

**TREATMENT OF MENTAL ILLNESS BY AFRIKAANS SPEAKING
CHURCH LEADERS IN POLOKWANE LIMPOPO PROVINCE**

by

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DECLARATION

I declare that **TREATMENT OF MENTAL ILLNESS BY AFRIKAANS SPEAKING CHURCH LEADERS IN POLOKWANE, LIMPOPO PROVINCE** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.



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ABSTRACT

South Africa has a growing rate of mental health care users. Because of the lack of health resources and personal beliefs many of these mental health care users consult with their church leaders. The treatment of mental illness by clergy in South Africa is largely undocumented. The aim of the study was to explore and describe the treatment of mental illness by Afrikaans speaking church leaders in Polokwane, Limpopo Province. To gain a deeper understanding of the views held by the Afrikaans-speaking church leaders, a qualitative approach was utilized. Ten participants agreed to participate in the study. The results tend to suggest that most of the respondents use a combination of supportive therapy and teachings from scripture to treat some mental illnesses, and that they feel positive towards collaboration with other mental health care professionals. Lastly the results indicated that most respondents emphasized the importance of homophily in referral criteria.

Key Concepts

Mental illness; Christian church; Afrikaans speaking; church leader; treatment

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CHAPTER 1

INTRODUCTION

1.1 Introduction

Studies have suggested that mental illness is increasingly becoming a serious problem in the developing world (Boshoff, Hugo, Stein, Traut, & Zungu-Dirwayi, 2003), with mental illness causing five out of the ten most debilitating mental health conditions in the world (Mathers & Loncar, 2005). The exact extent of mental health problems in South Africa is largely undocumented because of the lack of population based data. But recent evidence has suggested that prevalence rates of many mental disorders in South Africa are equal to prevalence rates in most other countries (Seedat, Williams, Herman, Moomal, Williams, Jackson, Myer & Stein, 2009). Lund, Stein, Corrigan, Bradshaw, Schneider and Fisher (2008) supports this statement by suggesting that the prevalence rate of mental illness in South Africa is increasing rapidly, with researchers estