete. Although the participants above acknowledge that God has given those special abilities, wisdom, and grace to treat mental illnesses, they perceive that MHCPs are also equally called by God and endowed with wisdom though they use different methods.

The extracts above also reveal that pastors have a therapeutic or counselling role in the lives of their congregants though they admit the need for further referral or

collaboration with MHCPs. The participants did not exalt their ways of management and treatment of mental illness above those of MHCPs. Equally, they did not exalt the treatment and management of mental illness by MHCPs. They acknowledge that, though they played a role in the treatment and management of mental illness, they believe that the treatment of a mentally ill person is incomplete without the help of a psychologist. As such, they acknowledge the limitations as well as strengths. This is reflected in the following statements:

"Yes, there are those cases, but it is not everything that has to be dealt with like I said spiritually. Psychiatrists are trained; they understand the brain of a person and other things. And we, where we are, these other things are just a glimpse, but it is not our main agenda to be trained about the brain of a person and other things. Ours is to focus on the spiritual mainly. But then psychiatrists are needed. In fact, I would say, in our churches we need such people. If they were to say what advice, if church had money or government could pay these people to work in churches, each church, I would suggest, a Pentecostal church must have a psychiatrist or a psychological counsellor that is just sitting there that monitor things. And then you also as a pastor, you work hand in hand with them. This means that there be people that you refer to them and there are people they refer to you as well. Then you work together. Then if you are a team, I believe it will make this stress that we have to become low because people will know that when I go to church, I am being helped psychologically and also spiritually."

(Participant 4)

"To my belief, it is that, even though I believe in prayer. I also believe that the knowledge that the psychologist has, even those practitioners who are dealing with the mind of a person has, it is also the gift of God, including hospitals themselves. Like myself, in my study, I have also dealt with the issue of counselling. So, I might not finalise my things."

*(***Participant 6***)*

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The above extracts also indicate how the participants in this study are eager to work hand in hand with MHCPs for the complete well-being of their congregants/patients. They do not see MHCPs as a threat or as competitors in what they do. They perceive and acknowledge them as experts when it comes to mental health problems, especially those caused by factors considered to be non-spiritual/supernatural. Furthermore, the participants seem to be comfortable with an integral or holistic approach in the treatment and management of people with mental health problems.

In this approach, pastors see themselves playing their role, which consists mainly of emotional support, prayer/deliverance, and encouragement through sharing scripture, teaching their congregants, and supporting them in taking their medication. They did not have any problem with their congregants/patients using psychotropic drugs. This could mean that for psychology and other MHCPs should also be more open to working with pastors so that in their practise, they are inclusive and not undermine or overlook the client-congregant's spiritually inclined needs and interpretation of what they are going through. As MHCPs, we should not undermine the work that the participants do in the lives of their congregant-clients. When someone is experiencing illness, they seem to draw strength from their religion/spirituality. As such, MHCPs should appreciate the role played by participants as religious/spiritual leaders.

5.6.2 *MHCPs should only treat mental illnesses that are caused by Bio-Psycho-Social factors*

Some of the participants in this study indicated that they perceived that mental illness caused by biological, psychological, and social factors are the ones which should be treated by MHCPs while those attributed to religious/spiritual factors should be left for pastors to attend to. This understanding, of by who and how should mental illness be treated, is highlighted by the following statements:

> *"If a person is suffering from an illness with a spiritual cause and you take them to a medically trained/health professional, they will not be able to help them."*

(Participant 15)

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"If it is a matter of witchcraft, it needs to be treated spiritually; the person must be prayed for and be healed. Just like the young girl I spoke about."

(Participant 16)

Yes, it is different. When someone is crazy, even if you can give them whatever you can, they cannot be OK. But the one with mental illness, can be treated, and be fine since you (referring to the researcher), use medical methods."

(Participant 17)

For some participants in this study, it emerges that what they perceive to be the cause of a mental health problem, will determine the kind of treatment approach to be used on the congregant. Participants in this study are very influential and they are the first to be consulted by their congregants and their families in the event of mental health problems. As mentioned before, what the participants refer to as madness, in psychological terms may be equivalent to psychosis. As such, they are likely not to refer those cases whereby sufferers may benefit from psychotropic drugs and subject them only to prayer and casting out of demons while being at ease to refer cases they consider to be mental illness (stress, depression, or trauma). It seems that participants are limited in understanding that psychosis (madness as they refer to it) may have its base on non-spiritual factors.

5.6.3 *Only pastors should treat and manage mental Illness*

Other participants in this study were of the perception that only pastors should treat and manage mental illnesses. This view was regardless of what was perceived to be the causal factor. They solely viewed themselves as appointed and called for that (divine healing). These participants believed that it is only Jesus/God who would heal people or mental health problems and other illnesses. Pastors, who believed this way, were unlikely to collaborate or refer to MHCPs. This perception of the participants is illustrated by the following statements:

"We trust God that we can as spiritual people as pastors, we can, as a prophet I can treat mental illness, as long as God can give me knowledge because from the beginning everything was created by God. So, nothing

is hidden at the sight of God. He can reveal what is the problem and we can treat that, and we can have a way of treating that illness. I believe God for that."

(Participant 5)

"My angle will be like this: my conviction, not only with mental illness, but with all sicknesses. My conviction is that God is a Healer. Even the Word of God says God is a healer. In the Book of Exodus, God tells the Israelites that I will be the Lord your Healer. This means that when you are ill, you will look to me for healing and God will be able to heal you. But the Bible continues to say Jesus is the Greatest Physician. Now, here is my understanding as I teach. I teach like this, there are illnesses. As I have said that the cause of this illness, there are natural things as well as spiritual things. I believe that there are illnesses that are caused by natural things, but there are also illnesses that are caused by spiritual things. So, I think that when the Bible says that Jesus is the Great Physician, it means that: If an illness is caused by spiritual things, I believe that if you can take the person to this Dr…P while the illness has a spiritual origin, Dr P will not be able to treat the illness and there is no pill which he can prescribe and treats the illness. But if you can take the illness to God this person will be healed. That is what the Bible says. It says, by his wounds, we are healed. It says, "He sent His Word to heal them all sicknesses. Remember that, even doctors, when they refer someone to another doctor, they refer when they realise that it is not their area or beyond their scope of practise. So, the doctor will refer the person to a doctor who deals specifically with that. So, with us, where we are, where we are standing, the Lord Jesus heals all sicknesses. So, when you are in Jesus, there is no need to refer to another doctor, because you have come to the Greatest Physician. So, you cannot say while you have been brought to the Greatest Physician and seek to be referred to smaller doctors."

(Participant 15)

"As far as I am concerned, I have read one book by Apostle L Mcdonaldo. He is also an apostle, prophet, and deliverance minister. He indicates in

the book that most of the problems that people have, they think they need professionals. Unfortunately, they might be on the wrong. Most of the problems are evil attacks and they need deliverance'. Some, who have seen the power of God, they can bear witness that when an illness seems impossible to treat, when a Man of God (pastor), steps in and pray, people become healed", So, *"We are very called for that. We, as the title apostle, we are called into apostolic and prophetic ministries. And apostolic and prophetic ministries are ministries as you know for sure that are called to mostly deliverance, healing and the prophetic."*

(Participant 19)

5.7 Theme 5: Participants' role in the management and treatment of mental Illness

In this study, pastors perceived their role as supporting the individual in many ways. They indicated some of their roles as providing support, pastoral motivation, guidance and counselling, teaching, deliverance prayer and referring their congregants when the need arose.

5.7.1 *Providing social support*

"We must just play a big role in their lives. We must just be there for them because we are people who take care of people. We are doctors spiritually."

(Participant 5)

"Like I said, this is a spiritual entity. The only help that we can do is to provide support in the form of supporting the family emotionally. We find that this family is hurt and the situation in the house is abnormal. We support those who are directly affected by prayers, talking to them, sending the follow up ministries, outreach teams. Because it is not only that person, that person does not even see what they are doing. But it is the family that is mostly affected by that"

"It is to support, embrace and teach…. because there is an element of trust that should be considered before you try to teach, that the people would feel loved, welcomed and feel not judged and feel accepted before you can try to teach. So, most of the time, we just teach, and you find that maybe the person is still feeling filthy. A born-again but feeling that there is just a lot of condemnation

(Participant 11)

"The church must be able to play a particular role in the family. I must be available for the people that I lead. Which will also then be able to give me an opportunity to follow up on saying, "Are you coping"? "Are you managing?" Are you using your prescribed medications accordingly?" "As a pastor, I do have the responsibility to safeguard my sheep in all angles, or rather the sheep of God that are entrusted to my care. If I am to say that I know you, I know the things that you are going through, I must make time, understand the realities that you face and also be able to follow up on cases."

(Participant 14)

Based on the extracts above, participants seem to see themselves as having a role to play in supporting their congregants and families. The participants in the present study perceive themselves as important players in the well-being of their congregants. Regarding this view, they see themselves as 'shepherds' who should always be available for their lambs, especially during times of distress. The support can be manifested when they love and embrace, accommodate none judgementally, understanding and not stigmatising them, supporting them in taking their medication (from Western-based health professionals) and visiting them in hospitals when admitted. Furthermore, the support is also demonstrated through giving them words of encouragement and prayer.

In psychological terms, providing unconditional positive regard is perceived by the participants as an important element that helps to eradicate the strength of mental

illnesses. Through this person-centred intervention, the participants are of the view that they can enhance the personal functioning of their congregants suffering from mental illness. It also emerges that participants were willing to working closely with Western-trained health practitioners if arrangements could be made for such collaboration. This means that participants seem to be willing and ready to refer their congregants who are suffering from mental illness to Western-trained health practitioners and health institutions. The following extracts seem to confirm this:

"And eventually, you will be getting calls that hey, something is not right. When you get there, you realise that indeed something is not well. You pray with her, recommend that she be taken to the hospital and most of the time, you find that they will admit them. And then we continue to see them and pray with them even if they are under medical care. And a week later they will discharge them. You find that Ok, we managed to deal with the causes of depression and we managed to deal with the spiritual part…which is able to bring upliftment to someone that helps them overcome the mental state that was depressed in them."

(Participant 3)

"Yes, as a pastor, I have to understand that there is a particular level that I can contribute to the person. Prayer is also important because a person is spiritual, but we have to recommend to the relevant people who are working with the mind to assist the person, parent of the person or the parents themselves and recommending the kind of assistance the person may need. The same as when you are sick, we pray for you, but we still recommend you go to the hospital to get medication."

(Participant 9)

5.7.2 *Counselling*

Participants in this study indicated that they also play a counselling role to their congregants with mental health problems/illness.   They described that their counselling role entails guidance, motivation and encouragement and teaching. This is reflected in the statements below:

"Then we will do some small counselling and telling them how much God loves them and we commit to praying for them, just giving them normal support without any medical intervention."

(Participant 2)

"Yes, I do counselling. And even God revealed to me that before you pray for other people; just sit with them down so that you find the roots of the problem. So, some people you might think these things are spiritual, but it is not spiritual. It is just that psychologically you just must talk to them, and you pray with them after."

(Participant 5)

"My role is to motivate and encourage them and to talk to people around them, because if somebody has got a mental problem, you need to talk to the people staying with them. Otherwise, they should always see positive with them. Because immediately they see the negative things, they will start to say, 'So it means that, People think that I am mad'. But they should allow him to make mistakes just like any other person. They should allow him to be out just like any other person so that they can see that they can be accepted as a human being

(Participant 11)

You see, when a person is taking medication, the doctors are dealing with the outside. But a pastor deal with the inside. So, my duty is to make sure that, this person is alive in the inside."

(Participant 14)

"And they must be supported, while being taught to be independent. We pastors must teach them to change their mindsets. They must be positive. This will take away the depression."

*(***Participant 16)**

The extracts above indicate that participants in this study perceived themselves to be playing the role of a counsellor. It also appears that in their counselling role,

participants rely on the Bible and prayer for efficiency. They do recognise and realise that they are not professional counsellors; hence they would refer to professional counsellors when a need arose. This is how Participant 2 put it:

"So, generally, not only with the issue of mental illness, but generally there are things that you realise that you are liminted….in your scope of practice or what you can do for this person. So, we do refer."

(Participant 2)

Psychologically the above extract suggests that church leaders (pastors) now see those insights of MHCPs can be extremely valuable in understanding and helping people who go for counselling. As such, when pastors and MHCPs understand each other's work, collaboration between the two professions will have a significantly positive impact on their ministries and the people they seek to help through counselling. Although the participants in this study do have a counselling role to play in the lives of their congregant-clients, they do realise that they are not professional counsellors. Hence, they still refer to MHCPs. This should prompt MHCPs to also acknowledge that though they may have some knowledge regarding the faith of the referred or from the same faith with the referred, they are not necessarily experts in spiritual issues. As such, they should be willing to refer or collaborate with the participants

5.7.3 *Prayer (Exorcism, deliverance and fasting)*

Most participants in the study pointed out that one of their major roles in the treatment and management of mental illness is to pray for the affected. Prayer was viewed as a powerful force with which to combat the detrimental effects of mental illness. Participants indicated that they would pray for the affected at their homes, in the hospital when they are admitted or accommodate them in their houses while praying for them for days. In the process, congregants would also be encouraged to fast along with the pastor, to confess any wrongdoing, repent and turn to the Lord if the sufferer considered not to be born again. The study findings suggest that participants have deep faith in the power of God. The following extracts demonstrate this belief:

"We acknowledge the power of God that is able to bring healing to whatever condition a person may have. The second thing is prayer. And remember prayer for us, we approach it in two ways. Number 1, it brings the actual healing or direct healing, and number 2. It is… Should I call it spiritual upliftment? Because I believe that when you pray with someone sometimes, they may not get direct healing immediately, but their hope is revived. And I think a sick…a mentally troubled person who has hope is in a much better position to recover than when you are troubled and there is no hope at all."

(Participant 2)

"The Holy Spirit will always communicate with you that; this person is not yet delivered deal with this person until he is delivered. So, when you have a confirmation and conviction that this person is now delivered, then you now know that you have done you part. So, you cannot leave that person undelivered."

(Participant 4)

"Yes. I pray for the person first. I pray for the person first, because if people have brought someone to me, I think they have that faith that the God who sent me will heal the person. So, I must first try to pray for the person, seeking the Grace of God to heal the person. I will then pray with the person, seek grace from God and then seek mercy and use proper healing scriptures that are appropriate for the situation and go hand in hand with the situation. And I pray for the person and I begin to cast that spirit out. And then I think after I pray for the person, I will give the family counselling, even the person, I will give the person counselling."

(Participant 5)

And it is then that I can say, take him to the hospital. But if they have taken the person to the hospital first, I will also work with the way that the hospital is working with the person. I will go during the visitation hours. I will visit the person, even though they are giving the person medicine or

counselling, but during visiting hours, I will still pray with the person and share the Word of God with the person and I will leave it from there. And I will just let the hospital take over. And I will just follow up what is happening. And maybe when the hospital has failed, it is then I can say, bring the person to me or maybe let me come to your place. Or maybe if I can accommodate the person as long as they can bring someone for the family, I will say, bring the person to me and I will pray for the person for maybe 5 days, until I have seen that I have tried all."

(Participant 13)

"*We lay our hands-on people in the name of the Lord Jesus, having faith that, this person will be delivered. Secondly, there is an element that Jesus speaks of. He says, "There are certain people, when they have some demons in them, you don't just pray simply or randomly. You must set apart time to fast, thereafter you can come and pray for those people."*

(Participant 17)

"*What is there is that it can be an issue of spending time with them in prayer and fasting. And then, if God wills, He can heal such kind of people and they be delivered. Those spirits, if ever its spirits, they will depart. We also do counselling, because isn't it that sometimes you find out that this person has depression, and they could need more counselling."*

(Participant 18)

"*So, we are called to deliverance ministry. And deliverance ministry has more to do with not necessarily normal people. Though yes, even with normal people, you may realise that they need deliverance because you may think that people are not ill, they are normal. But I have seen, in many ways that people need deliverance, even if we think that they are normal. You touch them; they start to behave somehow, especially when the unction (The power of God) is down. And then they start to manifest, manifest demons. These very demons, you find that it is not necessarily mental illness, but these are evil spirits blocking them somehow, for their future, for their careers whatever.*"

The extracts above indicate that most participants in this study value the power of prayer when helping their client-congregants affected by mental illnesses. It also appears from the above extracts that praying for someone with a mental illness is not just done casually or ordinarily so. It is an area deemed to be requiring an incredibly special gift, anointing or ability as the participants would call them in their own jargons. The participants also seem to rely heavily on the Holy Spirit to guide and empower them as they execute their duties on those affected by mental illness. This could suggest that, though pastors do not have training in mental health related problems and the skills thereof, they seem to have a major role to play in the lives of their congregants-which is prayer. However, this does not negate the fact that participants have a limited understanding of what mental is.

The positive thing is that although the participants above demonstrated that they have faith in God's healing power and miracles, they did not undermine Western psychotherapeutic methods or psychiatric care as inferior. This leaves an open room for discussions between psychology and the church for a more holistic and efficient approach to the treatment and management of mental illnesses. What is needed is a well-informed understanding as pointed by some participants earlier that God works through the religious/spiritual, the medical and the psychological. As such, there is a need for reflection form MHCPs as well regarding their understanding of a human being, care, and wellness. By so doing, MHCPs will find themselves more open to collaborate with those in the community who can help them care for their clients.

5.7.4 *Referral and follow up*

Another significant role which participants in this study indicated that they would play is that of referring their congregant-client to those they would identify as being able to further assist and manage them. In so doing, the participants indicated that, it is not a demonstration of lack of faith or weakness but self-knowledge and the desire for the wholeness and wellness of the congregant. They indicated that they would refer

congregants either to other pastors (More senior, experienced, or anointed) or to a MHP. This role which the participants play is demonstrated by the following extracts:

"Of the people that we pray for, even when they look fine, we still make the recommendation and say look just to verify that everything is well with you, just go and consult, see a psychologist, psychiatrist, a doctor or professional that can be able to best help you."

(Participant 3)

"But here, whatever that we are dealing with, if I realise it needs referral at some stage, I will say these things of yours will need further assistance. If it needs a psychologist, I will say that there are so many MHCPs in Polokwane, can you find a psychologist and go through these things."

(Participant 6)

"And then if I have maybe failed to help that person, I will refer that person to, maybe to my seniors, pastors whom I believe that maybe they are carrying "HIGHER AUTHORITY" than me or I recommend them maybe to pastors who might have dealt with such situations for a long time. After that, I can refer them to the hospital."

(Participant 13)

The extracts above denote the fact that participants in this study are aware of their scope of practice and limitations thereof. It appears that, when rendering their services to congregants-clients, they do not portray themselves as "Knowing it all" They realise that there could be other factors that they cannot resolve or identify during counselling or their intervention.

As such, they are willing to refer. This finding discards the norm which had led to antagonism between religious/spiritual and MHCPs for quite a long time. There seem to be more openness and flexibility from the participants. This could suggest that the church is moving from a conservative approach to personhood to a more liberal and accommodative one. For psychology, this means being aware of this interesting transformation in the church regarding psychological services. However, participants

also indicated that referral should not be a one-way system. They would like that, MHCPs also recognise their presence, their special gifts and make referrals to them. This view is reflected in these extracts below:

"*I believe that in our country that we live in, Pentecostal leaders are not much involved because they are regarded as unlearned people, or the skill of a pastor is not much valued in the secular world. So, for this thing to be solved, if there can be a body that can be introduced that works hand in hand with medical practitioners that do the tests on their medical science and then the spiritual part because remember, a human being is made of three components: the body, the soul and the spirit. So, the doctors can be able to deal with the body. Though, also we cannot deal with the soul. But then, the spirit, we can work something because all these things they come together in hand.*"

(Participant 4)

"*Nurses, doctors and social workers and others, when a person presents with signs or symptoms they do not comprehend as they are assessing the person and their assessment say the person is normal while they are not, that must be saying to them, this is not your case. You are not an expert in that field. Refer to relevant people. And Pentecostal preachers are the relevant people. You cannot pray if you do not know about prayer. We believe that our pastors, according to how God has gifted them, they will pray for these people.*"

(Participant 17)

The extract above may mean that the soul (mind) may be left to the psychologist to deal with. On the one hand, when MHCPs are not progressing in identifying or ameliorating the congregant-client's illness, they should be able to refer to the pastor for further assessment and management. However, it appears that the working together should be facilitated or regulated by a statutory body acknowledging the expertise and uniqueness of each profession.

5.8 Theme 6: Participants' views regarding collaborating with MHCPs

Participants in this study held differing views regarding collaboration/referral to Mental Health Professionals. This theme also reveals that most participants in this study had never referred (representing lack of experience), while a few have worked with MHCPs before. There was no uniform perspective from the participants in this study with regards to collaboration. This major theme was broken down into two sub-themes: 1) Views on Collaboration; and 2) Preference when collaborating. Participants had varying views on collaborating with formal MHCPs. Although there were differing views on collaboration, most of the participants viewed collaboration as positive. They did not have any problem with collaborating or working integrally with MHCPs. This view is supported by the following extracts:

"I *will refer them to those people because also they educated to help people's lives, we are….in fact we are working hand in glove as a unit*" In agreement with."

(**Participant 1**)

"I don't have a problem there because, that is one other area where we as Pentecostals lack in. Yes, we lack in there because, we cannot accommodate these people, and we see them as a threat. Or maybe that is the way in which the government has "displayed" them to us and also the way we are displayed to them…."

(**Participant 4**)

"*We can send them because we honour the knowledge that they have. We just honour the knowledge that they have. But as I said even on our side, before we can send those people having the same problem, we deal with the problem first. I believe God is not a failure. But we can send them if we see this need serious attention, especially psychologically, we can send those people there.*"

(**Participant 5**)

"*I have no problems with professionals. They are doing their job. And they must do their job. That is why I said, as for me. If I pray for somebody, if I see that this person is healed, I want her to go back and be checked by the doctor so that she can also have confidence that she is fine. What I don't believe in is that if I say you are healed, and in her heart or in that person's heart feels like I want to see the doctor and I tell him that you are healed, don't go and see the doctors. Myself, I believe that if that person wants to go back to be checked, let that person go to be checked, because doctors, even in the Bible they were there.*"

(Participant 8)

"*No, I don't have a problem…. Even if it were not mental illness, I could still send them to hospitals because I think those are the relevant people that can assist in those areas. It is not how about I feel but it is all about doing the right thing. Because sometimes we feel happy when we pray for somebody and they get healed immediately and it brings joy and fulfilment in the ministry but sometimes we pray for them and they do not get healed. You cannot stop them from going to the doctors. They must go to the doctor and get relevant medication to be assisted.*"

(Participant 9)

"*I think it is a good thing because like I said, not everything is totally spiritual. As a lay person, you will only know a few things but when you take somebody to health professionals, you find that they are……. We had a case of lady who was an intercessor in church. So, but later when we were thinking, this person is married, is an intercessor, then this person came saying that, "Now, I had a voice saying that I must divorce my husband" And then when you come to the Word, you realise that, it cannot be God it cannot be like this. So, you talk to this person and you see that she continues to behave that way. So, but we did, we prayed. We had a prayer meeting with them and realised that it is a mental health case. So, we referred that person, with consultation with her husband to the hospital*"

(Participant 10)

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"I think that is important because we will complement each other. Because there are certain areas that I will deal with them spiritually and they themselves read about these things in books."

(Participant 6)

"No. Not at all. We do not have a problem. We understand that we work hand in hand with them, since they have studied that. We also understand that an issue like mental illness goes hand in hand with prayer. Because when we speak about prayer, we are not speaking about giving a person certain thing. We are only talking about prayer. Yes, just like I have already indicated, the issue of mental illness concerns many people. It concerns pastors when it comes to deliverance. To pray for those people so that they can be free and be restored to normality. And, health professionals are supposed to play a role, since they can know and are experienced a lot. Above all, mental illness has multiple causes."

(Participant 18)

From the extracts above, it is evident that most participants in this study are comfortable to work together with MHCPs, whether spontaneously or consecutively. The participants holding this view about collaboration seem to understand that there is not only one causal factor to mental illness. They viewed mental illness as a multifactorial phenomenon. This means that the participant do not limit their intervention only to religious/spiritual care but they are also more open to medical and psychological care, based on the congregant-client's needs.

Interestingly, from this finding, it also emerges that participants do not only refer externally to MHCPs but they do also refer internally to others who they viewed as gifted in the area of deliverance, more experienced or of higher authority in the ministry. What is also important to note for MHCPs is that before the participants would refer or collaborate, they will start by praying for the affected individual for some time. It appears that it is only when they realise that there is no change or improvement on the affected whereby, they will then refer or agree to collaborate. Again, MHCPs should take note that when the pastor refers a congregant-client to them, they have not dumped them. They are still interested in knowing about the outcomes of the

medical/psychological intervention. They continue to follow up and praying for the congregant. The statements below bear witness to the fact that participants will start by prayer and refer later:

"When we realise that the situation is beyond what we can understand and even after praying/when we pray we realise that there seem to be no…improvement or no change or little change for that matter then we make recommendations. But I can confirm that almost 99.9 percent (Giggles…) of the people that we pray for, even when they look fine, we still make the recommendation and say look just to verify that everything is well with you, just go and consult, see a psychologist, psychiatrist, a doctor or professional that can be able to best help you."

(Participant 3*)***

"Eh. After I have prayed and when I have prayed, I do not see any results. This is because some situations, you pray for them, but they are still worsening. I pray, maybe I give it a day or two or three and from there, I refer to another pastor. So, after a day, or two or three. If they fail, I refer to the hospital"

(Participant 13)

"The third element is that it is not all the pastors who are gifted, to pray for mad people to be healed, because the Bible has shown us that we have different gifts. One (pastor) is given a gift of teaching, the other one of exhorting/encouraging, another one of healing and the other one of prophesying. So, there are pastors who are gifted that way. This then means that, when you encounter such cases and you know very well that you are not gifted in that area, refer to other pastors"

(Participant 17)

The above extracts also seem to demonstrate that there is an existing system or channel of referral within the Pentecostal church though it is informal and untested scientifically. This could be an opportunity for psychology to explore more on the referral system and take notes and share knowledge with the participants. In this

study, while most of the participants indicated that they did not have a problem with referring to or collaborating with MHCPs, a few where of the view that, there was no need for them to collaborate. The participants who held this view indicated that God is the ultimate healer who never fails denoting that referring to MHCPs would mean that they are undermining their own faith and God's trust on them. This is reflected in the statements below:

"*There is no need for us to work together or collaborate. You know why? As a pastor, I do not force a person that I should pray for them. When a person comes to me that is their faith which says, "Let me go there and be prayed for" Now, it will mean I want to take them out of their faith and say, "Go to the doctor" You do not do things by force. When you go to the hospital and they would want to operate you, they do not force you. You sign a Consent Form to show that you are agreeing. If you are not consenting, they will not force you. That's my take. I can't send someone to the doctor who has come to me for prayer" I do not work for the Department of Health. I am a pastor. I am standing here believing that God can heal. When a person comes to me and they want me to pray for them, I will pray for them. There is no way when you have come to me for prayer and I say, "Go to the doctor" The decision must come from the person that now I am going to the doctor. Now the problem is that many people expect that we be in church but represent the Department of health, so that when people come to us for prayer, we then say, "No we don't pray for people, go to the hospital" Then, in that way it means that I don't believe in what I preach. I believe that God is a healer. So, if a person believes that God can heal them, we pray together*"

"*Yes, for something like an accident" But I have never seen a case that I would say I am referring to the hospital. There is no one they once brought to me and we failed, especially those who were spiritually attacked, and they were in their initial phases of the illness. Unless for those who had been mad for a long time. Maybe they grew up being mad. We have never met with that kind of a situation being brought here. We also do not pray for someone like that. And therefore, maybe I can recommend the hospital if his/her family do not have that faith*"

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According to the extracts above, divine intervention alone may be sought to deal with what the congregant-client may present with to the participants. As such, for participants like these, referral to MHCPs is not supported. This could lead to the stigmatisation or the undermining of other pastors who do refer to MHCPs. These participants prioritised praying for the healing and deliverance of their congregant than referring to MHCPs.

This view held by the participants may instigate antagonism between pastors and MHCPs and disadvantage those who would benefit from the collaboration. Overall, the contradiction in belief in the treatment and management of mental illness seems to suggest that the church as a Christian theological institution is also not completely sure about its own stance on certain matters specifically pertaining to divine healing.

5.8.1 *Participants' preference when collaborating*

In the present study, most participants did not seem to consider or prefer to work with a MHP from the same faith as theirs. They indicated that they would just be satisfied when at least their congregant-client is referred to a psychologist. Whether the psychologist was of the same faith or not, it was not an issue. However, other participants indicated that if the psychologist or health professional shared the same faith with the participant, which would be an added advantage. The following extracts, demonstrate this finding:

> "*No, eh, education is very holistic. You can't say it should be people of your faith…*"

(Participant 1)

> "*To be honest. I really do not care (giggles) whether they are in the same faith with me or not. Look, the advantage of referring them to someone who is of the same faith with me is that they might give them hope in God. I do not know how they practise. Eh, but honestly, if they uphold their code of conduct as practitioners, I know that they will not mix things. They will do their professional work and I will do my spiritual work*

(Participant 3)

"*As long as they are professionals. I do not have a problem. Because if I say I want someone who is spiritual, what is the difference because we will still be at the same level?*"

(Participant 8)

"*I wouldn't necessarily want to say that I do that, or those issues of religion or faith. There are doctors that are not Christians but are particularly good in what they do. Only if my congregants can differentiate between altars. That is what I teach at church. If the doctor is not doing anything with them, which can link them to what this doctor kneels on, I am comfortable as a person.*"

*(***Participant 14)**

"*No, many are times, I do not look at the fact that the professional is from the same faith with me. It is just a matter of saying, 'Go to health professionals, they will help you.' This is because; I think that the main thing is not faith especially when it comes to science. It is a matter of someone getting help. If they are not going to cause any harm to the person. That, satisfies me*"

(Participant 16)

"*When we refer a person to SASSA, the issue of faith is not necessary. The person is supposed to handle those things. When we refer someone with a swelling to the hospital, there is a need for the person to be checked and scanned. That needs a professional in that field. Our faith, whether you believe in what we believe in, is not a factor. But if we happen to find that s/he is one from our faith, then that is an added advantage, but that is not what we pursue. That is not our criteria. We have people of traditional beliefs. When we deal with them, we do not deal with them and their faith. We deal with the profession that they are in. It could be a doctor, a nurse or whatever. We view them based on their profession, not their faith.*

(Participant 17)

"…. No, they are not from the same faith with us. What matters is that they are experts of mental health problems and they have experience. We understand that those are the relevant people"

(Participant 18)

From the extracts above it emerges that participant did not prefer homophily when referring. All they were concern about was that their congregant-client be helped by a professional. The participants seem to be of the view that the participants are knowledgeable in the field of mental health based on their training and skills, not based on their faith. Some even indicated that if the psychologist they referred to was of the same faith, that would be a disadvantage since they would see things the same way perhaps disadvantaging the congregant-client. This idea is reflected in this extract:

"As long as they professionals. I do not have a problem. Because if I say I want someone who is spiritual, what is the difference because we will still be at the same level?"

(Participant 10)

While the participants above indicated that they would refer their congregants, to any MHCP regardless of their faith, a few participants stated that they would preferably refer to those of the same faith with them. The extracts below illustrate the participants' views:

"I always prefer to refer to those who are of the same faith because, when you refer someone, instead of criticising or destroying the individual because of where the referral is coming from, they will be keen to help. Because if you refer them to people of different faith, instead of helping that person, they will fight that person saying, 'You thought that church was going to help you? You thought that pastor is going to help you? Why did you think of the pastor? Why did you not come straight to me or the hospital……? You understand?' But if you refer them to people of the same faith, it makes their work easier."

(Participant 4)

"We prefer to send those people to those with the same faith as we have. We prefer to send them there because we do not want different

knowledge. We want the same knowledge that we have for those people to give them the same material that we have. So, I prefer to send them to people who have the same faith and know God more. They know about God, the wisdom and knowledge of God."

(Participant 5)

"There is a specific person that we know that they will understand both the spiritual and the psychological. So, we refer, and we also help as we refer, we talk to that person"

*(**Participant 10)**

"Yes. I do. I normally prefer medical doctors that are born again because those who are not born again, they do not understand that there are demonic attacks. Because when you refer a person, you are saying, go for a second opinion. So, that person will be saying, the pastor has counselled the person and prayed for the person. But now he wants the second opinion. So, if the person is born-again, he can confirm or can say no, you did not see well pastor. Remember, that we are human beings even though we are pastors and are deemed to be powerful, but you must understand that as a human being it is possible that we can be in error."

(Participate 11)

"Yes. In the same faith because I do not think I can take somebody to a different faith from mine. If I realise that this person has got for example, 'spirits' as we call them and I realise that I cannot help the person myself, there will be a pastor there or somebody I know, this person used to pray for such people and they got 'delivered' Yes. There are people who, I may say, they are gifted in that line. That you may always think they are better positioned to deal with those problems

*(**Participant 12***)*

"Yes, the one I work with is a pastor. We share the same faith. Even when he is treating people, he also understands that he will pray first before counselling the people, before doing anything and will even advise family

members that, you see such cases, I am a medical officer, I have this profession but you see, because I am a pastor and I understand these things, such cases sometimes they need prayers. And we must look at them spiritually so, not with a physical eye. So, we engage even the family to stand in the gap by maybe praying by maybe praying and entering prayer and fasting a day. We are in one spirit trying to achieve a common goal, seeking the face of God."

(**Participant 13**)

From the above extracts, it emerges that the participants refer their congregant-clients where they would not be judged, and would be understood from the context of their faith. Furthermore, participants seem to understand that referring to a professional of the same faith will afford them the opportunity to continue being involved in monitoring the progress of the referred.

Referring to a psychologist of the same faith according to the participants' extracts above seems to be advantageous in that, the professional is understood to be not one sided (understands the psychological and the spiritual realms), has the same knowledge with the referrer and the referred and will never undermine the power of the gospel even when the referred is healed by non-religious/spiritual ways. Participants from the same way are regarded by the participants to also playing a role, firstly of praying and encouraging through scripture the referred congregants to accept or comfortable with non-religious/spiritual or scientific ways of healing.

5.8.2 *Factors affecting collaboration/referral to MHCPs*

Participants in this study indicated that when it comes to referral, there are factors that they would determine their referral process or system. The following extracts highlight the factors that participants would consider regarding referral:

"*I believe that in our country that we live in, Pentecostal leaders are not much involved because they are regarded as unlearned people, or the skill of a pastor is not much valued in the secular world.*"

(Participant 4)

"*You know what; it all depends on the area that your church is based in. Now, we are at the city centre here and most of my congregants are well to do. Now, it is exceedingly difficult just to refer them. You allow them to decide. You allow them to choose. Because choosing for them, sometimes it is good when you are at the village wherein you must guide them. But here, whatever that we are dealing with, if I realise it needs referral at some stage, I will say these things of yours will need further assistance. If it needs a psychologist, I will say that there are so many psychologists in Polokwane, can you find a psychologist and go through these things. I will allow them to do it. I will never from where I am sitting choose someone and refer them.*"

(Participant 6)

"*It all depends on the family like I said, because they are the one who incur the costs. We give the family that latitude. But we just say to the family take them to the psychiatrist. We may not have the list of them. But we just indicate to the family that this case needs a psychiatrist. It is the family that sees where their member consults with. We do not have a specific psychiatrist that we deal with. If it is a psychiatrist who can help, we don't have a problem with that.*"

(Participant 7)

"*If it is somebody reachable, then I can recommend that one. But if they are no reachable, I can recommend to any.*"

(Participant 9)

"*The only option was to take her to the hospital because the senior pastor had foreseen that this thing is a demonic attack. Because this person is a pastor and she said no because of her reputation, we cannot take her to the hospital immediately. So, we refer maybe after we have done everything. Maybe even if we couldn't heal her, we are going to refer to another church or a certain place where we believe there is a higher authority, because we prayed for her and when she started to recover.*"

(Participant 13)

Based on the extracts above, it appears that most of the participants in the present study do refer their congregant-clients to MHCPs (externally) or to fellow pastors (internally) for the care of their congregant. The emerging factors above, could suggest that participants do not view themselves as having dominion or control over their congregants' lives though they are influential to them. Factors such as the costs of psychological services, the limitedness of MHCPs and/or inaccessibility; the position of the affected in the church; the participant's awareness of their skills and abilities, including limitations, namely: the church's socio-economic status and geographic location and the congregant's choice emerged as factors that would influence referral or collaboration. So, the issue of referral or collaboration relies as well on the choice of the one to be referred, unless in exceptional cases whereby the options are limited. Therefore, as MHCPs we need to take note of these factors.

Taking note of these factors will make come up with possible ways to bridge the existing gap and begin meeting participants halfway in catering for their congregants. For example, MHCPs can initiate a long overdue conversation. Based on all the above, MHCPs need to take their services to the church. It appears that the door is wide open. The response of MHCPs in this regard, is likely to contribute towards making the church a haven for the mentally affected. Instead of the church becoming a place of stigmatisation, exclusion or even expelling of the mentally ill from the church.

PART B: PSYCHOLOGICAL DESCRIPTION AND INTERPRETATION

5.9 Psychological meaning and description of emerging themes and subthemes

All themes and subthemes that emerged from the data in this study have important implications for the clinical practice of psychology as well as the teaching of psychology. Firstly, regarding the perception of mental illness by the participants, it can be derived that mental illness is not easy to define. In other words, the definition of mental illness should not be made universal, though the illness itself is universal. There are a lot of variables that psychology should consider when it comes to the

definition of mental illness. The variables include the following: theological/spiritual beliefs, cultural beliefs, context, or location (where it happens), the duration it takes and its severity. It appeared that instead of defining mental illness, participants would rather describe or explain it based on its presentation.

5.9.1 *Participants' notions of mental Illness*

In this study, the participants predominantly described and explained mental illness as a religious/spiritual problem with a religious/spiritual origin requiring a spiritual solution. However, they also viewed it as a psychosocial and biomedical problem. Thus, they hold a multifactorial view of mental illness. This perception of mental illness held by the participants in this study, it appeared that it is mostly influenced by the participants' Biblical exposition, personal experience and African culture or heritage. Since this view of mental illness is one sided, it can be detrimental to the practise of psychology and its service users-the congregant-clients who consult with Mental Health Professionals. Viewing mental illness only from the religious/spiritual dimension may denote those other domains such as cogitative, affective, and/or vegetative components of mental illness may be ignored. Consequentially, several psychological diagnoses may be overlooked dismissed or undermined eventually leading to more serious complications. Symptoms of mental illnesses may be hidden or ignored in favour of referring to the presentation of the affected as experiencing a spiritual problem. Moreover, psychotropic drugs and psychotherapy may be discouraged since they may not be considered as "religious/spiritual" solutions.

The other disadvantage of explaining or describing mental illness only in religious/spiritual terms is that even though natural factors may have caused the mental illness, it will still be regarded as having been orchestrated spiritually. Based on the belief above, the affected may be subjected to divine methods such as prayer, fasting, repentance and faith declarations of scripture. All the above spiritual sources regarded as powerful in the Christian church, have been proven to work. However, in the event whereby there is an existing mental illness that has not been diagnosed or has been diagnosed, participants may influence their congregant-client to not consider a referral, to dismiss a diagnosis or abruptly stop psychotropic drugs. On the one hand, their multifactorial view of mental illness would provide a platform for participants to collaborate with MHCPs.

Overall, all the emerging themes above, it can be deduced that amongst Pentecostal pastor, mental illness manifests itself differently depending on people's circumstances. Pentecostal pastors perceive themselves as not having proper words (psychological) to describe or explain what mental illness is. However, they seem to have their own words to describe and explain mental illness as we have seen above. For example, it emerged that mental illness is having a loss of touch with reality and behaving above what is deemed normal. Because of lack of proper terminology and methods to diagnose mental illness, Pentecostal pastors eventually view most mental illnesses as a spiritual problem. People with mental illness/mental health problems in church, are not aware that they have mental health problems. Often, they are recognised by those who live with them and fellowship with them. As a pastor, you need to tread carefully when engaging or having an interaction with people with mental illnesses, be it verbally or non-verbally. They are perceived to be extremely sensitive and unpredicted. Furthermore, most of the pastors acknowledged that they rely on the health professionals 'expertise to confirm the existence of a mental illness in their congregant. While only few pastors indicated that they would rely on God's spiritual gift of "discernment" to determine or know beforehand what the person's problem would be when they consult with them.

Since participants always encounter people with mental illness one way or another, MHCPs can provide a platform whereby we assist the participants in refining their existing terminology, symptom recognition, their referral process and treatment approach. The intention will not be to change their way of doing things but to provide a platform for them to learn more about mental illness and its presentation, since most of them indicated that they did not have training in mental health issues. When differing views and ideas are more clarified between pastors and psychology, an integral or collaborative approach to treatment and management is inevitable. There is a need for MHCPs to pay attention to this dangerous perception of mental illness and initiate conversations with Pentecostal pastors to share knowledge and exchange notes. This is because although participants in this study explained or described mental illness to be a spiritual problem, most of them do not have a problem with collaboration or referral. The purpose of the dialogue will not be to change participants because they consider themselves as experts but raise an awareness about mental illness of which they are limited in understanding.

There was also no uniformity in terms of their perception of mental illnesses. There were a lot of variations as much as similarities. Like in other studies which were conducted before, their view of mental illness was influenced by several factors. But primarily, mental illness was a spiritual problem, demonic possession, or demonic/evil attack. As such, before any referral could be made either internally or externally, prayer for divine intervention was conducted, to seek revelation from God to understand the cause of the problem, which would then lead to the intervention deemed necessary. Their perception of mental illness was more descriptive than definitive in nature. This means that, instead of coming up with a conclusive or one concrete definition of what mental illnesses/mental health problems are, most of them explained and described mental illnesses/health problems in terms of what they perceived to be their causes and how they manifested.

5.9.2 *Participants' recognition and diagnosis of mental Illness*

Some of the interesting areas that have emerged from the findings relate to participants' symptom description. The symptoms that the participants have identified as those of mental illness refer to what as psychology, we refer to mental illness, especially psychosis. However, their perception of mental illness seems to refer to something beyond mental illness-madness. Participants also seem to classify mental illness as MHCPs do. For example, participants indicated that mental illness would progress in levels (perhaps representing the severity of the illness). They mentioned words like, "It starts as stress, then depression and eventually severe depression or loss of mind". This could denote Major Depressive Disorder with psychosis. Another participant mentioned that the highest degree of disability is madness. The use of the terms 'mental illness' and 'madness' interchangeably is indicative of the fact that there is no common definition or description of mental illness in the Pentecostal church, unlike in psychology whereby we refer to the DSM or ICD-10 code to classify and categorise mental illness. So, there is an opportunity for psychology to learn from the spiritual knowledge that participants have regarding the understanding of mental illnesses; more especially because they admitted that they lack knowledge and training on mental health related issues.

Regarding the diagnosis of mental illness, it has emerged from the findings that participants acknowledge that they are inadequately or not trained at all to handle

mental health problems. And interestingly, most participants in this study have indicated that they would love to be equipped with knowledge and training in dealing with mental health problems. They also indicated that they are aware that them being trained in the mental health field would not make them MHCPs but would help to shed more light based on the work they do. Although participants acknowledged that they lack in mental health training, it does not mean that they do not have other means or ways of assessing and diagnosing mental health problems. Some did mention a practise called: spiritual warfare-which refers to intensive and deep prayer of fighting spiritually against evil forces of darkness.

Participants indicated that in the process, God would reveal to them the nature of the problem and how it should be dealt with. The revelation would point out to either a religiously/spiritually inclined method or a referral to an MHP. Such a referral could open a channel to discuss more controversial issues such as the presence of mental illness due to a generational curse or heredity. Much insight can be shared between the two professions around many other aspects of mental illnesses such as being demon possessed or psychosis. As a result, many diagnoses that could be made in the church but missed will be recognised and dealt with accordingly. On the one hand, those who have been misdiagnosed by MHCPs as having mental illness in the place of religious/spiritual problems may have their diagnosis reviewed or formally withdrawn.

5.9.3 *Participants' notions on the causes of mental illness*

The findings of this study also reveal that not all participants view mental illness as resulting from a single factor-the spiritual. All the participants held a multifactorial view of mental illness. In this view of mental illness, participants indicated that mental illness could result from a combination of factors such as religious/spiritual, biological, psychological, and social. This view of mental illness by the participants could be influenced by the differences in doctrine and theology of the Pentecostals. Those who subscribed to this explanation of mental illness believed that it was not permanent and could be cured by both spiritual and medical (psychological interventions). The multidimensional view of the cause of mental illness may be indicative of participants' readiness or willingness to be more open to the views and methods of MHCPs. If the condition of mental illness is understood to manifest with medical, psychological,

and/or spiritual symptoms, assistance from a psychologist may be viewed as significant in alleviating symptoms.

The multidimensional or multifactorial view of mental illness by the participants in this study, is a fascinating one. Based on their beliefs, in the past and even currently in other countries, participants are known for not considering the views and methods of MHCPs, citing that their own methods are superior. Participants in this study, seem to envisage a holistic approach, whereby their views are respected by psychology and vice versa as already mentioned. They view the work that they do as a calling from God and that God has given special abilities and wisdom to carry that work. Interestingly, the participants in this study also viewed Mental Health Professionals as having been given special wisdom by God to understand mental illness. The multidimensional approach to mental illness is significant to both psychology and the Pentecostal community. Both deal with a human being who is said to be a 'triune being' meaning that they have a body, soul (mind) and spirit. So, it may mean that when one of the three domains is affected, psychopathology may develop. For example, someone may be affected in the mind because of spiritual related issues such as sin, feeling abandoned by God etc., and experience psychological distress. Similarly, when the body is affected, both the mind and the spirit may also be affected. So, the integrated or multimodal approach to psychotherapy inclusive of pastors and psychologist may help to alleviate the symptoms that a congregant presents with.

5.9.4 *Participants' notions on the treatment of mental Illness*

In terms of treating and managing mental illness, it has emerged that there seems to be three approaches recognised. The first approach recognises that mental illness should be treated by both MHCPs and pastors regardless of what is perceived to be the cause. In this approach, participants did not undermine or disregard their own methods. They also did acknowledge their limitations in terms of providing treatment and care to their congregants. The participants did not oppose referral or the use of psychotropic drugs alongside religious/spiritual methods such as prayer and counselling. They were open and more willing to engage with MHCPs. In this approach the pastor is viewed to be inclusive, collaborative, or integrative. This approach seems to go beyond the issue of referral but to continuously working together with the psychologist for the complete care of the congregant-client. This approach one can

refer to as "Full Collaborative/Integrative Approach." However, it will now rely on psychology's view of this approach clarifying all it means and entails. In this approach, participants are of the view that, there is no need to compete, MHCPs and pastors must honour and acknowledge each other's work. In addition, the participants were also of the view that their role is neither inferior nor superior to the role that MHCPs play in the treatment of mental illnesses. This approach, equally calls for MHCPs to be more open to working with pastors, considering their congregant clients' religious/spiritual needs and their religious/spiritual understanding of their presenting problem.

Secondly, regarding the treatment and management of mental illness, some participants, where of the view that MHCPs should only treat and manage mental illnesses which are believed to be having a non-spiritual cause, i.e., (bio-psycho-social) base. These are the participants who viewed mental illness mainly as having a spiritual base or as madness. They felt that if such a case is referred to a psychologist, their psychological methods would not help. However, as stated earlier the issue of terminology and symptom description comes into play. For example, when a person continuously abuses substances, they may develop Substance Induced Psychotic Disorder (SIPD).

Since psychosis resembles symptoms of a spiritual problem, a spiritual attack, using this approach to treatment, pastors may not consider referring to a psychologist and continue with prayer even if the affected person has not stopped taking/abusing substances. Wherein, if the affected is prayed for and referred the MHP, they may pick up the abuse of substances and suggest rehabilitation. In another instance, a student experiencing normal academic related stress and/or adjustment problems may be interpreted to having been bewitched and not timeously referred to psychology and be subjected to prayer. Again, the participants seemed not aware that what they refer to as psychosis (religious/spiritual problem), may result from on-going persistent psychological problems. This approach in the treatment and management of mental illness may be referred to as 'Partial Collaborative/Integrative Approach'.

The third approach to treatment and management of mental illness, according to the data detected from participants in this stand, indicates that it is only pastors who should

treat mental illnesses. Participants in favour of this approach in the treatment and management of mental illnesses indicated that there was no need for them to collaborate with psychology. The participants emphasised that they believed that God heals all illnesses those caused by natural causes and those caused by supernatural causes. In their view, there was no need for an integrated or collaborative approach. Their opinion is based on their view of the scripture that indicated that Jesus is "The Great Physician" (Matthew 9:12); and another one in Exodus Chapter 15: 26, which states that, "I will heal you of all your diseases." Participants, who were comfortable with this approach to the treatment of mental illness, indicated that collaborating or collaborating with MHCPs would mean that they doubt their own faith in God and the faith of the congregant-client.

Other participants who upheld this approach indicated that as apostolic and prophetic ministers, they are very called deliverance for all people, whether those with mental illnesses or not. It emerged as well that, these participants, were influenced by factors such as having a personal experience, what one would refer to as a testimony and one the one hand, other participants had never encountered someone who was referred to them and they fail to 'deliver'. This approach is indicative of the idea that Pentecostals differ in their theology and that Pentecostals seem to be an experiential group of Christianity a characteristic which may differentiate them from mainstream churches (Catholics, Lutherans, and Methodists). MHCPs need to stay attuned to this approach and identify an opportunity when it arises to initiate dialogue. This approach can be referred to as the Non-Collaborative/Integrative Approach.

5.9.5 *Notions of Pentecostal pastors' roles in the treatment and management of mental Illness*

Most importantly to note for MHCPs is that participants seem to see themselves as having a role to play in supporting their congregants and families. They perceive themselves as important role players in the well-being of their congregants. Regarding this view, they see themselves as 'shepherds' who should always be available for their lambs, especially during times of distress. The support can be manifested when they love and embrace, accommodate non-judgementally, understanding and not stigmatising them, supporting them in taking their medication (from Western-based health professionals) and visiting them in hospitals when admitted. Furthermore, the

support is also demonstrated through giving them words of encouragement and prayer. In psychological terms, providing unconditional positive regard is perceived by the participants as an important element that helps to eradicate the strength of mental illnesses. Through this person-centred intervention, the participants are of the view that they can enhance the personal functioning of their congregants suffering from mental illness.

5.9.6 *Views on collaboration with MHCPs*

It also emerges that participant were willing to working closely with Western-trained health practitioners if arrangements could be made for such collaboration. This means that participants seem to be willing and ready to refer their congregants who are suffering from mental illness to Western-trained health practitioners and health institutions. This signifies a clarion call for MHCPs and pastors to work together whereby MHCPs teach pastors about different types of mental illnesses, their etiological factors, and their clinical presentation to compare. Instead of more divergence between the two professions, there could be a turn around. As it has emerged earlier, this view may be detrimental to the congregants' wellness and ultimately open a door for them to be stigmatised.

The issue of homophily when referring or collaborating with MHCPs was viewed differently by the participants. There are those who preferred homophily in referral and there are those who did not. Those who did not prefer homophily indicated that all they were concerned about was that their congregant-client be helped by a professional. The participants were of the view that MHCPs are knowledgeable in the field of mental health based on their training and skills, not based on their faith. Some even indicated that if the psychologist they referred to was of the same faith, that would be a disadvantage since they would see things the same way perhaps disadvantaging the congregant-client.

Conversely, from the data obtained regarding referral and collaboration, it emerged that some participants would refer their congregant-clients to where they would not be judged, but rather would be understood from the context of their faith. Furthermore, participants seem to understand that referring to a professional of the same faith will afford them the opportunity to continue being involved in monitoring the progress of

the referred. Referring to a psychologist of the same faith seems to be advantageous in that, the professional is understood to be not one sided (i.e., having the understanding of the psychological and the religious/spiritual aspects); has the same knowledge with the referrer and the referred; and will never undermine the power of the gospel even when the referred is healed by non-spiritual ways. Participants from the same faith are regarded by the participants to be also playing a role, firstly of praying and encouraging through scripture the referred congregants to accept or be comfortable with non-religious/spiritual or scientific ways of healing.

Some participants in this study were of the view that divine intervention alone may be sought to deal with what the congregant-client may present with to the participants. As such, for participants like these, referral to MHCPs is not supported. This could lead to the stigmatisation or the undermining of other pastors who do refer to MHCPs. These participants prioritised praying for the healing and deliverance of their congregant than referring to MHCPs. This view held by the participants may instigate antagonism between pastors and MHCPs and disadvantage those who would benefit from the collaboration. Overall, the contradiction in belief in the treatment and management of mental illness seems to suggest that the church as a Christian theological institution is also not completely sure about its own stance on certain matters specifically pertaining to divine healing.

Interestingly, from the above finding, it also emerged that participants do not only refer externally to MHCPs, but they do also refer internally to others who they viewed as gifted in the area of deliverance, more experienced or of higher authority in the ministry. What is also important to note for MHCPs, is that before the participants would refer or collaborate, they will start by praying for the affected individual for some time. It appears that, it is only when they realise that there is no change or improvement on the affected whereby, they will then refer or agree to collaborate. Again, MHCPs should take note that when the pastor refers a congregant-client to them, they have not dumped them. They are still interested in knowing about the outcomes of the medical/psychological intervention. They continue to follow up and praying for the congregant.

Another significant role which participants in this study indicated that they would play, is that of referring their congregant-client to those they would identify as being able to further assist and manage them. In so doing, the participants indicated that, it is not a demonstration of lack of faith or weakness but self-knowledge and the desire for the wholeness and wellness of the congregant. They indicated that they would refer their congregants either to other pastors (more senior, experienced, or anointed) or to a MHP.

5.10 Concluding remarks

This chapter highlighted that the participants within this study consisted of Pentecostal Pastors around Polokwane, who consistently put for the effort of meeting the diverse needs of their congregants. In this chapter, it became evident that every day, these participants attempt at their disposal to address the mental health needs of their congregants. Even though most of the participants in this study perceived mental illness to be a spiritual problem, some of their description of its manifestation or presentation, were similar to those of the DSM and ICD classification codes. It also emerged that there are those mental illnesses, perceived to be beyond MHCPs' scope of practice. Mental illnesses such as psychosis, which they viewed as madness/craziness, were spiritual in nature and should not be referred to or treated by MHCPs.

Although the participants in this study revealed their reliance on God to minister to their congregants with mental health problems, they conceded that they were not well trained or not at all trained in mental health issues. As such, they valued and appreciated working together with MHCPs. However, other pastors indicated that, there is no way that they would seek help from MHCPs, since that would suggest that their God is a failure, and they would have disappointed their congregants by doing so.

CHAPTER SIX
DISCUSSION OF FINDINGS

6.1 Overview

The present study was carried out to understand the processes in which mental illness is understood and treated by selected Pentecostal pastors around Polokwane. The study was undertaken within the Bio-Psycho-Social-Spiritual (BPSS) model which served as a lens to understand their perception of mental illness and how it should be treated. Qualitative in-depth interviews were conducted to explore Pentecostal pastors' perception and treatment of mental illness. The findings of this study demonstrated that religious/spiritual and cultural factors play a role in the participants' understanding and treatment of mental illness. Although religious/spiritual factors dominated their understanding of mental illness, they also acknowledged other non-religious/spiritual sources as causes of mental illness. Below, the emerging themes are discussed in terms of the implications of the participants' understandings of mental illness, the process by which mental illness gets diagnosed, identified, and recognised, treated, and managed; the participants' perceived role of the church's mental health perception; as well as their collaboration with MHCPs.

6.2 Participants' notions of mental illness

Overall data obtained from this study indicate that participants hold a multifactorial or multi-dimensional view of mental illness. However, even though participants acknowledged other factors such as biomedical and psychosocial, the predominant explanation of mental illness from the participants was supernatural. Moreover, spiritual factors were also perceived to be responsible for the existence of psychological and psychosocial problems. The perception of mental illness held by the participants in this study appeared to be mostly influenced by the participants' religious/spiritual beliefs, personal experience, and socio-cultural context.

This finding is in keeping with the highlighted significance of spiritual and cultural explanations for mental illness by Monteiro (2015) who asserted that the BPS model should include a focus on socio-cultural-spiritual dimensions of conceptualising and

treating mental illness to represent the unique cultural EM to understand mental illness in Africa. In agreement, Waldron (2010) stated that conceptualisations of illness, disease, symptom presentation and treatment are shaped by various social, cultural, ethnic, economic and political variables within individual societies and are interpreted, assessed, diagnosed and treated in unique ways in different cultures. Thus, the BPSS was the most relevant model to utilise in this study.

The present study also highlights the predominance of supernatural factors in the explanation and treatment of mental illness. Findings of this study are consistent with previous findings that explored pastors' EMs of mental illness in Africa (Asamoah et al., 2014, Kamanga et al., 2019; Kpobi & Swartz, 2018a; Mabitsela, 2003; Murambidzi, 2016; Yonderk et al., 2019), indicating that pastors uphold a religious/spiritual worldview of mental illness regarding its causes and treatment. The religious/spiritual view acknowledges cultural and religiousspiritual beliefs. Thus, it is consistent with Indigenous and African traditional beliefs which recognise the special ability bestowed upon pastors and traditional healers to heal mental illness (Ae-Ngibise et al., 2010; Sorsdhal et al., 2009; Kamanga et al., 2019; Kpobi & Swartz, 2018b) and their ability to understand those who consult with them from their religious/cultural and cultural perspective. The above was cited in many previous studies regarding why many people with mental illness consult with their pastors and traditional healers. For example, Ae-Ngibise et al (2010) established that pastors and traditional healers' understandings of mental illness were consistent with hegemonic cultural EMs of mental disease aetiology. In concert, Kalender (2019) observed that in South Africa especially, community and religion/spirituality are traditionally tied.

From this study, findings show that there is no universal definition of what mental illness is. Thus, there were various explanations and description of what mental illness was. However, the dominant description of mental illness was that it was a spiritual illness specifically-madness/craziness and spirit possession. When probing further, it emerged that what the participants described as madness and spirit possession, somehow matched the symptoms of psychosis as outlined in the DSM-5. This finding is in keeping with what other previous researchers found in African and non-African countries. For example, in Africa Kpobi and Swartz (2018a:2018c) found that Pentecostal pastors in Ghana agreed that the behaviours displayed by people with

mental illness suggest a malfunction in their brains and used the term 'madness' to describe what they considered as mental illness. In both studies above, the term 'madness' was commonly used to describe a condition whereby the person's behaviour was considered unusual, disruptive and/or unpredictable. In contrast, Parks (2020, p.19) mentions that:

"Mental illness is a condition and not the result of demonic possession; however, some symptoms of mental illness may mirror acts of demonic possession. Because demons use people and influence them, some individuals believe people with personality disorders to be under demonic possession".

Results of a study carried out Kamanga et al (2019) in Malawi, showed that Pentecostal pastors were of the perception that 'biblically, when a person is possessed with demons or evil spirits also called '*ziwanda*' would portray a change in behaviour and present as walking naked, aggressive behaviour, talkativeness, poor self-care, for example, dressing in rugs. This agrees with what most participants in this study alluded to as mental illness. Specifically, most participants referred to the Biblical story of the man who was named 'Legion' as mental illness or madness in their terms. Although the pastors' definition and description of mental illness centres on a religious/spiritual element, they mimic the Western description and definition of mental illness. This is echoed by Mabitsela (2003) who found that pastors' definition of psychological distress (mental illness) shared common features with several of the DSM-IV diagnoses, yet they did not see psychological distress as an illness requiring medical treatment. Nevertheless, in line with the findings of Leavey (2010), it should be noted it is no definitive and singular clergy (pastoral) view on the origins of mental illness. In agreement, Gaffenney (2016) observed that the various views of mental illness held by Pentecostal pastors acknowledged the complex, multifaceted nature of mental illness.

Some participants in this study perceived mental illness to be a psychological problem. The participants who perceived mental illness to be a psychological problem indicated that a person is a triune being (thus, a person is made up of body, mind (soul) and spirit. According to participants in this study, if one of the factors is affected,

psychopathology will result. Thus, according to the participants, a person may be affected or attacked in one of the three areas (body, soul (mind), spirit) and develop a mental illness. In agreement, Parks (2020) mentions that psychological disorders are not all spiritual, but mental as well, and that is why local church members need to understand mental illness. Once the pastor believes and shares that not all mental illnesses are of the devil, the mindsets of congregation members will follow (Parks, 2020). This view of mental illnesses by the participants helps to ease the unwillingness to refer their congregants to MHCPs. The views of the participants above differ from those who viewed mental illness solely as a religious/spiritual problem, thus seeking only a religious/spiritual solution (Sullivan et al., 2013). According to the participants in this study, the condition of mental illness manifests with psychological/ or medical symptoms. As such, assistance from a psychologist and/or doctor may help in alleviating the symptom. This could be indicating a paradigm shift taken by theology to be more integrated with psychology.

In a study carried out by Grossklauss (2015) in Germany, it also became evident, that despite most of the participants not working with spirit possession, they understood its expression to represent the manifestation of physical and psychological symptoms that are attributed to an outside force or spirit that enters the body and takes control over the person's mind, behaviour and emotions. Thus, despite the clear indication and presence of psychological experiences and social experiences that could lead towards the development of symptoms that characterise a mental illness, one of the participants in Grossklaus's (2015) study was insistent that the real enemy faced by humans, is Satan or the devil and that one's redemption is through prayer.

Likewise, in the study conducted by Gaffeney (2016) in the US, results showed that Pentecostal pastors perceived that a sufferer from demons may refer to the one who is suffering in whatever form-recurrent divorce, persistent unemployment and failure in business, poverty, incurable disease, frequent indulgence in sexual immorality and mental illness were tied to demonic manipulation and control. Jackson (2017) also established amongst Pentecostal pastors that, they viewed mental illness as having existed for years beginning in Biblical times and manifested itself as demon possession.

6.2.1 *Varying degrees of mental Illness*

One interesting finding which emerged from this study is that participants recognise and acknowledge the different degrees or levels of severity for mental illness, again as described and categorised in the DSM-5. Although mental illness was mostly perceived as psychosis, other forms of mental illnesses such as anxiety, depression and adjustment disorder where also recognised as mental illnesses though of less severity. This view was supported by participants who took part in Kpobi and Swartz's (2018a) study wherein the participants' explanations for what constituted mental illness pertained to descriptions of psychotic behaviour and other forms of mental disorders (such as depression, anxiety, etc., were not the same as madness but could lead to that if not checked. This concurs with what Uwannah (2015) discovered in her study. The participants taking part in Uwannah's (2015) study viewed mental health conditions as a spectrum of disorders ranging from less severe conditions such as depression to more severe conditions such as schizophrenia. Thus, schizophrenia (a psychotic disorder) was viewed more as stigmatising than bipolar disorder both in society and amongst the participants. In support, Parks (2020) mentions that depression, for example, is a group of mood disorders with differences in symptoms and degrees of severity.

There is both normal and abnormal depression. Many depressive recessions are typical because they are caused by everyday existential problems and people take these symptoms in stride, with most individuals not becoming overwhelmed because the symptoms do not last (Parks, 2020). Thus, if people when depression is viewed not as a mental illness from the onset by the participants, it may escalate to Major Depressive Disorder (MDD) and cause more harm to the affected as compared to when it is early detected and treated. Eventually, it may transform to MDD with psychotic features which is likely to be viewed as demon possession by the participants.

The above finding was replicated by Kpobi and Swartz (2018c) who found that there was a consensus among the participants that someone presenting with symptoms suggestive of PTSD was not mentally ill. As noted by Kpobi and Swartz (2018c), such symptoms were considered socially appropriate reactions given their exposure to some traumatic experience, signifying that they had an appreciation for the potential

psychological effects of stressors and other social factors. Specifically, participants in Kpobi and Swartz's (2018c) study indicated that a person was having a mental illness when their behaviour was bizarre, aggressive, or disruptive. Likewise, in this study, depression was described not necessarily as a mental illness but was perceived as a precursor to actual madness (mental illness).

Because of lack of proper terminology, knowledge of and methods to diagnose mental illness, Pentecostal pastors eventually view most mental illnesses as a religious/spiritual problem. People with mental illness/mental health problems in church, are not aware that they have mental health problems. As a result, mental illness may be ignored, hidden, or misdiagnosed as demon or spirit possession. This finding was echoed by Wilkins (2019) and Smith (2016) who found that Mental illness is a topic that is often neglected and shunned in the Black American community. Similarly, participants who took part in White's (2016) study shared how the African American clergy (pastors) either ignored the issue of mental illness or identified it as a demon or trick of the enemy.

Likewise, in Harare, Zimbabwe Murambidzi's (2016) study highlighted that there was a general lack of information among the clergy (pastors) and the public which related to the prevailing myths and misconceptions, stigma and discrimination, limited referrals and collaboration with formal mental health system, and the underutilisation of formal mental health services. However, Jackson (2017) and Parks (2020) noticed that although pastors lacked knowledge, pastors would say that the issues were not even psychological but spiritual, and they would not even think of seeing an MHP. For this study, the main objective was to aid Pentecostal pastors as well as MHCPs to gain a better understanding of mental illness and demon possession n with the view of enhancing collaboration for the congregants' positive mental health.

Besides viewing mental illness solely as a religious/spiritual problem, findings of this study reveal that participants agreed that mental illness can also manifest as a bio-psycho-social problem. This finding by the participants replicates other previous studies carried out in Africa and outside Africa. In South Africa, Mabitsela (2003) discovered that Pentecostal pastors indicated that a human being is believed to function as a system with interconnected religious/spiritual, physical, and

psychological subsystems. Specifically, the participants in Mabitsela's (2003) study described psychological distress (mental illness) as a negative experience affecting the whole being, including religious/spiritual; physical and psychological areas are impairing a person's ability to function effectively. Similarly, in 2012, Kruger investigated Afrikaans speaking pastors in Polokwane. Her study's findings revealed that the participants held a holistic view of a human being and what they explained to be mental illness. To be specific, the participants perceived mental illness as a complex and vastly occurring phenomenon affecting a person's whole being, not only the religious/spiritual (Kruger, 2012).

Likewise, in the USA Harris (2018) also established that Pentecostal pastors held a holistic understanding of mental health and illness by describing the combination of emotional, religious/spiritual, mental, and physical health as influencing one's mental state. This finding is worth taking note of since previously pastors seemed to mostly have a single factor view of mental illness. There seem to be a paradigm shift and more openness to other EMs of mental illness (Kruger, 2012). Thus, there is now recognition of biological, psychological, and social worlds as affecting a person's wellbeing (Jackson, 2017). This multidimensional or factorial understanding of mental illness alludes to a combination of healing approaches to treat mental illness.

6.3 Notions on the diagnosis and recognition of mental Illness

Most participants in this study felt that they were not well equipped or trained to diagnose mental illnesses like MHCPs. This usually, led to misdiagnosis and/or spiritualisation of mental illness leading to its denial or delayed treatment. As such, they would not hesitate to refer their congregants suspected to be having mental illnesses to MHCPs and would be more open for collaboration. These findings were echoed by Murambidzi (2016) that most of the clergy (pastors) in his study had no prior mental health education and training and as such, could not confidently assert that they were able to identify and address the mental health needs of their congregants. Specifically, Murambidzi's (2016) study revealed that pastors still had recognition problems relating to differentiating mental illness from spirit possession. Jackson (2017) observed that Pentecostal pastors recognised their limitations, such as lacking knowledge regarding symptomology, aetiology, severe pathology, DSM

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diagnosing, and effective treatment planning where both meaningful methods and evidence-based practices are used.

Likewise, in his study Park (2015) established that the clergy (pastors) were not trained in mental health and that additional training and education would be beneficial to assist people with mental health problems. The results of the study by Park (2015) also highlighted the importance of providing mental health training and education to the pastors and increasing collaboration among the pastors and MHCPs to strengthen the referral process. In a later study, Parks (2020) found that many pastoral counsellors, do not have formal training and do not know how to identify and recognize the differences between mental illness or religious/spiritual oppression.

Thus, Parks (2020) argued that untrained pastoral counsellors may do more harm than good if they cannot correctly diagnose symptoms. Similarly, a study done by Kpobi and Swartz (2018c) in Ghana showed that the mental health literacy of the practitioners was relatively low thus, presenting some concern about misdiagnosis and treatment. Thus, the mental health knowledge of Pentecostal pastors is important to assess to avoid potential negative outcomes for congregant patients. This finding is surprising since participants are known to be having "spiritual" gifts or powers endowed within them by the Holy Spirit to aid them know people's problems before hand and be able to interpret and treat those (Asamoah et al., 2014). However, other participants in this study acknowledged that they lacked knowledge and skill in mental health training (Jackson, 2017) it did not mean that they do not have other means or ways of assessing and diagnosing mental health problems. Thus, some participants indicated that they can determine through spiritual means such as prayer, discernment, prophecy, revelation, observation and spiritual counselling/interviewing whether a case was spiritually inclined and to determine when it was purely an issue which MHCPs could diagnose and deal with (Kpobi & Swartz, 2018a).

This study has proven that what would be considered in psychological terms as clinical presentation or clinical impression is spiritually determined while for the psychologist it is determined by the information provided by the client and/or tests conducted. This finding was consistent with what previous researchers found amongst Pentecostal pastors and confirms varying theological beliefs within the Pentecostal church. In

Ghana, for example, Pentecostal pastors studied by Asamoah et al (2014) argued that they possessed the spiritual ability to diagnose the problem be it psychological, physical, or religious/spiritual. Similarly, results of a study conducted by Kpobi and Swartz (2018a) also revealed that Pentecostal pastors believed that they had special spiritual abilities to discern, diagnose and treat mental illness. Thus, they demanded recognition from MHCPs and from the government. In support, Asamoah et al (2014) and Leavey (2010) found that Pentecostal pastors were interested in the spiritual aspect of their clients, unlike the Western-trained psychologist and psychiatrist who would ignore that dimension or not be able to detect its presence. Generally, results of this study revealed that the participants held differing views regarding how and by whom mental illness should be diagnosed.

The special ability to detect the presence of mental illness by Pentecostal pastors could be useful in the psychotherapy practise, more especially in circumstances whereby a patient is presenting with spiritually inclined symptoms. Moreover, this finding insinuates that MHCPs need to consider looking at clients' problems outside the confines of the DSM and the ICD-10 codes (Grossklaus, 2015). This can be achieved either through an integral or collaborative approach or considering culturally and religiously/spiritually inclined classifications of mental illness and treatment plans thereof.

6.3.1 *Notions on the signs and symptoms of mental Illness*
The signs and symptoms that most Pentecostal pastors perceived to be those of mental illness mimicked what was like those MHCPs considered being of mental illness or a mental health problem although they were Biblically related to the story of Jesus and the Legion a Biblical event in Mark Chapter 5. Most participants in this study indicated that the Legion presented with or displayed signs and symptom of madness, which is an equivalent of mental illness according to the participants. This finding is in keeping with other previous findings. In support, (Parks, 2020) noticed that many times, the clergy (pastors) face a fine line in discerning if a person is demonically possessed or has a mental illness.

According to Parks (2020), there is often a biblical text appropriate for the situation as well as a psychological explanation. For example, scholars in the modern secondary

literature presented the Gerasene demoniac in the Gospel of Mark as having acute "mania." Using current psychiatric nosology to describe his pathology indicates several symptoms of a mood disorder instead (Parks, 2020). However, in the same study, Parks (2020) argued that there was a need for a re-appraisal of how the Bible was used on this topic. Thus, rather than focusing on limited accounts of explicit mental illness within the biblical story, or on demonic possession as a growing number of UK Christians appear to be doing, there was a need to develop an authentic Christian language of mental health from the perspective of sufferers (Parks, 2020).

Apart from having a Biblically or spiritually inclined method of diagnosing mental illness, this study revealed that Pentecostal pastors' symptom identification was culturally inclined. This was echoed by Kamanga et al (2019) who established that pastors agreed that deviation from one's cultural behaviours is the main indicator that someone is getting mentally ill. Unlike MHCPs who rely on the DSM-5 and ICD-10 code to reach to a diagnosis, amongst Pentecostal pastors, especially in Africa, cultural norms seem to play a role in the diagnosis of what can be said to be mental illness. To be specific, Kamanga et al (2019)'s study observed that physiological changes (expressions), psychological changes, socio-cultural, spiritual behavioural change, unprovoked aggression, and violence, extreme anger, stress, depression, anxiety, bizarre beliefs (delusions) and possession with demons (evil spirits) were concepts for mental illness and what caused it.

Like in other previous studies (e.g., Kpobi & Swartz, 2018a:2018b), participants in this study seemed to be familiar with symptoms of mental illness representing psychotic disorders as compared to those of other categories of disorders as outlined in the DSM. In concert, Murambidzi (2016) found that pastors experienced challenges related to the difficulties of differentiating mental illness from spiritual possession when the person presented with psychotic symptoms and lack of visible mental illness markers where the person was not psychotic. Consistent with Murambidzi's (2016) findings, in this study, most participants reported that they would rely on the presence or absence of overt behaviour for the recognition of mental illness. Since this could lead to misdiagnosis, Jackson (2017) suggested that counsellors (MHCPs) were the needed professionals that are competent and trained to recognise symptoms of severe pathology, along with understanding how both environmental and biological

components can affect the mental health of an individual. In agreement, Webber (2009) noted that while the scriptures do not present a diagnostic case manual of mental disorders, they allowed pastors to watch God's people in the context of suffering, and the range of psychological distress they experience

Contrary to what the participants in the present study identified as symptoms of mental illness (madness) Mabitsela (2003) found that psychological distress (mental illness) is recognised mainly by signs of mood, behaviour, and cognitive disturbance. Again, it involved a disturbance in expressed communication and interpersonal relationships and was identified by disturbances in mood and affect, manifesting with depression, hopelessness, helplessness, discouragement, and a range of emotional problems.

Moreover, Mabitsela (2003) also observed that psychological distress (mental illness) affects the cognitive functioning such that attitude and perception of the affected person is negatively influenced, leading to a distorted outlook of the world and of the self, such as pessimism and low self-esteem. In extreme cases, Mabitsela (2003) noted that severe disturbances in cognitive functioning may occur, resulting in the affected person experiencing confusion, visual hallucinations, auditory hallucinations, and delusions. Thus, how and what the participants interviewed by Mabitsela (2003) identified and recognised as symptoms of mental illness were in keeping with the DSM unlike in this study whereby, they were able to mainly recognize symptoms of psychosis. Compared to this study's findings, Mabitsela's (2003) study results could have been influenced by the terminology used to refer to mental illness as "'psychological distress". As such, instead of viewing mental illness as only psychotic symptoms, the participants in that study were also able to identify affective, interpersonal, and cognitive symptoms of mental illness.

6.4 Notions on the causes of mental illness

Consistent with other previous finding, this study established all the participants in this study, attributed mental illness to multiple causes. However, spiritual attributions of mental illness were emphasised as the main causes. Important to note though is that, although other factors were considered, they were believed to be spiritually influenced. All the participants acknowledged other causes to the mental health disorders,

including biological components, social components, and psychological factors. The participants realized that there could be multiple causes, depending on the issue and the individual, and most of the time there was more than one contributing factor to mental illness. This finding was echoed by Murambidzi (2016) who discovered that participants from Protestant and Pentecostal churches tended to attribute mental illness to multiple factors, including spiritual and bio-psycho-social factors, as compared to those who were African Independent Churches (AICs). Thus, it was significant for this study to separate Pentecostal pastors from AICs and those from Classical and Neo-Pentecostal churches.

This view of mental illness by the participants could be influenced by the differences in doctrine and theology of the Pentecostals. Those who subscribed to this explanation of mental illness believed that it was not permanent and could be cured by both spiritual and medical (psychological interventions). This finding is in keeping with what Harris (2018) found in her study. In Harris's (2018) study, most participants posited a holistic understanding of mental health and illness by describing the combination of emotional, spiritual, mental, and physical health as influencing one's mental state. Similarly, results of Yendork et al (2019)'s study discovered that amongst Neo-Prophetic (Pentecostal) churches in Ghana, the perceived causes of mental illness were related to lifestyle issues, spiritual factors, trauma, biological factors and multiples causes. Thus, there was no single factor which was perceived as the sole cause of mental illness. Mental illness was viewed as emanating from a plethora of sources.

6.4.1 *Spiritual causes*

Religious/Spiritual factors dominated Pentecostal pastors' understanding of mental illness. This finding agrees with what other previous studies found when exploring the understanding of causal factors of mental illness amongst Pentecostal pastors. This finding was consistent amongst Pentecostals in African states. More specifically, all participants agreed that mental illness is caused by witchcraft, generational curses, spells demons (i.e demon possession, demonic attacks), sin or sinful living. This discovery is in keeping with what previous studies discovered. Like in this study, the predominant belief about the causes of mental illness in the study carried out by Kpobi and Swartz (2018a) was that mental disorders were caused by evil or unclean spirits

and witchcraft. Similarly, Murambidzi (2016) found that the clergy (pastors) attributed mental illness, to spiritual attacks and possession by some malevolent spirits, "demons" that "occupy the person's mind" thus resulting in mental illness.

Likewise, the results of a study by Kamanga et al (2019) indicated that a person may have mental illness because of possession by evil spirits commonly termed as ziwanda. The possession by evil spirits was associated with a person who breaks cultural norms and may be affected by evils spirits as a punishment or a curse. To concur, Yendork et al (2019) also established that Pentecostal pastors perceived mental illness to be resulting from spiritual causes. Specifically, the participants in Yendork et al (2019)'s study perceived that mental illness could be caused by curses, weak spirituality, and evil machinations by the witches, evil spirits, and demons. In contrast, Parks (2020) who studied Baptist pastors in America with the view of differentiating mental illness from demon (evil spirit) possession in his study mentioned that family members can pass down mental illness through the generations just as the Bible presents generational curses, the same occurs in the natural realm. As a result, a BPSS based intervention would be the most appropriate strategy by paying attention to all those factors in psychotherapy.

When the participants perceived mental illness to be resulting from a spiritual source, preferably a spiritual intervention was sought and believed to be the best intervention strategy. The above perspective agrees with Sullivan et al (2013) who discovered that when a problem is viewed as religious/spiritual, a religious/spiritual solution was sought. To confirm the above, Asamoah (2016) discovered that Pentecostal pastors indicate that witchcraft, an aspect of demonology, is seen by Pentecostals as an advanced form of spirit possession, which is a prevailing belief in Africa, even within Christian circles. It has continuously posed problems for the Africans. Unlike in the Western world whereby mainstream Christian and Jewish groups generally consider natural factors as primary causal elements in mental illness and mental health interventions, despite their acknowledgement of the importance of supernatural phenomena; Pentecostal believers on the other hand emphasize the role of the supernatural in causation and healing of mental and physical disorders (Levey, 2008).

6.4.2 *Biological causes*

This study revealed that Pentecostal pastors acknowledged the influence of biological factors on mental health. Specifically, the study revealed that all participants agreed that mental illness could arise from substance abuse, Traumatic Brain Injuries (TBIs), biochemical imbalance, malnutrition, chronical medical conditions, heredity. This discovery was echoed by Stanford and Philpott (2011) whereby the participants reported biological factors (inherited genes and chemical imbalances in the brain) as most important causes of mental illness and that biomedical therapy was the most effective treatment for it. Interestingly for the present study, Stanford and Philpott's (2011) study revealed that among evangelical and Pentecostal clergy (pastors), alcohol and drug use suggested that either a demonic force has gripped a person, or that addiction may lead to vulnerability to demonic attack. Like the Pentecostal pastors interviewed by Stanford and Philpott (2011), participants in this study were of the view that biological causes of mental illness were influenced by a spiritual source. For example, heredity was viewed as a generational curse amongst the Pentecostals. On the one hand, a naturally occurring TBI could be viewed because of witchcraft.

Likewise, participants taking part in Kpobi and Swartz's (2018c) study believed that mental illness could be genetic and run through families. However, most of the participants also believed despite the admissions there were instances when spiritual means could be used to orchestrate road traffic accidents which would then result in brain injury (Kpobi & Swartz, 2018c). In contrast, Pentecostals who took part in Kruger's (2012) study in Polokwane acknowledged purely biological factors as causes of mental illness. The study by Kruger specifically the pastors identified organic causes such as biological or medical reason to be the main causes of mental illnesses. However, it should be noted that the participants taking part in Kruger's (2012) study were predominantly Afrikaans speaking from affluent Pentecostal churches. Thus, race and socio-economic status of the participants may have influenced the findings.

This study also confirmed the findings of Harris (2018) wherein results indicated that mental illness was also viewed as stemming from a chemical imbalance or a brain defect. For example, in the study by Harris (2018), one of the participants described the cause of mental illness as a 'chemical imbalance in the brain', further explaining that the chemical imbalance results from 'poor nutrition'. In concert, some of the

participants who took part in Kpobi and Swartz's (2018c) study stated that Traumatic Brain Injuries resulting from car accidents could also cause mental illness. The biological view of mental illness by Pentecostal pastors is significant, especially in Africa, specifically because it deviates from the original Pentecostal belief that mental illness is caused by spiritual factors alone (Monteiro, 2015). The acknowledgement of biological causes of mental illness is in keeping with the BPSS model of mental illness and thus increases the likelihood that Pentecostal participants will receive and pursue help by MHCPs, as well as accept psychotropic medications that can change the neurochemistry of the brain (Harris, 2018).

6.4.3 *Psycho-social causes*

Psychologically, all participants in this study agreed that mental illness could result from factors such as past life experiences, stress, negative thinking, trauma, loss, depression. Socially, participants attributed the onset on mental illness to divorce, poverty, life/environmental circumstances such as being unemployed, poor living environment, relational problems, and family conflicts. This finding corroborates with the results drawn from Trice and Bjorck's (2006) study conducted amongst Pentecostal pastors. In that study, depression (mental illness) was attributed to social causes such as difficult life events. Likewise, results of a study conducted by Payne and Hays (2016) indicated that PTSD and depression (mental illness) occurred due to a person's life circumstances, handling disappointments or adversities, going through something specifically traumatic, or even due to avoiding issues when they arise and refraining from discussing them. This was also echoed by Kruger (2012) who observed that religious/spiritual leaders (pastors) identified learned behaviour and traumatic incidents/stressful life events as some of the most likely causes of the onset of a mental illness.

Again, results of this study also support what Kamanga et al (2019) observed amongst Pentecostal pastors. To be specific, in that study the participants Loss of beloved one or loss, of property, stress, extreme anger, anxiety, depression, problems in life, and life challenges such as loss of relatives or conflict between two individuals. Similarly, in a study that was conducted by Murambidzi in 2016, pastors reported the following as psycho-social sources of mental illness: poverty, financial challenges, and stressful life events such as violence, abuse, and trauma. There participants taking part in

Murambidzi's (2016) study specifically reported that when one is subjected to stressful life experiences, the person may fail to withstand the pressure, become emotionally overwhelmed and eventually break down. Thus, besides the religious/spiritual dimension, psychological make-up of a human being as well as their surrounding social circumstances are recognised as factors that can cause mental illness, though it seems that they are influenced by supernatural factors. However, it is important to indicate that, though these factors were recognised as causes of mental illness, some participants regarded them as spiritually orchestrated.

6.5 Notions on the treatment and management of mental illness

Data provided by the participants of this study indicate that they hold different views regarding how and by whom mental illness should be treated and managed. Specifically, Pentecostal pastors perceived that mental illness can be treated and managed from three approaches this researcher has named as follows: (i) The Full Collaborative Approach; (ii) The Partially Collaborative Approach; and (iii) The Non-Collaborative Approach. The approaches are discussed later in full. The participants' treatment and management approaches that were consistently referred to could be described as aspects of pastoral treatment and management. These included prayers, the use of scriptures for guidance, teaching, counselling, and motivation. However, important to note is that most participants held the view that both themselves and MHCPs can treat mental illness. This approach to treatment and management of mental illness by the participants can be termed 'Full Collaborative Approach' since it provides a platform for both participants and MHCPs to display their knowledge and skills for the holistic well-being of those taken care of.

6.5.1 *The Full Collaborative Approach*
Specifically, participants in this study believed that MHCPs and psychiatrists were also used by God to heal through methods of consultation, therapy, and prescribing psychotropic medications. As such, they did not have problems with referring or collaborating with MHCPs. This finding is surprising and not in keeping with many previous findings amongst Pentecostal pastors. For example, a study conducted by Leavey (2008) discovered that Pentecostal pastors claimed that while mental illness had genuine natural causes, psychiatrists were unable to detect the presence of

demonic influences. Thus, Pentecostal pastors declared a major interest in engaging possibly with the demonic (negative spiritual forces) rather than the patient as compared to psychiatrists and other MHCPs. In concert, most Pentecostal pastors studied by Kpobi and Swartz (2018a) considered themselves to be operating at a higher level of efficacy than biomedical professionals and they considered their methods to produce more enduring results given their use of the gifts of the Holy Spirit, whom they consider as all-powerful. As such, they demanded respect and reverence and expected their instructions to be followed by their congregants (Kpobi & Swartz, 2018a). This perception by Pentecostal pastors may influence their congregants/patients to undermine or ignore the use of mental health services (Uwannah, 2017). Moreover, Pentecostal pastors holding such a view may trigger some anxiety or depression in their congregants or followers or they may not see the need to refer to or collaborate with MHCPs (Kpobi & Swartz, 2018b).

Similarly, a study conducted by Harris (2018) indicated that Pentecostal pastors mentioned that they would not send problems that were viewed as spiritual in nature to MHCPs. Such pastors were more likely to rely solely on prayer, faith in God, miracles, exorcism, or some form of supernatural healing power to deliver and refuse to collaborate with MHCPs or refer their congregants to them. In agreement, Kamanga et al (2019) observed that in most cases, there was a competition between the pastors and the healthcare professionals. Specifically, Kamanga et al (2019)'s study revealed that most pastors believed in faith healing prayers to heal mental illness, while the healthcare professionals encouraged the use of medicine. Thus, contrary to these previous findings, this study identified that although Pentecostals pastors valued their spiritual methods of intervention, they did not undermine, or renounce conventional Bio-Psycho-Social methods of intervention used by MHCPs.

In line with this finding, Parks (2020) remarked that a person cannot heal, for example, a mental illness caused by family dynamics through prayer alone. Parks (2020) observed that people that people go to their pastors if they have one, because pastors have a better knowledge of the family, and family members feel more comfortable with them. This view of mental of mental is worth taking note of because it provides a platform for MHCPs to work collaboratively with pastors in helping their congregants with mental health problems.

In concurrence, participants who took part in Asamoah's (2016) study found that physical and psycho-social problems may lead to mental illness syndrome. From the results of Asamoah's (2016) study participants agreed that physical abuse such as rape may cause the victim to hallucinate or experience nightmares. In that case medical treatment was needed to treat any wound sustained from the rape; and a psychologist was needed to counsel the victim to heal the emotions. This was also echoed in the findings of Williams (2008) who observed that, while early Pentecostals typically condemned reliance on medicines, mental healing, or various other natural means of healing; in the second half of the twentieth century, healers (pastors) combined divine healing with traditional medicine, alternative medicine, as well as psychology and Psychoanalysis. This willingness of Pentecostals and charismatics in the latter decades of the twentieth century to utilise natural healing methods represents a sharp break from early Pentecostal teachings (Williams, 2008).

Likewise, this study has noted a similar trend. Equally so, Kruger (2012) observed that religious leaders (pastors) seem to have moved to a more Western view of treating certain mental illnesses, especially those they believe to be organic in nature. Thus, this finding from participants in this study strayed from early perceptions that Pentecostal had on the treatment and management of mental illness. As also observed by Roux (2019) in her study, as new generations are converted to the Pentecostal faith and as the Pentecostal ministry is passed down from one generation to the next, some of the uniqueness of the Pentecostal heritage is retained, and some is lost. To confirm the above, all participants taking part in Parks' (2020) study concluded that a person displaying symptoms of mental illness should seek counselling, whether pastoral or therapeutic. Parks (2020)'s study participants believed that it was helpful for individuals to have at least some understanding of mental illness and demonic possession because people might deal with and encounter both struggles.

6.5.2 *The Non-Collaborative Approach*

Regarding the perception of how and by whom mental illness should be treated, findings of this study revealed that, only a few participants indicated that mental illness should only be treated religiously/spiritually by pastors. Participants, who held this view, did not see any need to collaborate or be involved in an integrative treatment

approach with MHCPs. Based on their perceived ability to heal mental illness spiritually as authorised and empowered by God, participants under this category seemed to undermine bio-psycho-social interventions. This finding is echoed by Kamanga et al (2019)'s study which showed that Pentecostal pastors claimed that doctors do not have nor had little faith in God. Thus, they perceived that sending patients to doctors was like putting doctors first over God which is not acceptable in their faith (Kamanga et al., 2019) even though they did acknowledge the significance of hospitals as God's creation.

The participants in Kamanga et al (2019) emphasised the belief that God heals all illnesses those caused by natural causes and those caused by supernatural causes. In this study, the participants who were comfortable with this approach to the treatment of mental illness (non-collaborative), were of the view that collaborating with MHCPs would mean that they doubt their own faith in God and the faith of the congregant-client. This was also echoed by Kamanga et al (2019) who found that pastors felt that hospitals and doctors are a creation of God and so they cannot take precedence over God. In agreement, in his study Parks (2020) observed that participants were of the view that any Christian (according to Pentecostals) can deliver an individual from demons, and thus from mental illness, although individuals have differing abilities for this work.

Just like in Harris's (2018) study, some Pentecostal pastors in this study asserted that they would not send problems that were viewed as religious/spiritual in nature to mental health counsellors. They postulated that Jesus is the healer of all illnesses, whether caused by spiritual or natural factors. Similarly, Parks (2020) established that although Pentecostals may use psychological terms and concepts, they did not consider professional treatment essential for casting out demons, nor did they think people require any ordination or training. In agreement, Payne and Hays (2016) found that the clergy (pastors) discussed treatment methods such as deliverance ministries, the spirit of discernment, prayer, fasting, and applying the Word of God and taking mentally ill congregant members to prayer camps for healing than refer to MHCPs. Nevertheless, it should be noted that even though believers need to pray, prayer does not always change the disposition of the suffering person (Parks, 2020). According to Parks (2020), many things are the result of wilful actions, and when people cannot

cope with the results, they look for something or someone to blame for their actions. Moreover, Parks (2020) gave an example that depression could result from traumatic experiences, such as loss and grief and that when an individual experienced trauma, the individual's mood, perception, and thoughts could change.

Consistent with other previous findings, this study has noted that there are still Pentecostal pastors who believe that mental illness can only be treated by God alone without using MHCPs. To attest to the above, Williams (2008) observed that early Pentecostals condemned reliance on medicines, mental healing, or various other natural means of healing, especially for believers, focusing instead on deliverance from evil spirits and complete faith in God as keys to the healing process. This view regarding the treatment and management of mental illness also emerged from Kamanga et al (2019)'s study whereby Pentecostal pastors believed that it is only God who can heal all types of illnesses both spiritually and physically and that hospitals are a creation of God and therefore prayers should come first when someone is mentally ill. This seemed to indicate that even though a Pentecostal pastor refers a congregant to the hospital, and they be healed, the understanding or interpretation would be that the person was healed through God's power (Harris, 2018).

Likewise, Almanza (2017) also established that amongst Pentecostal pastors, there existed some extreme tendencies such as maintaining that mental health patients should not seek clinical treatment but rather wage spiritual battle. In concert, White (2016) reported that African American clergy (pastors) and the Black church relied more on faith and prayer as the main source for addressing mental health issues. However, contrastingly so, Parks (2020) suggested that ministers (pastors) must know when to refer people to professional help.

According to Parks (2020), the more information ministers (pastors) have at their disposal, the better equipped they are to help their church members find help and healing. Thus, pastors may hold the above view about the treatment of mental illness because of lack of knowledge about mental health. As such, the findings of this study are significant since they are indicative of a pathway to collaboration between pastors and MHCPs. When a Pentecostal church or pastor does not engage themselves in the ministry of deliverance or exorcism, it is regarded as cold or worldly or to be

presenting an incomplete gospel or even lacking faith in God (White, 2017). Pentecostal churches holding such a view, tend to undermine or ignore their congregants' presentation of symptoms of mental illness and eventually discourage referral to MHCPs and other MHCPs. In agreement, Matthew, and Stanford (2003) observed that pastors dismissed the diagnoses of a significant large number of mental health disorders, as well as lack of support for the use of prescribed medications for depression and anxiety in the Pentecostal church.

6.5.3 *The Partial Collaborative Approach*

Results of this study demonstrated that some participants were of the view that mental illness should be treated by both themselves and MHCPs. However, the participants specifically mentioned that MHCPs should deal with mental illnesses caused by psycho-social factors only while the participants dealt with those perceived to be caused by spiritual factors. To highlight this view, one of the participants said this:

> "*When someone is crazy, even if you can give them whatever you can, they cannot be OK. But the one with mental illness, can be treated, and be fine since you (referring to the researcher), use medical methods".*

Thus, the participants who subscribed to this view of managing and treating mental illness in this study felt that referring a case they perceived to be having a spiritual base (i.e., witchcraft) to a psychologist, their psychological methods would not help (Sullivan et al., 2013). In this approach, just like in the former (non-collaborative) as a result of the lack of knowledge and skill in recognising and diagnosing mental illness, the participants may misdiagnose a mental illness to be spirit possession leading to them not referring to MHCPs. For example, when a person continuously abuses substances which affect their brain leading to Substance Induced Psychotic Disorder (SIPD), which is manageable by psychotropic drugs and psychotherapy, they may be denied that chance to recover biologically and psychologically is they are only subjected to pastors.

This finding was echoed by Harris (2018) who reported that some Pentecostal pastors were of the view that they would not send problems that were viewed as religious/spiritual in nature to mental health counsellors (MHCPs). Thus, when a

problem was perceived to be religious/spiritual in nature; the Pentecostal pastors would deal with it without making a referral to an MHP. More specifically, Harris (2018) noted that participants who endorsed demonic possession as the primary cause of mental illness were less likely to refer patient-parishioners to MHCPs, because they were more likely to rely solely on prayer, faith in God, miracles, exorcism, or some form of supernatural healing power to deliver. Likewise, many participants who took part in Parks' (2020) study felt that only a pastoral counsellor should handle religious/spiritual matters and that only a therapist should address mental issues.

Contrastingly, the clergy (pastors) interviewed by Vander Waal et al (2012) indicated that they were highly likely to make referrals for issues that they viewed as more serious in nature, such as depression, nervous breakdowns, domestic violence, sexual abuse, and alcohol/drug addiction. According to Vander Waal et al (2012), the clergy (pastors) likely recognised these issues as often being beyond their scope of training and expertise and were willing to send church members to MHCPs for further help. In agreement, data gathered by Kamanga et al (2019) indicated that if the participants perceived the mental illness to be due to physical or biological causes, all the participants unanimously agreed that the person should be sent to hospital for determination of the severity of the illness and establishment of the treatment.

Overall, considering the varying approaches to the treatment and management of mental illness by the participants in this study, it can be said that the determination of the cause of the problem defines the treatment approach that will be employed in its treatment (Sullivan et al., 2013). Thus, if a mental illness is perceived and diagnosed to be non-religious/spiritual, the case might be referred to other secular-based treatments or for professional attention (Harris, 2018).

On the one hand, regardless of what is perceived to be mental illness and its source, there are pastors who are readily willing to collaborate for the well-being of their congregant. In contrast, there are those who entirely are not willing to treat mental illness alongside MHCPs. To illustrate the above, Sullivan et al (2013) observed that pastors with the 'religious/spiritual problem, religious/spiritual solution' were likely view all mental and emotional problems as purely religious/spiritual issues since they initially questioned the existence of mental illness. From this perspective,

'psychological' problems are viewed as merely manifestations of demon possession, evil spirits, or the work of the devil. Thus, according to the perspective, the use of psychotherapy and medication demonstrates a lack of faith and may even hinder healing (Sullivan et al., 2013). Secondly, Sullivan et al (2013) also coined the "mental problem, religious/spiritual solution" perspective which had the widest acceptance among Christian faith communities. This perspective as noted by Sullivan et al (2013), holds that mental illnesses and emotional problems may be real, but that they require a primarily or exclusively religious/spiritual solution. Thirdly, Sullivan et al (2013) highlighted that there is the mental illness, spiritual and mental solution whereby participants believed that mental illness is real and benefits from the use of mental health services. They believe that mental and emotional issues are both mental and religious/spiritual. Agreeing, Parks (2020) mentions that clinical needs and spiritual concerns are often inextricably intertwined among people of faith.

6.6 Participants' perceived roles

As was the case in many previous studies (e.g., Leavey et al., 2007; Mabitsela, 2003; Young et al., 2003; Grossklauss, 2015; Smith, 2017; Murambidzi; 2016), this study has found that participants perceive themselves as important role players in the mental health of their congregants. The roles that Pentecostal pastors provide to their congregants are worth noting by psychologists who desire collaborating with them. In South Africa, like in many LMICs (see, Kruger, 2012; Murambidzi, 2016), many people experiencing emotional distress consult with pastors, specifically because pastors are considered by their congregants as accessible, sharing the same spiritual and cultural beliefs. Specifically, the clergy's (pastor's) personal familiarity and experience can be invaluable to facilitate appropriate and continuous mental health care for their parishioners by contextualising the patient's illness and life history (Rudolfsson & Milsten, 2019). However, like in many other previous studies, most pastors in this study alluded the fact that they were not adequately trained and skilled mental health issues like MHCPs. Mostly, they employed biblical and other spiritual methods in helping their congregants. Specifically, from this study, it emerged that participants played the following roles to their congregants: Leading prayers and teaching their congregants, supporting them emotionally, physically, and psychologically, educating

them, motivating and inspiring them, being sources of referral to other services, counselling them and being part of their family events.

6.6.1 *Participants pray for congregants*

Most participants in this study pointed out that one of their major roles in the treatment and management of mental illness is to pray for the affected. Prayer was viewed as a powerful force with which to combat the detrimental effects of mental illness. As such, participants indicated that they would pray for the affected at their homes, in the hospital when they are admitted or accommodate them in their houses while praying for them for days. In the process, congregants would also be encouraged to fast along with the pastor, to confess any wrongdoing, repent and turn to the Lord if the sufferer considered not to be born again. Likewise, Park (2015) found in his study that out of the many religious/spiritual practices, prayer appeared to the most dominant religious/spiritual intervention practice (i.e., attend Faith Based Organisation (church), scripture reading, prayer, meditation, exorcism, confession, faith healing, other rituals, oil anointing, laying on hands, and fasting) in which 89.5% of the clergy (pastors) reported to engaging in with mental health concerns.

In agreement, Jackson (2017) observed that Pentecostal pastors incorporated prayer, laying on of hands, casting out of demons and other Biblical approaches to drive out the devil. Similarly, in their study regarding pastors' roles, Young et al (2003) reported that the pastors described a tendency to pray and quote scripture in their sessions and to include some references to confession and faith healing. Thus, Pentecostal pastors perceived their role as one of praying for their congregants. From this study, it emerged that prayer was either employed to completely heal the affected or for the affected to have hope in the other treatment method (Harris, 2018). This finding is fascinating since it portrays a positive attitude of pastors towards Bio-Psycho-Social methods of intervention.

However, there seem to be no studies which have explored the efficiency of prayer in healing mental illnesses. It also appears from the above extracts that praying for someone with a mental illness is not just done casually or ordinarily so. It is an area deemed to be requiring an incredibly special gift, anointing or ability as the participants would call them in their own jargons. The participants also seem to rely heavily on the

Holy Spirit to guide and empower them to execute their duties on those affected by mental illness. This could suggest that, though pastors do not have training in mental health related problems and the skills thereof, they seem to have a major role to play in the lives of their congregants-which is prayer. This leaves an open room for discussions between psychology and the church for a more holistic and efficient approach to the treatment and management of mental illnesses. As such, there is a need for reflection from psychologists as well regarding their understanding of a human being, care, and wellness. By so doing, psychologists will find themselves more open to collaborate with those in the community who can help them care for their clients.

6.6.2 Participants *counsel their congregants*

Young et al (2003) discovered that pastors averaged more than six hours of counselling work weekly and often addressed serious problems like those seen by secular psychologists, with whom they reported readily exchanging referrals. Most of the pastors interviewed by Young et al (2003) reported that they observed and addressed severe mental illness and substance abuse in their congregations and that they also counselled individuals outside their own denominations. Consistent with this previous observation, this study indicated that they are involved in counselling their congregants experiencing mental health problems. They further indicated that their counselling was Biblically based, and it encompassed guidance, teaching, motivating, and encouragement based on a given case. Thus, although the participants used religiously/spiritually based methods to counsel their congregants, the methods they used resonate conventional methods of some psychological theories (Stanford & Phillport, 2011).

Likewise, Asamoah et al (2014) noted that pastors were involved in counselling services which appeared to be more of advising, providing directions to patient and family members of patients with regards to how to handle the patient. In addition, Smith (2017, p.10) mentions that Pentecostal pastors "counsel and advise parishioners who approach them with relatively common mental health issues, but they refer parishioners with a serious mental health issue to MHCPs". Overall, a study conducted by Frontus (2015) highlighted that (pastors) believed that serving the community's needs was an inherent part of their role and that their role was essentially

all-encompassing; that a personal directive from God informed their role as a religious/spiritual leader; and that listening to others is an important function of their role.

Although the counselling and support services provided to the patient and their family members were not formal, they resonated with what psychologists offer during family education and supportive psychotherapy (Young et al., 2003). It can thus be presumed that although Pentecostal pastors lack training or extensive knowledge in mental health, by virtue of their calling and position in society, they have a significant role to play in the lives of their congregants (Rogers et al., 2013). When their roles are more clarified and understood by MHCPs who also see these congregants good working relations for the benefit of the affected can ensue. As noticed by Rudolfsson and Milstein (2019) in their study, MHCPs mentioned that their profession did not allow them to take part in their patients' lives, as boundaries were important for psychotherapy to be successful and described a need to prioritise their work with the patient. Thus, in the study by Rudolfsson and Milstein (2019), pastors had more access to their church members as compared to MHCPs.

Likewise, findings of this study have shown that unlike Mental Health Professionals, pastors had more access to their congregants' lives as compared to psychologists. As a result, pastors would be more trusted and consulted in times of need. In support, the clergy (pastors) visit people at their homes as a part of their professional role and often have longstanding personal relationships with congregants (Rodgers et al., 2013). Thus, apart from dealing with mental health problems, pastors provide services such as being around when families are bereaved, a child is born, property is bought, when people celebrate the marriages etc. According to Rudolfsson and Milstein (2019), as compared to clinicians, the clergy (pastors) may know multiple generations within a single-family and they at times follow the lives of individuals from birth to marriage, and until death. Instead of only viewing themselves as religious/spiritual leaders, they self-identified as multitasked caregivers who also serve as teacher, counsellor, marriage therapist, parole officer, social worker, and conflict mediator (Frontus, 2015). Likewise, a study conducted by Murambidzi (2016) indicates that confirmed that one important role of the church expressed by most participants was offering counselling and crisis support services to people experiencing various life problems.

6.6.3 *Participants are referral sources*

Another significant role which participants in this study indicated that they would play, is that of referring their congregant-client to those they would identify as being able to further assist and manage them. In so doing, the participants indicated that, it is not a demonstration of lack of faith or weakness but self-knowledge and the desire for the wholeness and wellness of the congregant (Mabitsela, 2003). They indicated that they would refer their congregants either to other pastors (More senior, experienced, or anointed) or to an MHCP.

The extracts above denote the fact that participants in this study are aware of their scope of practice and limitations thereof (Jackson, 2017). It appears that, when rendering their services to congregants-clients, they do not portray themselves as "Knowing it all". They realise that there could be other factors that they cannot resolve or identify during counselling or their intervention (Kruger, 2012). As such, they are willing to refer. This finding discards the norm which had led to antagonism between religion/spirituality and psychologists for quite a long time. There seem to be more openness and flexibility from the participants. Similarly, Kruger's (2012) study revealed that Afrikaans speaking pastors in Polokwane believed that the main role the church must play in the management of mental illness is more of providing a referral path to other health professionals that mentally ill individuals would not have been referred to. Similarly, this study discovered that Pentecostal pastors view their role in the treatment and management of illness as one of referring them to MHCPs. As aforementioned, pastors were the first to be consulted when congregants experienced emotional distress. Likewise, Kruger (2012) noted that pastors played a role in the referral of their congregants to other pastors whom they perceived as more skilled and knowledgeable or to MHCPs.

Smith (2017) established that the most prevalent approach mentioned by pastors was to either refer a person to a psychologist at the outset or to do so if the mental health issue is serious or beyond the pastor's capability to deal with properly. On the other hand, Frontus (2015) found that most of the clergy (pastors) believed that the direct provision or referral of mental health services for help-seekers was an integral part of their pastoral duties. In another study, Vander Waal et al (2012) found that Christian clergy (pastors) played an important role in identifying individuals with mental health

and substance abuse disorders and providing education, support, and referrals to needed services. Likewise, Asamoah et al (2014) observed that one main role Pentecostal pastors play in mental health care is identification of cause of mental illness. Leavey (2010) also reported that Pentecostal pastors perceived their role as one of being able to detect the presence of demonic spirits, unlike psychiatrists who were not able to do so. Thus, they canvassed for collaboration.

The role of providing referral to other pastors or MHCPs seems to be invaluable for some Pentecostal pastors, while on the one hand, some may feel powerless or as betraying the trust that their congregants have on them. For example, Pentecostal pastors interviewed by Mabitsela (2003) mentioned that they sometimes opt for referral with social problems that are beyond their understanding or cannot handle and they often collaborate with experts that are state funded such as social workers and police. However, they seldom refer to psychologists as compared to psychologists. The pastors studied by Mabitsela (2003) cited the following reasons for not referring to MHCPs: First, professional psychological services are seen as very expensive for most of their members. Secondly, these Western-orientated mental health services are not recognised by most congregants. Thirdly, psychological service facilities were not readily available in the township.

Moreover, Pentecostal pastors seem to accuse MHCPs of ignoring the religious/ spiritual side and only concentrating on the physical and psychological (Harris, 2008; Harwick, 2013). Thus, this finding is significant for psychologists. As such, they are too willing to refer. This finding discards the norm which had led to antagonism between pastors and MHCPs for quite a long time (Sullivan et al., 2013). There seem to be more openness and flexibility from the participants. This could suggest that the church is moving from a conservative approach to personhood to a more liberal and accommodative one (Kruger, 2012). For psychology, this means being aware of this interesting transformation in the church regarding psychological services. However, participants also indicated that referral should not be a one-way system. They would like that; MHCPs also recognise their presence, their special gifts and make referrals to them (Kpobi & Swartz, 2018b).

6.6.4 *Participants are educators*

Consistent with other previous findings, participants in this study viewed their role as one of providing their congregants with mental health education (Asamoah et al., 2014). Specifically, the participants indicated that they would form in-house teams made up of MHCPs as subsystems of their churches as a way of providing more awareness about mental illness. In this regard, one participant mentioned this in the following way:

> "*Believe you me, if it was my choice, I would have a medical centre in the church… (Laughter from both interviewer and participant) …. I will have a medical centre in the church (Laughter)…. And I mean that would eliminate a whole lot of confusion that is in the churches today.*"

The above finding was echoed by Asamoah et al (2014)'s study whereby a good number of the participants indicated that churches are sites for mental health education in the country and they participated in the programs to provide some health education to members. Thus, the clergy (pastors) appeared to use the church setting to create opportunities through their programmes for life enhancement. Similarly, Owoeye (2012) observed that Pentecostals educate their congregations through sermons, Bible studies and seminars in their conventions and retreats, and they also counsel all their members, especially the young ones, to abstain from reckless or frivolous sexual behaviour.

Likewise, in her study, Mabitsela (2003) concluded that despite the limitations of Pentecostal pastors in treating psychological distress they are ideal people who can take part with other MHCPs in the planning, promoting, and delivering preventive mental health care in the Black community. According to Grossklaus (2015), both MHCPs and pastors work predominantly with people: The former in clinics and practices and the latter in churches and schools (religion lessons). Thus, it can often happen that in pastoral counselling, pastors are confronted with needs which perhaps MHCPs could better deal with (Grossklaus, 2015). Furthermore, Grossklaus (2015) indicates that church members often go and see their minister first and depending on their problems he can either help or he refers them to a psychologist.

6.6.5 *Participants are sources of support*

Like other previous findings, this study has found that Pentecostal pastors see themselves as having a role to play in supporting their congregants and families in various ways (Asamoah et al., 2014). Specifically, participants saw themselves as 'shepherds' who should always be available for their lambs, especially during times of distress (Mabitsela, 2003). They further indicated that the support is manifested when they love and embrace, accommodate non-judgmentally, understanding and not stigmatising them, supporting them in taking their medication (from Western-based health professionals) and visiting them in hospitals when admitted (Murambidzi, 2016).

Furthermore, the support was also demonstrated through giving them words of encouragement and prayer. This finding also emerged from Asamoah et al (2014)'s study. Asamoah et al (2014)'s study established that Pentecostal pastors provided social support services included the provision of certain basic needs of the patient, lack of which might be the source of the mental illness. Thus, support was also provided in the form of emotional care, whereby the pastor would regularly organize hospital visitations with some members of the church to give hope to patients and families who are hurting one way or the other (Asamoah et al., 2014). Participants in this study also indicated that they literally accommodated emotionally distressed congregants in their homes while some envisioned having victim empowerment centres in their churches. This view by the participants in this study was echoed by participants in Murambidzi's (2016) study who observed that pastors perceived the church as a fountain of emotional and psychological care and support to people experiencing various problems, including mental illness. Like in this study, Murambidzi's (2016) exposed that the participants reported having health departments in their churches, active community linkages through church-home groups, as well as close working relationship with the family structure which was regarded as the first level of care and support as noted by one of the respondents.

Likewise, a study conducted by Rudolfsson and Milstein (2019) in Sweden revealed that pastoral caregivers described that many of the people they met had nowhere else to turn as they could neither get a public psychiatry appointment nor afford to see a private-practicing psychologist. Thus, people came to pastors because the

pre-determined number of sessions offered in public psychiatry was not sufficient (Rudolfsson & Milstein, 2019). Generally, it seems that as compared to psychologists (MHCPs), pastors are trusted, are more accessible and maintain close relations with those they minister to by means of follow up (Asamoah et al., 2014).

In addition, Mabitsela (2003) found that the Pentecostal church provides its members with a sense of belonging; members share religious and spiritual values and serves as a life skills centre that empowers the community by disseminating information through workshops, projects, conferences, and preaching services that are usually organised by church leadership. Overall, Mabitsela's (2003) study discovered that the Pentecostal church is also concerned with the well-being of its members, whether social, physical, and spiritual. Thus, the role of the pastors in mental healthcare cannot be ignored. Pastors also provide support to their members to important life events. As such, they end up being like family members (Rudolfsson & Milstein, 2019). As family members, they influence, they role model, they visit and are usually first respondents when there is crisis. Thus, they serve as gatekeepers to their congregants' overall well-being.

6.7 Participants' perception regarding possible collaboration with MHCPs

Pastors are very crucial to the choice of treatment modalities and therefore present as potential collaborators in promotive, preventive, and curative treatment intervention (Kamanga et al., 2019). Thus, there should be a way for pastors to make referrals to MHCPs and for MHCPs to have a familiarity with the roles of pastors. Likewise, Mabitsela (2003, p.101) remarked that, "considering the common ground of trying to offer explanations for human behaviour and improve human conditions between psychologists' pastors, both should partner in their determination to understand human behaviour." When pastors and MHCPs collaborate, this researcher hoped that individuals and families will benefit a great deal from the relationship (Greyveinstein, 2018).

As much as participants differed in their perceptions regarding the treatment of mental illness, they also presented varying views regarding referring to and collaborating with

psychologists. This theme that emerged from this study also revealed that most participants had never referred (representing lack of experience), while a few have referred to or worked with psychologists and other MHCPs before. However, most participants in this study were willing to collaborate and refer their congregants to MHCPs except for only two participants who were adamant that there was no need for collaboration. The participants who were not willing to collaborate indicated in their practise, they never encountered a case whereby they failed. On the one hand, the other participant felt that it will be like doubting God and undermining their congregants' trust in their services.

Although there were differing views on collaboration, many of the participants in this study viewed collaboration positively. Participants in this study, did not view MHCPs as competitors but as complementors and future collaborators. This also calls for MHCPs to hold the participants with the same regard (Rogers et al., 2013) as this will create a mutual understanding going forward. Specifically, in this study, participants regarded MHCPs as experts or academics in mental health. Therefore, psychology needs to rise to the task and equip these frontlines to congregants and communities at large (Vandervaal et al., 2012). This study also showed that most participants were comfortable in working together with psychologists, whether simultaneously or consecutively. The participants holding this view about collaboration seemed to understand that there is not only one causal factor to mental illness. They viewed mental illness as a multifactorial phenomenon. This means that the participants did not limit their intervention only to spiritual care, but they were more open to medical and psychological care, based on the congregant-client's needs.

This study's finding is in line with Payne's (2009) study who observed that pastors who can utilise their religious/spiritual expertise, and refer out when needed, prove to be extremely effective service providers. In the contrary, pastors who are limited in their views can potentially hinder growth in those they serve (Payne, 2009). Interestingly so, from this finding, it also emerged that participants do not only refer externally to MHCPs, but they also referred internally to other pastors whom they viewed as gifted in deliverance, more experienced or of higher authority in the ministry. This finding amongst Pentecostal pastors resonates with what Kruger (2012) observed amongst Afrikaans speaking Pentecostal pastors who took part in her study. The results from

Kruger's (2012) study indicated that all the participants interviewed were in favour of collaborating with medical and psychological practitioners specifically because they understood that illness could be medical, psychological and/or spiritual. Thus, the collaboration of MHCPs and pastors has a potential to improve mental health care delivery and close the widening treatment gap (James et al., 2014), especially in South Africa and other LMICs.

Moreover, the collaboration or integration between psychology and religion/spirituality is necessary from the point of assessment to treatment planning and the intervention specifically, because "theology overlaps with psychology at this point" (Grossklauss, 2015). Grossklauss (2015, pp.34-35) further mentions that:

> "Since pastors believe in the existence of demons/spirits based on their theological education, but in a counselling situation they do not have the necessary psychological knowledge to enable them to differentiate between, for example, a demonic burden (theology) and schizophrenia, personality disorder, or catatonic states or delusions (psychology). 'The need to differentiate and understand the distinction or overlap between demonic and psychological experiences is, imperative. The urgency rests with the need to be able to appropriately treat individuals with the relevant intervention.' Thus, the need for collaboration between mental health professionals and Pentecostal pastors is inevitable, especially in an African context whereby pastors hold a theologically based worldview of mental illness"

In support, Rudolfsson and Milstein (2019) indicate that collaboration between clinicians and religious/spiritual congregations provides a way to initiate and sustain continuities of mental health care. Both groups work with complex issues such as finding meaning and purpose in life, coping with important losses, and resolving marital conflicts (Rogers et al., 2013). However, in the process of helping their congregants, it seems that pastors are aware of having limited competence for dealing with their congregants' mental health problems (Smith, 2017), thus they were willing to collaborate with experts in mental health. Specifically, Smith (2017) observed that Pentecostal pastors counselled and advised congregants who approach them with

relatively common mental health issues, but they referred congregants with a serious mental health issue to MHCPs. Thus, pastors show respect for the professional expertise of MHCPs by referring congregants to those professionals if they felt could not deal with a congregant's mental health issue (Rudolfsson and Milstein (2019).

Likewise, results of a study by Frontus (2015) revealed that while a majority of the clergy (pastors) reported that they do address the mental health concerns of help-seekers, they also acknowledged that their efforts are different than what would be offered by a professional mental health provider. As noted by Rogers et al (2013), successful collaborations require respect for the expertise of the clergy (pastors) and a genuine desire to uncover the ways that collaboration will meet their goals as well as those of the psychologist. As such, for collaboration to be successful, it needs complementary expertise, seeking mutual benefit, and defining shared values are three stances fundamental to a collaborative spirit" MHCPs have their area -which is the physical side while they handle the religious/spiritual side (Rogers et al., 2013). In agreement with the above, Chatters et al (2011) mention that mental health liaisons could capitalize on the clergy (pastors') roles as gatekeepers to formal services and benefit from their specialized knowledge regarding life circumstances (e.g., financial resources) and attitudes that affect members' use of formal services. This is because, for collaborations to be successful, they require respect for the expertise of the clergy and a genuine desire to uncover the ways that collaboration will meet their goals as well as those of the psychologist (Rogers et al., 2013).

In this study, while most of the participants indicated that they did not have a problem with referring to or collaborating with psychologists, a few where of the view that, there was no need for them to collaborate. The participants who held this view indicated that God is the ultimate healer who never fails denoting that referring to MHCPs would mean that they are undermining their own faith and God's trust on them (Williams, 2008). According to the extracts above, divine intervention alone may be sought to deal with what the congregant-client may present with to the participants. As such, for participants like these, referral to MHCPs is not supported. This could lead to the stigmatisation or the undermining of other pastors who do refer to psychologists (Sullivan et al., 2013). These participants prioritised praying for the healing and deliverance of their congregant than referring to MHCPs. This view held by the

participants may instigate antagonism between pastors and MHCPs and disadvantage those who would benefit from the collaboration (Rogers et al., 2013).

Overall, the contradiction in belief in the treatment and management of mental illness seems to suggest that the church as a Christian theological institution is also not completely sure about its own stance on certain matters specifically pertaining to divine healing (Harri, 2018). The findings of this study deviates from what other researchers found regarding possible collaboration with Pentecostal pastors. For example, Asamoah (2016) observed that generally, there was a belief among a section of Pentecostal/Charismatics that orthodox medicine and faith are adversative, and there is no tangential point of collaboration. Asamoah (2016) remarked that such a view hinders the care rate as collaboration is virtually non-existent.

On the one hand, Asamoah (2016) indicates that criticisms from medical personnel who do not believe in divine healing indicate a lack of confidence in the clergy (pastors) and other deliverance ministers. As a result, this poses a challenge since it may not permit regular referral of cases or collaboration with other health professionals in treating patients. In support, study conducted by Kamanga et al (2019) revealed that pastors believed that there is no trust between doctors (MHCPs) and pastors. The pastors were suspicious that doctors (MHCPs) believe that pastors cannot understand the pathophysiology of illnesses and believed that doctors (pastors) have no or little faith in the power of God. One pastor who took part in Kamanga et al.'s (2019) study specifically mentioned this: "MHCPs and pastors do not trust each other hence it is difficult to work together and refer patients to each other for more holistic care." Moreover, Kamanga et al (2019)'s study discovered that pastors believe that MHCPs have little faith in God while healthcare workers believe that pastors do not understand the pathophysiology of illness. However, the pastors acknowledged that there was a need for themselves and MHCPs to collaborate.

Mabitsela (2003) revealed that Pentecostal pastors viewed MHCPs as practitioners who tend to ignore the spiritual side and only concentrate on the physical and psychological. This view was later supported by Bulbia and Laher (2013) who remarked that Western definitions of and approaches to mental illness have been critiqued for their lack of incorporation of cultural and spiritual elements. Likewise, in

his study Murambidzi (2016) discovered that the pastor-MHP relationship is largely characterised by hidden conflict, mistrust, discontent, and lack of appreciation of the role and contribution of the counterpart profession. In support, a study conducted by Kruger in 2012, church leaders (pastors) were of the view that their lack of knowledge about what services psychologists and psychiatrists render could cause distrust. Kruger (2012) mentions that pastors felt that some MHCPs might disregard the spiritual importance in counselling and might even influence their church members to become less religiously devout. Thus, they would resort to internal referral or refer to MHCPs of the same faith with theirs.

6.7.1 *Participants' preference when collaborating with MHCPs*

Most participants in this study did not prefer homophily (i.e., like mindedness or similar beliefs) when collaborating as found in other studies previously. All the participants were concerned about was the expertise of the MHCPs. All the participants were concerned about was that their congregant-client be helped by a professional. The participants, were mostly of the view that psychologists (MHCPs) are knowledgeable in the field of mental health based on their training and skills, not based on their faith (Rogers et al., 2013). Some even indicated that if the psychologist they referred to was of the same faith, that would be a disadvantage since they would see things the same way perhaps disadvantaging the congregant-client (Hardwick, 2013). They indicated that all what matters was a different opinion, especially from medical science. In the present study, most participants did not seem to consider or prefer to work with a MHP from the same faith as theirs. They indicated that they would just be satisfied when at least their congregant-client is referred to a psychologist. Whether the psychologist was of the same faith or not, it was not an issue. However, other participants indicated that if the MHCP shared the same faith with the participant, which would be an added advantage. Specifically, one participant mentioned this:

> *"To be honest. I really do not care (giggles) whether they are in the same faith with me or not. Look, the advantage of referring them to someone who is of the same faith with me is that they might give them hope in God. I do not know how they practise. Eh, but honestly, if they uphold their code of conduct as practitioners, I know that they will not mix things. They will do their professional work and I will do my spiritual work."*

Thus, this finding deviates from what Kruger (2012) observed in her study results. Kruger (2012) found that regarding collaboration, pastors advocated for faith-based treatments to be included and preferred treatment by like-minded Christian professionals before secular MHCPs. Likewise, this finding contradicts Stanford and Philpott's (2011) finding whereby Baptist senior pastors were likely to refer their congregants to MHCPs they knew to be a Christian. In Stanford and Philpott's (2011) study, the predominant factor related to referral also appeared to be knowledge of the MHP's faith. Thus, the Baptist pastors preferred to refer their members to MHCPs that recognised the importance of biological and psychosocial influences in mental illness while providing a therapeutic environment that is supportive of faith. In concert, Rogers et al (2013) observed that collaborations thrived in the presence of shared values, especially common respect for religious/spiritual ideals, and are strangled by value conflicts on important issues. Thus, in the study by Rogers et al (2013) individuals who understand both cultural mind-sets, psychological and religious/spiritual were viewed as best prepared for collaboration.

While this study has exposed that Pentecostal pastors will refer their congregants, to any MHCPs regardless of their faith, a few participants in this study consistent with other findings in the past stated that they would preferably refer to those of the same faith with them. Specifically, in this study, the participants indicated that they would refer their congregant-clients where they would not be judged, but rather would be understood from the context of their faith (Kruger, 2012). Moreover, the participants mentioned that referring to a professional of the same faith would afford them the opportunity to continue being involved in monitoring the progress of the referred.

In addition, referring to a psychologist of the same faith according to the participants in this study was favoured because, the MHCP is understood to be not one sided (understand the psychological and the religious/spiritual), has the same knowledge with the referrer and the referred and will never undermine the power of the gospel even when the referred is healed by non-spiritual ways. Thus, participants from the same faith were regarded by the participants also to be playing a role, firstly of praying and encouraging the referred congregants through scripture to accept or be comfortable with non-spiritual or scientific ways of healing. To concur, Kruger (2012)

observed that MHP from the same faith are believed to be sharing similar values with the referring pastor. Similarly, in a study by Hardwick (2013) Pentecostal pastors embraced collaboration with counsellors, with a preference for counsellors who believed in God.

However, it should be noted that although the MHP shared the same faith with the referred, that did not make them a pastor if they were not ordained as such. Specifically, Hardwick (2013) noticed that for the pastors who referred to MHCPs, they indicated that it was not necessary for the Christian MHP to provide "Christian counselling. All they simply wanted was someone who would not go against their Christian worldview and was not anti-God". Similarly, Jackson (2017) found that Pentecostal pastors desired that within the collaborative process, the Pentecostal doctrine is respected and incorporated. The participants in Jackson's (2017) study were of the view that it is through this type of collaboration where counsellors (MHCPs) must be able to understand that Christ will have to remain at the centre of the services and treatment that is provided, and that healing will come through God in that process.

6.8 Factors affecting collaboration and referral between participants and MHCPs

Participants in this study indicated that when it comes to referral and collaboration, there were factors that would determine their referral process or system one of them was same faith (Kruger, 2012) as already discussed above. This study's results indicated that most participants were not opposed to referring their congregants to MHCPs. However, there were many factors the participants brought up as possible enhancers or obstructions to collaboration/referral. These were the recognised: the costs of psychological services, the limitedness of psychologists and/or inaccessibility; the position of the affected in the church; the participant's awareness of their skills and abilities, including limitations; collaboration not being one sided; the church's socio-economic status and geographic location and the congregant's choice emerged as factors that would influence referral or collaboration. From this study, it also emerged that the issue of referral or collaboration relies as well on the choice of one to be referred, unless in exceptional cases whereby the options were limited.

Although other studies have indicated that pastors influence their congregants' help-seeking behaviour (Jackson, 2017), to the contrary, this study has found that the pastors left the choice to the affected individual. They felt that they did not want to impose since they were not the ones going to settle the bills. Specifically, they indicated that they left that to the family in a case whereby there was a need for referral. The above finding seems to be consistent with Murambidzi's (2016) findings which showed that personal beliefs and attitudes, and economic reasons in some cases, were factors affecting referral and collaboration between the two professionals. This finding also resonated with Mabitsela's (2003) findings.

According to Mabitsela (2003), Pentecostal pastors sometimes opt for referral with social problems that are beyond their understanding or cannot handle and they often collaborated with experts that were state funded such as social workers and police. However, they seldom referred to psychologists. In the study by Mabitsela (2003) as aforementioned, the participants cited the following reasons for not referring specifically to psychologists: First, professional psychological services are seen as very expensive for most of their members; secondly, these Western-orientated mental health services are not recognised by many congregants. Thirdly, psychological service facilities are not readily available in the township(s). Moreover, Pentecostal pastors seemed to accuse psychologists of ignoring the spiritual side and only concentrating on the physical and psychological. In concert, Leavey et al (2016) observed that at a social or structural level, the clergy (pastors) are more likely to be sought in contexts where financial and medical resources are scarce or where the clergy (pastors) are positioned as trusted gatekeepers, particularly among ethnic minority and newly arrived communities, which is exactly the case of South African rural communities like Polokwane. Many people affected psychologically seem not to have psychological services, especially in rural areas (Ae-Ngibise et al., 2010).

From the present study, it also emerged that participants would not refer an individual based on their position in church. Specifically, if the affected was a pastor of an elder, their mental illness would be concealed and preferable, spiritual healing would be pursued. Likewise, in the study conducted by Wilkins (2019) amongst Black Pentecostal churches, results indicated that mental health was not communicated by

the pastors because of stigma, lack of knowledge, mistrust, and preference for nonmedical coping mechanisms (Wilkins, 2019). In support, Sullivan et al (2013) also observed the following as factors that affecting collaboration and referral between pastor and MHCPs: Firstly, lack of trust that the clergy/clinician collaboration can happen. Thus, efforts by outsiders to bring together pastors and clinical mental health resources were often perceived by pastors and chaplains as uni directional. Meaning that the clergy (pastors) were encouraged to refer parishioners to mental health, but MHCPs did not refer patients to the clergy (pastors). Secondly, some of the participating clergy (pastors) feared that MHCPs may drive congregants away from God and the church. Thirdly, stigma undervalued the contribution of the clergy (pastors) and mental health clinicians. Fourthly, Sullivan et al (2013) also observed that religion/spirituality remained undervalued in the context of evidence-based therapies-both in terms of training and in terms of the scientific literature. Sullivan et al (2013) also noticed from their study that there was lack of knowledge about how the clergy (pastors) and mental health clinicians could collaborate.

The results of the present study were also echoed by Ae-Ngibise et al (2010) whereby the participants attested that many people with mental health problems widely consulted traditional and faith healers (pastors) because, they were accessible, available and their affordable nature. Thus, a common theme amongst the participants in Ae-Ngibise et al (2010)'s study when talking about the appeal of traditional and faith healers (pastors) was the 'easy accesses to such practitioners, 'practising in every community' and 'in both rural and urban areas. For formal MHCPs, taking note of these factors will make come up with possible ways to bridge the existing gap and begin meeting participants halfway in catering for their congregants. For example, psychologists can initiate a long overdue conversation. Based on all the above, psychology needs to take its services to the church (WCC, 2021). It appears that the door is wide open. The response of psychologists in this regard, is likely to contribute towards making the church a haven for the mentally affected (WCC, 2021). Instead of the church becoming a place of stigmatisation, exclusion or even expelling of the mentally ill from the church.

6.9 Discussion of results within the theoretical framework

The present study was carried out within the BPSS model of mental health and healing as its guide. The BPSS model was chosen for this study because it integrates religion/spirituality as a fourth dimension to interpret, assess, diagnose, and treat mental illness (Hefti, 2011). Moreover, the BPSS model provides a holistic and integrative framework and is a useful tool to understand how religion/spirituality influences mental as well as physical health (Hefti, 2011). In the words of Shonin and Van Gordon (2013), the BPS of mental illness, acknowledges the importance of biological, psychological, social, and spiritual factors as determinants of psychopathology. Thus, the BPS model represents a much more acceptable and inclusive model of understanding mental illness (Hefti, 2011). The findings of this study have revealed that many Pentecostal pastors around Polokwane understand mental illness to be a multifactorial phenomenon. Although spirituality dominated their views, other dimensions of the BPSS model were also noted as significant. As observed by Sulmasy (2002), the BPSS model is not a 'dualism' in which a 'soul' accidentally inhabits a body.

Sulmasy (2002) indicates that within the BPSS model, the biological, the psychological, the social, and the religious/spiritual are distinct dimensions of the person, and no one aspect can be disaggregated from the whole. Thus, each aspect can be affected differently by a person's history and illness, and each aspect can interact and affect other aspects of the person (Sulmasy, 2002). When one of the factors of the model are affected, it is believed that balance is lost, resulting in psychopathology (Sulmasy, 2002). Specifically, when a person is mentally ill, there are disruptions or disturbances in more than one relationship of the individual's life.

Sulmasy (2002, p.26) further remarks that:

> When a person is ill: 'Inside the body, the disturbances are twofold: (a) the relationships between and among the various body parts and biochemical processes, and (b) the relationship between the mind and the body. Outside the body, these disturbances are also twofold: (a) the relationship between the individual patient and his or her environment, including the

ecological, physical, familial, social, and political nexus of relationships surrounding the patient; and (b) the relationship between the patient and the transcendent.

As such, it is evident that illness can disrupt the integration of one's life and provoke a spiritual crisis around meaning, purpose, and connectedness (Puchalski, 2013).

The overall findings of this study are in line with the basic tenets and core ideas of the BPSS model. The participants in this study firstly had a multifactorial or dimensional view of what mental illness is and what causes it. Equally so, regarding the treatment of mental illness, apart from only two participants, all participants perceived that mental illness should not only be treated and managed spiritually but BPSS, thus holistically. When people are confronted with distressing life situations and occurrences, they rely on their religion/spirituality to interpret those events and eventually face them and make meaning out of them. As mentioned by Rego and Nunes (2019), religion/spirituality casually influences health by means of social support and improved health behaviours, enhances positive psychological states (e.g., faith, hope, inner peace), offers psychological strength for acquiring/maintaining positive health behaviours and influences health by distant healing or intercessory prayer. Thus, the participants' responses in the present study have demonstrated a positive attitude towards the bio-psycho-social aspects of their clientele. This is also indicative of the participants' willingness to form partnerships with other professions. Specifically, for psychologists, Rego and Nunes (2019) indicate that for psychologists, according to their ethical responsibilities, may include the assessment of their patients' religious/spiritual needs in therapy, as it will help to identify the patients' values, belief systems, religious/spiritual history, distress and needs.

Prest and Robinson (2006) mentioned that the BPSS model   reinforces a focus on all system levels, including the self (cognition and beliefs, affect, behaviour, spirituality, physiology, etc.), family, other close relationships, the community (e.g., cultural and economic influences), and so on. Thus, as it has been demonstrated by this study's findings, participants seemed to be operating within this EM.

In this study, the participants had a tendency to spiritualise mental illness. Similarly, Murambidzi (2016) established that the tendency to spiritualise mental illness was common among participants' descriptions of their clients' presentations and their subsequent response. While the participants in Murambidzi (2016)'s study acknowledged biomedical and psychosocial causes, the study revealed a predominance of supernatural explanations for mental illness. Like Murambidzi's (2016) study, this study attested to both the importance of religious/spiritual beliefs and cultural practices in the life and wellbeing of local people as well as the utility of the BPSS model in explaining the broader sociocultural and religious/spiritual nuances of mental illness. This finding is worth taking note of since it strays from the famous spiritual/diabolic world view some previous researchers have noticed amongst Pentecostal pastors (e.g., Asamoah et al., 2014; Mabitsela, 2003; Leavey, 2010).

Findings of the present study also add to the efficiency and utility of the BPSS model both in research and clinically. This shows that the BPSS can be an effective model for training MHCPs, especially between African based Pentecostal pastors and MHCPs who operate within a multi-religious and cultural setting (Moteiro, 2015). In essence, the BPSS model acknowledges diversity of cultures and religions (Monteiro, 2015). Hence, the participants in this study were willing to refer to and collaborate with MHCPs. However, the participants emphasized that the collaboration or referral should not be unidirectional.

The above finding also concurs with Winarski (1997's) assertion that based on the common acceptance of the BPSS model; practitioners of diverse views can sit together, view the patient in many ways, and blend their different views into a bio-psycho-social/spiritual treatment plan. In the process the entire patient is acknowledged, and different team members' competencies to deal with the different aspects are validated (Greyvenstein, 2018). Thus, the BPSS model has assisted this study to incorporate knowledge from other disciplines, in this case the participants' views of mental illness and its treatment to psychology. Moreover, the blending of knowledge within a system as just described must occur within each practitioner (Winiarski, 1997). As such, the BPSS model also provided this study with a platform for various professionals to share and exchange knowledge, work in collaboration and above all display their expertise for the common good of the patient.

Guided by the BPSS model, this researcher was of the view that it is important for MHCPs to explore and understand the unique approach of the Pentecostal faith tradition to mental illness and health. This is an important area of exploration as the mental health literature suggests that the attitudes of the helper play a critical role in the therapeutic relationship and mental health outcomes of the help-seeker (Jackson, 2017). Moreover, it is common that amongst religious/spiritual leaders (pastors), the conceptualisation of mental illness bears a religious/spiritual element or basically be influenced by their theological beliefs (Murambidzi, 2016). Within this approach to patients as people it is often necessary to give thorough attention to the patient's religious/spiritual beliefs, or worldview (Cox & Verhagen, 2011). Thus, this study sought to understand how pastors of Pentecostal churches perceive mental illness and how it is treated. The pastors are influential and provide leadership and guidance to their members of various life issues, including health decisions and behaviours. As Levin (2010) argues, data alone do not increase understanding of a topic without theoretical models that help us make sense of such data. So, it is important to make use of available data to tailor efficient intervention programmes for mental health problems which incorporate religion/spirituality and culture. As Levin (2010) points out, theoretical perspectives are akin to lenses that enable us to see findings that might not fit into clinicians' worldviews and thus be cast aside or disparaged. Hence, this study aimed to understand the notions that Pentecostal pastors have of mental illness to enhance an intervention programme.

6.10 Towards an intervention programme between Pentecostal pastors and MHCPs

Religious/Spirituality and psychological studies reveal that both MHCPs and pastors share the same commitment towards the alleviation of their patients' suffering (Leavey et al., 2016). Again, it is common that many people with mental health problems; consult first with their religious/spiritual (pastors) for help or vice versa (Ae-Ngibise et al., 2010). Most pastors usually care for their members with mental health problems using solely a religious/spiritual approach (Asamoah et al., 2014). The danger of using a solely religious/spiritual approach to care for congregants with mental health problems is that some aspects of personhood may be left unattended to. The same

applies when an individual is cared for from only a biological, social, or psychological approach. So, for an efficient treatment and care of congregants with mental health problems, this researcher advocated for a holistic approach to care and treatment like the COPE model developed by Milstein et al (2008). Considering that, this researcher has opted for the BPSS model which provided a framework for understanding a human being holistically.

More often, MHCPs and pastors use different methods and resources in the process of helping those who consult with them (Stanford & Phillport, 2011). The methods and resources may be similar or different. Thus, guided by the findings of this study, it is significant for pastors to acknowledge the expertise of MHCPs in explaining human behaviour from their theoretical perspectives (Grossklaus, 2015). On the one hand, MHCPs need to also learn from and rely on Pentecostal pastors and understand people's behaviour from their EM's (Kpobi & Swartz, 2018b). This study has demonstrated that there are valuable lessons that both can learn from each other. With that said, this researcher now presents the proposed intervention programme or guidelines for collaboration between Pentecostal pastors and MHCPs. Other previous studies have proposed similar guidelines and a programme of models based on research findings such as the findings of this study.

There is evidence for scientific based intervention programmes between pastors and MHCPs. For example, Milstein et al (2008) designed an intervention programme between pastors and MHCPs coined COPE. Like the proposed programme of intervention in this study, COPE is directed by Milstein (A licenced clinical psychologist) and a pastor. The goal of C.O.P.E on its inception was to acknowledge the borders between parts of persons' lives and to build bridges of collaboration to facilitate care (Milstein, 2008). The COPE is a prevention-science-based paradigm to improve the continuity of mental health care through reciprocal collaboration between clergy and mental health professionals (Milstein et al., 2008). Furthermore, the COPE program facilitates reciprocal collaboration between clinicians (MHCPs) and clergy (pastors), regardless of their religious/spiritual traditions (Milstein, 2008). Two central ideas guide the functioning of the cope programme: Firstly, clergy (pastors) (with their discrete expert knowledge about religion/spirituality) and clinicians (MHCPs) (with their discrete expert knowledge about mental health care) can better help a broader

array of persons with emotional difficulties and disorders through professional collaboration than they can by working alone (Milstein et al., 2008). Secondly, COPE is focused on burden reduction which the authors defined as a reduced need for one group of service providers to deliver direct care because of sharing expertise with service providers from another group or profession. Finally, the main objective of COPE is to improve the care of individuals by reducing the caregiving burdens of clergy and clinicians through consultation and collaboration (Milstein et al., 2008).

Most recently, the World Council of Churches (WCC, 2021) has developed a Health Promoting Churches Programme (HPC) to support churches as healing communities. The WCC (2021) specifically seeks to assist churches through the HPC program to establish a Church Health Committee (CHC) which is well constituted, well equipped, and passionate about leading the implementation of health initiatives in the congregation. According to the WCC (2021)'s Handbook, the HPC galvanises the envisaged healing ministry through four interventions which are: education, action, advocacy, and public witness. Thus, the church should design and explore various creative ways of promoting health education which include health talks during the service, having individuals with lived experiences being empowered to share their experiences and motivational talks in the pulpit to inspire beliefs, values and ideas that promote health (WCC, 2021). Generally, the WCC (2021)'s handbook, provides practical guidelines on the implementation of a church-based health programme. In line with the WCC (2021) guidelines, the WHOLENESS collaborative programme is thus proposed.

6.10.1 *Description of the WHOLENESS collaborative intervention programme*
Based on the findings of this study and the aim of this study, this researcher therefore proposes an intervention programme or guidelines to be adopted by Pentecostal pastors and MHCPs seeking clients from a Pentecostal background. The proposed guidelines or intervention programme can be referred to as the WHOLENESS collaborative programme between Pentecostal pastors and MHCPs. Wholeness is a noun denoting the state of forming complete and harmonious whole and unity. Thus, the programme envisages that MHCPs and Pentecostal pastors work in unity within

their differing worldviews, knowledge, skills, and abilities for the wholeness of their service users. Moreover, the programme will be facilitated by a clinical psychologist and Pentecostal pastors in and around Polokwane City. The programme seeks to acknowledge the influence of religious/spiritual beliefs as well as biological, psychological, and social factors as causes of mental ill. When any of these factors are affected, psychopathology develops. From the findings, it has occurred that both the services of MHCPs and pastors are relevant to the overall wellness of their clients. As such, the primary objectives of the programme will be:

(a) To educate Pentecostal pastors about mental illness (signs and symptoms, recognition and identification, diagnosis, treatment methods, degrees of severity and its causes.

(b) To facilitate bi-directional referrals between MHCPs and Pentecostal pastors.

(c) To reduce stigma associated with mental illness in the Pentecostal community.

(d) To advocate for the recognition and acknowledgement of Pentecostal pastors' spiritual gifts and abilities in the treatment of mental illness.

(e) To appreciate pastoral roles such as counselling, providing support, deliverance, prayer, referring in mental health care and vice versa and follow up visits.

(f) To aid in the formation of in-house mental health teams or ministries in the Pentecostal church.

(g) To promote mental health treatment seeking amongst Pentecostal congregants, especially in Black communities; and

(h) To have MHCPs educated about the Pentecostal religious/spiritual beliefs and their significance in psychotherapy.

6.10.2 *Implementation of the WHOLENESS collaborative intervention programme*

As part of implementation of the WHOLENESS collaborative programme, the researcher will design a brief curriculum on mental health to help Pentecostal pastors to:

i. Define and formulate the congregant member's presenting problem using both psychological and spiritual methods. This will entail liaison between the Pentecostal pastor and clinical psychologist whenever there is a case whereby

mental illness is suspected. Thus, both spiritual and clinical assessment and consultation is done by both practitioners

ii. Recognise signs and symptoms of mental illness. The Pentecostal pastor and clinical psychologist work hand in hand in describing observed signs and symptoms that the congregant member will be presenting with using their methods of observation (i.e., Clinical Interview and Discernment/Prayer respectively). Using the DSM-5 and other prescribed methods, the clinical psychologist will shed light on the symptoms of mental illness.

iii. Interpretation and diagnosis of the problem (conceptualisation): Using their unique methods and guided by the aims and objectives of the programme will reach a point of interpreting what the congregant member presented with as well as the most suitable diagnosis again using their different methods

iv. Planning for intervention: After making the diagnosis, the following phase will be to plan for treatment and intervention. Based on what the two professionals agree about as the main cause of the presented problem they will plan on what to do first as a priority depending on what the diagnosis warrants (i.e., whether prayer first, then referral or vice versa).

v. Treatment and Management: An identified congregant member with a mental illness will then be treated accordingly guided by the objectives of the WHOLENESS collaborative programme whereby both scientific (medical) and spiritual treatment and management methods are acknowledged and valued.

vi. Referral (when necessary): When the attending Clinical psychologist and pastor initially do not breakthrough, communication needs to be affected whereby either an internal referral (to another pastor) or to a medical officer/psychiatrist is done.

vii. Follow up: When a congregant member is treated and managed as an out-patient, the clinical psychologist will have to follow up through the attending Pentecostal pastor to review the congregant member's progress. On the one hand, in an event whereby a congregant member is admitted, the pastor needs to continue following up, providing spiritual support and encouragement to the admitted congregant member.

6.11 Concluding Remarks

This chapter discussed the study findings in relation to the emerging themes from the results as well as the reviewed literature. Based on the findings of this study, it appears that mental illness is a broad and complex phenomenon which its perception will always be shaped by a plethora of factors. In this chapter, the main themes that were discussed included the notions of mental illness that Pentecostal pastors held of mental illness, its causes, its recognition and diagnosis, treatment approaches, roles, and their views regarding collaborating with MHCPs. The discussion of results that emerged from this study were in keeping with the proposed model of the study, the BPSS. This section was concluded by outlining the Wholeness Collaboration programme that has been inspired by the findings of this study and the burden of mental illness in South Africa wherein there is a large treatment gap. The intervention programme seeks to foster collaboration between MHCPs and enhance the treatment, care, and management of their service users. This study's findings, including the intervention programme also, have implications for the broader field of psychology, especially for research, training, and clinical practice in South Africa.

CHAPTER SEVEN
SUMMARY, LIMITATIONS & CONCLUSIONS

7.1 Summary

The purpose of this study was to explore and describe Pentecostal pastors' perception and treatment of mental illness. The goal was to develop an intervention programme consisting of Pentecostal pastors and MHCPs who are both consulted by people experiencing mental health problems. The study was qualitative in nature and was carried out within the BPSS model as a framework. This study achieved the goal of in gathering information that would be beneficial in creating a therapeutic alliance between Pentecostal pastors and MHCPs. From the study, different themes emerged, and all the discussion was centralised around them as well as the guiding theoretical model of the study. An overview of the contribution of this study to the body of knowledge is also given in this section. Moreover, this section will also present the implications of the study, its limitations, and the recommendations.

7.1.1 *The Notions of mental Illness*

This research sought to explore and identify how Pentecostal pastors around Polokwane perceive mental illness regarding what it is, what causes it, how it is recognised and diagnosed, by whom and how it should be treated and managed and what are their perceived roles in its treatment and management. Furthermore, this research also sought to discover the opinions held by Pentecostal pastors regarding collaborating with MHCPs with the goal of developing an intervention programme. Pentecostal pastors are often consulted by individuals with mental health problems in South Africa and other LMICs, where a large treatment gap exists (Burns & Tomilta, 2014). The lack of health resources, including personal beliefs about mental illness, usually propelled many people to consult with their pastors (Kruger, 2012). Thus, this study explored what Pentecostal pastors understood to be mental illness. With all the above in mind, when individuals experiencing mental health, problems do consult with Pentecostal pastors around Polokwane, it was not known what exactly how they define, describe, or explain mental illness.

Overall data obtained from this study indicated that Pentecostal pastors hold a multifactorial or multi-dimensional view of mental illness dominated by theological beliefs and their culture. Pentecostal pastors who took part in this study were Blacks of African origin all residing around Polokwane. Based on their theological beliefs and cultural orientation, Pentecostal pastors explained and described mental illness as a spiritual problem influenced by demon possession, curses, witchcraft, and sin. Most of the participants referenced the Biblical text in Mark Chapter where a man known as Legion was viewed as representing someone with mental illness, which was at times referred to as madness. In their responses, mostly would indicate that they are Africans, and they are in Africa, thus the belief that mental illness is a spiritual problem was eminent. In support, Waldron (2010) mentioned that conceptualisations of illness, disease, symptom presentation and treatment are shaped by various social, cultural, ethnic, economic, and political variables within individual societies and are interpreted, assessed, diagnosed and treated in unique ways in different cultures.

From the findings, it appeared that language was used to delineate between madness (*bogaswi*) (psychosis) and mental illness (mood and anxiety disorders) by some of the participants. Moreover, just like in the DSM-5, mental illness was viewed as varying in degrees of severity. Many participants indicated that it would start as simple stress, then depression and eventually graduate to psychosis (*bogaswi*) if not treated. Essentially, the knowledge of mental illness amongst Pentecostal pastors was limited to psychosis. Hence, the main example that was given of mental illness was that of the Gadares man in the Bible. As much as Pentecostal pastors held differing views on what mental illness is, they also held a multifactorial view of what causes it, but mainly spiritual forces topped the list. In fact, although they acknowledged other factors to be responsible, participants believed that they were influenced by spiritual sources such as demons. As an example, they would mention that God created a perfect human being, with no mental illness. Thus, it is the devil and his agents who orchestrated mental illness through natural means. The present study also highlighted the predominance of supernatural factors in the explanation and treatment of mental illness, a common belief amongst Pentecostal pastors in Africa. On the one hand, some participants in this study perceived mental illness to be a psychological problem. The participants who perceived mental illness to be a psychological problem indicated

that a person is a triune being (thus, a person is made up of body, mind (soul) and spirit

7.1.2 *Causes of mental Illness*

Most importantly, for this study, like in other previous studies, participants did not exclude or undermine the influences of other factors such as biomedical and psychosocial as responsible for mental illness (Murambidzi, 2016). However, it appeared that mental illness as a religious/spiritual problem was more severe and clinically it represented psychosis which was referred to as madness. Other mental illnesses such as depression and anxiety were perceived as of lesser forms and could easily be dealt with by MHCPs. According to participants in this study, if one of the factors is affected, psychopathology will result. Besides viewing mental illness solely as a religious/spiritual problem, findings of this study revealed that participants agreed that mental illness can also manifest as a bio-psycho-social problem. This finding was worth taking note of since previously Pentecostal pastors seemed to mostly hold a single factor view of mental illness.

7.1.3 *Diagnosis and recognition of mental illness*

Most participants in this study felt that they were not well equipped or trained to diagnose mental illnesses like MHCPs. This usually led to misdiagnosis and/or spiritualisation of mental illness leading to its denial or delayed treatment. As such, they indicated that would not hesitate to refer their congregants suspected to be having mental illnesses to MHCPs. Again, because of lack of proper terminology, knowledge of and methods to diagnose mental illness, Pentecostal pastors eventually viewed most mental illnesses as a spiritual problem. People with mental illness/mental health problems in church, are not aware that they have mental health problems. As a result, mental illness may be ignored, hidden, or misdiagnosed as demon or spirit possession. However, some participants indicated that they are able to determine through religious/spiritual means such as discernment, prophecy, revelation and spiritual counselling/interviewing whether a case was religiously/spiritually inclined and to determine when it was purely an issue which MHCPs could diagnose and deal with.

The special ability to detect the presence of mental illness by Pentecostal pastors could be useful in the psychotherapy practise, more especially in circumstances whereby a patient is presenting with spiritually inclined symptoms. The signs and symptoms of mental illness according to the participants in this study mimicked what MHCPs considered to be of psychosis. Again, the Biblical story of the man affected by demons was cited as a reference. As such, other Biblical stories whereby the characters seemed to have been depressed or in anxiety were not mentioned. Thus, Pentecostal pastors' methods of recognising and diagnosing mental illness is religiously/spiritually based. They use the Bible and prayer as their main tools and observing behaviours.

7.1.4 *The treatment and management of mental Illness*

It has emerged from this study that what is understood to be the cause of mental illness by the participants would determine how it should be treated. Thus, if it was perceived as a religious/spiritual problem, a religious/spiritual solution (i.e., prayer, deliverance, fasting, etc.) would be sought as an intervention. As it has appeared in the results specifically, three approaches to treatment were outlined by the Pentecostal pastors, namely: The full collaborative approach; the partial collaborative approach, and the non-collaborative approach. Thus, regarding the treatment and management of mental illness, most participants indicated that both MHCPs and Pentecostal pastors can treat mental illness using their own methods and were not opposed to working with each other. On the one hand, there are those who felt that MHCPs should only deal with metal illnesses caused by bio-psycho-social factors and leave those caused by spiritual factors to the pastors. A very few participants in the study mentioned that mental illness should only be dealt with by pastors regardless of causes citing that they were empowered by God, and it was part and parcel of their calling to do saw. These participants did not see the necessity to engage in a partnership with MHCPs.

7.1.5 *Roles in the treatment and management of mental Illness*

Participants in the present study perceived that they have a role of counselling (teaching, encouraging, motivating, guiding), supporting (morally, spiritually, mentally, materially, physically) their congregants in times of joy as well as in times of sorrow. When a member and family were affected by mental illness, the pastors indicated that they would share encouraging scriptures and pray with them either at their own homes

or the congregants' homes. In the event whereby the congregant was admitted, they would visit the affected in the hospitals to provide prayer and support. It also emerged that the pastors in this study are involved in the referral process as sources of referral, either to MHCPs or to other pastors within the Pentecostal movement who were deemed as specialists or more anointed in dealing with what they perceived as mental illness. Participants in this study felt that they also played a role in educating to their churches and communities by arranging seminars, workshops and conferences aimed at discussing mental health related topics. With regards to the referral process, it appeared that there are multiple factors which affected the process and were worth taking note of. For instance, issues such as the MHCPs' faith; socio-economic status of the church and the affected; position of the affected in the church; accessibility and costs of MHCPs; and choice of the affected emerged as issues that can affect the referral process or collaboration between MHCPs and Pentecostal pastors.

7.1.6 *Collaboration with MHCPs*

Most participants demonstrated a high level of willingness to collaborate with MHCPs. However, the participants did emphasise that they desired the collaboration to be di-directional. Furthermore, the participants did not all view MHCPs as competitors, but they saw them as scientific experts who are also given special knowledge and abilities by God to treat mental illness their own way. Based on that, participants also wanted MHCPs to recognise and acknowledge their God given special abilities to recognise, diagnose and treat mental health problems alongside them. Thus, instead of perceiving divergence, participants in this study perceived convergence between themselves and MHCPs. Most importantly, the participants in this study hoped for a bi-directional relationship with MHCPs. As observed by Ae-Ngibise et al (2010), collaborations are more efficient and successful when they are based on mutual respect and bi-directional conversations.

7.1.7 *The WHOLENESS collaborative intervention programme between Pentecostal pastors and MHCPs*

Based on the results of this study, an intervention programme providing guidelines on the collaboration between Pentecostal pastors and MHCPs was established. The programme is spiritually and culturally sensitive and envisages a smooth referral process, knowledge sharing and exchange, stigma elimination, positive health seeking

behaviours and collaboration between Pentecostal pastors and MHCPs. Although the programme is developed from a specific group of Christians, it can be adopted and be implemented by other Christian sects. The programme is non-clinical (i.e., it is community based) and is led by a clinical psychologist and Pentecostal pastors. The programme is also developed in response to the large treatment gap that exists in South Africa and the recognition that many people experiencing mental health problems consult with their pastors who are more often trusted by their congregants, role models and more accessible as compared to psychologists. Elsewhere, research indicates that professionals wishing to serve clients with high quality and professional services must be aware of and respect religion/spirituality as a multicultural issue (Plante, 2016).

It is noted extensively, especially in African Psychology or African Worldviews literature, that relations between religion/spirituality and psychological factors are not the same in every culture. As such, scholars like Baloyi and Ramose (2016); Madu (2015); Mwoye (2015); Sodi and Bujowoye (2011) call for many and diverse psychotherapies. Madu (2015), also remarked that for quite a long time, many psychotherapists worldwide, including those in Africa, have been trained in Western-based explanations of psychological distress/illness. Thus, many Western-oriented Explanatory Models of psychological distress/illness have undermined the influence that cultural and/or religious/spiritual beliefs in psychotherapy.

In agreement, Bulbia and Laher (2013) posit those Western definitions of, and approaches to mental illness have been critiqued for their lack of incorporation of cultural and religious/spiritual elements. As such, the integration of religious/spiritual interventions or even discussions into the therapeutic process have implications for multicultural competence, which many graduate schools are requiring students to have training in since there are implications relating to referrals, and even collaboration with other professionals, including priests or pastors (Henderson, 2018). This programme or guidelines are proposed in line with the guiding theory of this study-the BPSS.

7.2 Implications of the study findings

7.2.1 *Implications for policy*

The importance of having to consider the role of religion/spirituality in health, mental health and psychiatry in South Africa particularly has been emphasised in recent legislation on African traditional health practice (Janse van Rensburg et al., 2012). South Africa is a multi-cultural and multi-religious country. In the country, the prevalence of mental illness has risen (Burns & Tomilta, 2015). Nevertheless, the proportion of psychologists and psychiatrists needed to provide services to people affected with mental illness is incongruent with the demand. Again, due to the religious beliefs and socio-economic conditions, people with mental illness consult with their pastors first before they come to formal MHCPs (Ae-Ngibise et al., 2010; Sorsdhal et al., 2009). Thus, there is a need for a formulation of spiritually and culturally based intervention programmes to reach out to the affected communities which are recognised and regulated by the government.

The beliefs that the Pentecostal church pastors and members hold of mental illness cannot be ignored. They may influence their intake of psychotropic drugs. It is therefore significant for policies to be developed guiding the collaboration and/or the integration of religious/spiritual beliefs into a formal health setting (Greyvenstein, 2018). Moreover, it appeared in this study that some mental illnesses have symptoms mimicking spirit possession which might not be obvious to the trained eye of the clinician involved. Thus, to avoid misdiagnosis, mis prescription and mistreatment, policies and guidelines governing the treatment of religious/spiritual patients such as advocated for by this study need to be documented and further examined (Greyveinstein, 2018). There is a serious need for culturally and spiritually embedded methods of intervention in Africa which do not exclude religious/spiritual as advocated for by scholars like Bojowuye and Sodi (2011) and Madu (2015).

7.2.2 *Implications for future research*

The expansion of research is key to not only understanding the world we live, but by also key in assisting in how we confront issues in the world, contributing to the improvement of everyday life (Jackson, 2017). This study aimed at the perception and treatment of mental illness by Pentecostal pastors, focused only on Black Pentecostal

pastors in Polokwane. There might be a need in the future, to broaden the scope of this research to other communities and amongst other races. Secondly, this research may be replicated by making use of focus group discussions as a method of data collection to observe the interaction of the pastors and how their present their differing views.

In addition, future research could also explore the efficacy of the Pentecostal pastors' methods of recognising and diagnosing mental illness, as well as the efficiency of their treatment and management methods and/or compare them with those of MHCPs. The findings could be useful in further developing or enhancing existing programmes of intervention. Another aspect that could be pursued in the future amongst Pentecostal pastors could be how their educational level, socio-economic status or geographic location, the pastors' personal experience with mental illness, the position of the affected member in church could affect referral or collaboration with MHCPs. Lastly, this study could be extended to look specifically into the benefits of same faith referral (homophily) and referral to a secular MHP. In the near future, there could also be a need to evaluate the efficiency of the WHOLENESS collaborative intervention programme.

7.2.3 *Implications for clinical practice*

This study has revealed that both MHCPs and pastors share the same commitment towards the alleviation of their patients' suffering. However, the resources, knowledge and skills are different. Thus, both should avail themselves to be used of in the process of helping those who consult with them are either similar or different. From this study, it also emerges that there exists a need for MHCPs to acknowledge pastors as spiritual leaders and rely on them to understand people's behaviour from a religious/spiritual perspective during formal consultation from the assessment point to the intervention point.   In the diagnosis phase for example, pastors may assist in clarifying religious/spiritual symptoms that are harmful or not in keeping with the Pentecostal tradition. The same applies to the treatment phase. In the case whereby symptoms of mental illness seem not to be subsiding and the patient's condition improving, MHCPs may need to look at the treatment methods offered by Pentecostal pastors as guided by the Wholeness Collaborative Intervention Programme Guidelines. In response to calls of integrating religion/spirituality into psychotherapy, MHCPs (psychologists)

need to be open, sensitive, and willing to learn about the role religion/spirituality plays in their patients' lives. Recently, religion/spirituality and its relation to mental health has become an increasingly important topic in clinical practice and in academia, especially because the religion/spirituality beliefs that mental healthcare users uphold, have a bearing in psychotherapy for both the user and the service provider.

There is also a growing need to understand the interaction between psychology and theology, especially considering the experience of spirit possession which brings to call both disciplines. The study findings and the intervention programme proposed in this study have multiple implications for the practicing psychologist in South Africa. It advocates for a new approach to the conceptualisation and management of mental illness which acknowledges the influence of religious/spiritual beliefs, culture, socio-economic status, geographic location, and race. Specifically, the programme requires the psychologist to be more involved at a community level beyond the therapy room. Likewise, Makgahlela (2016) suggested that all practicing psychologists in the South African context must be culturally sensitive, competent and employ culture-informed interventions when offering psychological services to their multicultural South African clientele. When religious/spiritual elements are integrated into therapy with religious/spiritual patients, the outcomes of psychotherapy can be enhanced in many ways. As such, the collaboration or integration between psychology and religion/spirituality is necessary, from the point of assessment to treatment planning and intervention. Because, as noted by Grossklaus (2015, p.34):

> [T]heology overlaps with psychology at this point, since pastors believe in the existence of demons/spirits because of their theological education, but in a counselling situation they do not have the necessary psychological knowledge to enable them to differentiate between, for example, a demonic burden (theology) and schizophrenia, personality disorder, or catatonic states or delusions (psychology).

So, psychologists need more clarity and understanding of the subject from a theological perspective as much as pastors need the same understanding from a psychological perspective. For many Africans, affiliation with religious/spiritual ideology is viewed as an important component of their psychological health since

religious/spiritual issues may represent integral parts of many Africans' self-identity (Mabitsela, 2003).

7.2.4 *Implications for Pentecostal pastors and congregants*

The findings of the present study also bear significant implications for Pentecostal church members living with mental illness. Through these findings, the affected will learn to accept their psychiatric diagnosis and deal with any stigmatising circumstances. Thus, instead of being viewed as weak in faith or having sinned or under demonic attack, the pastors' acknowledgement of other factors (i.e., biological, psychological, and social) other than spiritual factors, Pentecostal members may increase the use of psychotropic drugs while complementing them with prayer. By way of collaboration between Pentecostal pastors and MHCPs, the fear and anxiety of consulting with biomedical (MHCPs) will be minimised. Pastors are influential. They are also pastors are considered by their congregants as accessible, sharing the same spiritual and cultural beliefs. Thus, their personal familiarity and experience can be invaluable to facilitate appropriate and continuous mental health care for their parishioners by contextualising the patient's illness and life history (Rudolfsson & Milstein, 2019).

7.2.5 *Implications for training*

Many South African universities that train clinical psychologists and other MHCPs do so mainly from Western-based psychological theories which many are times to note appreciate religious/spiritual beliefs. If the status quo remains, clinical psychologists may not be able to render efficient services to clients who come from religious communities. Thus, there is a need for inclusion of a religious/spiritual module in the curriculum of the training institutions. The subject can be taught by a religious/spirituality leader from a given faith community since South Africa as a multi-cultural and multi-religious country. So, if psychologists are limited in their training or understanding of their patients' religious/spiritual needs, such a predicament should pave a way perhaps of collaborating with experts in that regards-religious/spiritual leaders (pastors) to provide holistic care to their patients. In the event whereby collaboration is unlikely, the training of psychologists (MHCPs) should include some module on religion/spirituality.

7.3 Recommendations

The following recommendations are made in line with the study findings and implications elaborated in the previous sections. The recommendations proposed herein could contribute toward the provision of better health care for R/S mental health care users in the South African context:

- It is recommended that theologically, an extensive module on mental health be included in the curriculum of training Pentecostal pastors in South Africa.
- Universities and other training institutions in line with recent research on religion/spirituality and psychotherapy include religion/spirituality and culture in their curricular to enhance the cultural competence of their students as required by WHO and other organisations. This will also be a response to calls from Afrocentric inclined psychotherapists to have African based psychotherapies acknowledging the diverse spiritualities of Africans. Moreover, this will improve the overlapping relationship between theology and psychology which many are times has been characterised by antagonism and scepticism.
- The government through relevant departments and institutions be involved to monitor, supporting and enhance collaborative intervention programmes between MHCPs (psychologists) and Pentecostal pastors in South Africa

7.4 Contributions to the field of psychology

This study contributed to a growing body of literature by focusing on Pentecostal pastors who are largely consulted by patients who believe that they may be possessed by evil spirits when they have mental illness. In doing so, the study has provided evidence that indicates that more interaction, integration and collaboration between psychology and theology is required. The findings of this study have also helped to shed light for MHCPs (psychologists) on Pentecostal pastors and their notions of mental illness for purposes of enhancing effective referral pathways or collaborative systems. This assisted in the development of an effective collaboration or integrative programme between MHCPs and Pentecostal pastors. Due to the lack of research in the field of religion/spirituality and mental illness, this study also contributes to the

growing body of knowledge in the critical field of religion/spirituality and transcultural psychology. Moreover, this study has revealed that MHCPs need to become more aware of the active role they need to play in providing psychoeducation in various contexts and to different professionals. Over and above, this study provides insight that might allow new ways to be adopted to better provide effective tools to serve the Pentecostal and other Christian communities in Polokwane and better inform psychological services.

7.4.1 *Contribution to the Pentecostal church*

The central role played by Pentecostal pastors in the management of mental illness as supported by the study findings cannot be ignored. This study, therefore, highlighted a need for Pentecostal pastors to be recognised and elevated to a level that they can collaborate with mainstream health sector.

7.5. Limitations

Although this study provided some insight regarding Pentecostal pastors' perception of mental illness and its treatment, the study's sample size was small. Thus, the study could be broadened, and a large sample size be investigated. Data from this study were obtained only from individual interviews, which could have affected the trustworthiness of the findings. Findings of this study could be improved if data regarding Pentecostal pastors' perceptions can be obtained through focus group discussions and observations. The researcher is a Pentecostal pastor and clinical psychologist and known to some of the participants. There might have been some bias on the researcher's interpretation of the data or on the participants' responses. Thus, the results of this study can be improved by having a researcher who is neither a Pentecostal pastor nor clinical psychologist. Again, the findings of the study could have been improved if congregant-patients who received treatment from Pentecostal pastors were included in the sample.

7.6 Conclusion

The aim of this study was to explore how Pentecostal pastors understand, describe, and treat mental illness towards the development of an intervention programme or

guidelines for MHCPs and Pentecostal pastors. This study's findings have provided insight to both psychology and the Pentecostal community regarding mental illness. It has emerged from the themes that Pentecostal pastors hold a multifactorial perception of mental illness which is dominated by spiritual causes. Overall, Pentecostal pastors' notions of mental illness were Biblically and culturally inclined. There also appeared to be similarities regarding the categorisation of mental illness between Pentecostal pastors and Western-trained MHCPs. Thus, they understood mental illness, its causes, and presentations in similar terms with those of the DSM-5, although their explanations were inspired by their theological and cultural beliefs.

In addition, their terminology of mental illness revolved around psychosis, which was referred to as madness. Thus, Stress and Trauma related disorders and some mood disorders were regarded as less severe forms of or not mental illness at all. The participants in the present study also admitted that they lacked knowledge related to mental health issues and were inadequately trained in that regard. Nevertheless, they indicated that together with MHCPs had a role to play in the treatment and management of mental illness. As such, they were open to collaborate with MHCPs. Based on this study's results an intervention programme of collaboration (The Wholeness Collaborative Intervention Programme) between MHCPs and Pentecostal pastors was proposed. Thus, this study was able to achieve its main aim. The study's policy, research, clinical, theoretical, and training implications were discussed.

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APPENDICES

Appendix 1(A): Individual interview Guide English Version

Objective	Interview questions
1. To establish Pentecostal Pastors' perceptions and treatment of mental illnesses.	a) I would like you to share with me your perception of mental illness?
	b) As a person who encounters individuals diagnosed with mental illness, I would like you to share with me your understanding of events and factors that could have led to your congregant's mental illness?
	c) When you hear the terms mental health, mental illness, or the term disorders, what are the first thoughts that come to your mind?
2. To determine Pentecostal Pastors' perceptions on how and by whom mental illness can be diagnosed and treated	d) After realizing that your congregant/church member is ill, and before going to the hospital, where do you go or what did you do in order to seek help for your church member/congregant?
	e) May you explain to me what led you to take your congregant/church member to the mental health care system?
3. To determine Pentecostal Pastors' perception regarding their own role in the management of mental illness	f). Could you briefly explain or describe to me what your own role is/ would be in the management of mental illness
	g) Kindly share with me what other agencies and providers of health care that you are currently/ have used for your congregant/church member?
4.To canvass and describe Pentecostal Pastors' perceptions regarding possible collaboration for intervention purposes.	h) Do you collaborate with any other organisations, services and resources to help your congregants or those who seek help from you?

	i) If you do collaborate, how do you go about it? Do those you collaborate with acknowledge your expertise?

Appendix 1(B): Individual Interview Guide: Sepedi Version

Nepo/Maikemišetšo	Dipotšišo tsa potšišabatho
1. Go nyakišiša maitemogelo a baruti bao ba thušago/ kopanago le maphutego/ batho ba go ba le bolwetši bja mogopolo/monagano	**a).** Ke kgopela le nhlalošetše kwišišo ya lena ya bolwetši bja monagano/mogopolo
	b). Bjale ka motho wo a felago a thuša goba a kopana le batho ba go ba le bolwetši bja monagano, ke kgopela le nnyetlele gore naa kwešišo ya lena keefeng go seo se ka bago se hlotše/bakile gore mophutego wa lena a feleletše a na le bolwetši/goba mathata a mogopolo?
	c). Ge le ekwe go bolelwa ka bolwetši bja mogagano/mathata a mogopolo, ke eng seo se le tlelago mogopolong? Kwešišo ya lena ke e feng?
2. Go kwišiša tsela tšeo baruti ba kereke ya Baphološwa ba kwišišago gore bolwetši bjo bja mogopolo bo swanetše go lekolwa, go begwa le go alafiwa ke mang?	d).Ke kgopela le nkanagele gore naa ka morago ga go lemoga gore mophutego wa lena o a lwalwa/fokola ka bolwetši/mathata a mogopolo, le dirile eng goba le ile kae le yena gore a humane thušo?
	e). Ke kgopela gore le nthlalošetše gore ke eng seo se ilego sa le dira gore le moiše bookelong/lefelong leo ba thušago bao ba go ba le bolwetši bja monagano?
10. Go utolla gore naa baruti ba phutego ya Baphološwa mmono goba kwišišo ya bona ke ye e feng malebana le karolo yeo ba e ralokago go tlhakodišeng maphutego a go ba le bolwetši bja monagano?	f).Ke kgopela gore le ntshwantshetše goba le ntlhalošetše gore karolo/mošomo wo le o dirago mo kalafong ya bolwetši/bothata bja mogopolo?
	g). Ke kgopela gore le ntlhalošetše gore batliši bja tša Bophelo bja monagano goba mekgatlo ye mengwe yeo le šomišanago le yona go

	thuša mophutego wa lena wo ana go le bolwetši bja monagano/mogopolo?
11. Go bontsha/Go tšweleletša tsela yeo baruti ba kereke ya Baphološwa ba kwišišago ka yona tšhomišano magareng ga bona le badiredi ba tša maphelo?	**h).** Ke kgopela gore le nlthalošetše gore ge e ba le šomišana le mekgatlo e mengwe go ba badiredi ba tša maphelo, ke ba ba feng, goba kebo mang?
	i). Hle, nthlalošetseng, ge e ba tshomišano e gona, le šomišana bjang? j). Le e bona jwang tšhomišano yeo? k). A naa, mošomo wo le o dirago, re lebeletše thušo yeo le e fago, ba ya e lemoga le go itlotla?

Appendix 2(A): Participant consent letter: English version

Department of Psychology

University of Limpopo

Private Bag X1106

Sovenga

0727

Dear Participant

Thank you for showing interest in this study that focuses on: ***The Perception and Treatment of Mental Illness by Selected Pentecostal Pastors in Polokwane: Towards an intervention programme.*** Your responses to the interview will remain strictly confidential. The researcher will attempt not to identify you with the responses you give during the interview or disclose your name as a participant in the study. Please note that your participation in this study is voluntary and you have the right to withdraw from participating at any time should you wish to do so.

Kindly answer all the questions as honestly as possible. Your participation in this study is very important. Thank you for your time and cooperation.

Kind regards,

…………………… ……………………………

MaudaL.T Date

Doctor of Philosophy Candidate

……………………. ………………………………

Prof. Sodi T/Supervisor Date

Appendix 2 (B): Participant's consent letter: Sepedi Version

Department of Psychology

University of Limpopo

Private Bag X1106

Sovenga

0727

Letšatšikgwedi:_____

Thobela Motšeakarolo

Ke leboga go bontšha kgahlego ga lena go lesolo le la go nyakišiša ka botlalo. Kwešišo, hlalošo le hlathollo ya baruti/baetapele ba tša sedumedi ya bolwetji bja mogopolo/monagano. Dikarabo tša lena go diputšišo tše, ditla tshwarwa ka mokgwa wa sephiri. Monyakišiši o tla leka ka mešegofela gore a seke a le amanya le dikarabo tše le tla di fago, le ge ele go se utulle leina la lena bjalo ka motšeakarolo lesolong le. Le tsebišwa gore go tšea karolo ga lena go lesolo le go dirwa ka boithaopo, le gore le nale tokelo ya go ikgogela morago nako efe goba efe ge le nyaka. Le kgopelwa go araba diputšišo tše ka botshephegi bjo bogolo. Go tšea karolo ga lena go lesolo le go bohlokwa kudu kudu.

Ke leboga nako ya lena le go tšhomišano ya lena.

Wa lena

……………………   ……………………………

Mauda L.T.   Letšatšikgwedi

Moithuti

Appendix 3(A): Consent form to be signed by participant: English version

<div align="right">

Department of Psychology

University of Limpopo

Private Bag X1106

Sovenga

0727

Date_____

</div>

I _____hereby agree to participate in a PhD study that explores the perception of mental illness by selected Pentecostal pastors in Polokwane: Towards an intervention programme.

The purpose of this study is fully explained to me and I understand that my participation in this study is voluntary and that I am not forced to participate. Furthermore, I understand that I can withdraw from participating in this study at any time. I also understand that my responses will be kept strictly confidential.

I understand that this research project is not necessarily going to benefit me personally.

Signature…………………………..

Date…………………………………

Appendix 3(B): Consent form to be signed by participant (Sepedi Version)

Department of Psychology

University of Limpopo

Private Bag X1106

Sovenga

0727

Date_____

Nna _____ke a dumela go tšea karolo mo Nyakišišong ye ya grata ya PhD, yeo e hlokago go fatolla tsebo, kwešišo, le thlološo ya bolwetši ba monagano ke baruti ba kereke/phutego ya BaPhološwa mo masepaleng/tokologong ya Polokwane.

Ke tloga ke hlalošeditšwe morero le nepo ya Nyakišišo ye, ebile ke ya kwešiša gore go tšeakarolo g aka, ga se ka kgapeletšo, ke ka boithaopo. Gape, ke ya kwešiša gore nka no lesa gare ga sebaka, le gore di karabo tšeo ke tlo di fago, di tla bolokwa tša se be pepeneneng moo di ka fihlellwago ke mang le mang.

Ke kwešiša gape le gore Nyakišišo ye ga e tlo nkgola ka selo, kudukudu ke lebeletše bophelo bja ka.

Mosainowa motšeakarolo………………………..
Letšatšikgwedi………………………………………..

Monyakišiši…………………………………………

Mofahloši……………………………………………

301

Appendix 4: Invitation to participate in research

<div align="right">

Enq: Mauda L.T

19 Lengau Street,

Southern Gateway

Polokwane

0699

Cell: 0782285033

</div>

To: The President Limpopo Pastors' Fraternal

P O Box 711 Ga-Mothiba

0726

Dear Bishop Selepe R.S

RE: **INVITATION TO PARTICIPATE IN RESEARCH**

I am a registered student at the University of Limpopo (UL) studying towards a Doctor of Philosophy (PhD) Degree in Psychology under the supervision of Prof T Sodi, Dr JP Mokwena and Dr S. Moripe. The Title of my study is: The perception and treatment of mental illness by selected Pentecostal pastors in Polokwane. Hereby permission is requested to conduct research with churches affiliated with the Limpopo Pastors' Fraternal. The main objectives of the study are as follows:

- To understand and describe Pentecostal pastors' notions of mental illnesses.
- To determine Pentecostal pastor's perceptions on how and by whom mental illness can be diagnosed and treated.
- To determine Pentecostal pastors' views regarding their own roles in the management of mental illness; and,
- To canvass and describe Pentecostal pastors' perceptions regarding possible collaboration between themselves and mental healthcare professionals. The results as well as the recommendations of the study may be used by mental health professionals and churches as guidelines to formulate specific interventions aimed at managing mental illness and enhance effective partnerships or collaboration with each other.

The results will also be made available to the Fraternal and research participants on request. Participation in this research is voluntary and research participants will have to withdraw at any time. Information provided i.e., data gathered during the interviews including the names of the participants and names of churches will be treated with utmost confidentiality.

I hope that my request will be considered.

Yours faithfully

…………………....
MaudaL.T .
PhD Student

Appendix 5: TREC letter

University of Limpopo
Department of Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 3935, Fax: (015) 268 2306, Email: anastasia.ngobe@ul.ac.za

TURFLOOP RESEARCH ETHICS COMMITTEE
ETHICS CLEARANCE CERTIFICATE

MEETING: 06 February 2019

PROJECT NUMBER: TREC/02/2019: PG

PROJECT:

Title: The perception and treatment of mental illness by selected Pentecostal pastors in Polokwane: Towards an intervention programme.

Researcher: LT Mauda
Supervisor: Prof T Sodi
Co-Supervisor/s: Dr JP Mokwena
                       Dr S Moripe
School: Social Sciences
Degree: PhD in Psychology

PROF P MASOKO
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: **REC-0310111-031**

Note:
i)   This Ethics Clearance Certificate will be valid for one (1) year, as from the abovementioned date. Application for annual renewal (or annual review) need to be received by TREC one month before lapse of this period.
ii) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee, together with the Application for Amendment form.
iii) PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

Finding solutions for Africa

Appendix 6: Letter of Approval from Limpopo Ministers Fraternal

E-mail: blessing.selepe@gmail.com

Cell: 0785873685

 To: **Fraternal Pastors**

11/03/2019

 Ref: **Mr Lesley Takalani Mauda**

This letter serves to introduce you to **Mr Lesley Takalani Mauda**, A PhD candidate at the University of Limpopo, Studying towards a Doctor of Philosophy (in Psychology) degree.

As discussed with you in our meeting, he has the president's permission to approach pastors with a view of interviewing them as part of his research project entitled: **The perception and treatment of mental illness by selected Pentecostal pastors in Polokwane: Towards an intervention programme.**

I trust you will be able to assist him

With best wishes

Yours sincerely

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Bishop R.S Selepe

(President)

Appendix 7: Language editor's letter of confirmation

Mr MM Mohlake

University of Limpopo

Turfloop Campus

Private Bag x 1106

Sovenga

0727

04 December 2020

To Whom It May Concern

Editing confirmation: LT Mauda's Thesis

This letter is meant to acknowledge that I, MM Mohlake, as a professional editor, have meticulously edited the dissertation of Mr Lesley Takalani Mauda entitled "The Perception and Treatment of Mental Illness by selected Pentecostal Pastors in Polokwane: Towards an Intervention Programme".

Thus, I confirm that the readability of the work in question is of a high standard.

For any enquiries, please contact me.

Regards

Mosimaneotsile M Mohlake

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Disclaimer: Subsequent alterations remain the responsibility of the author.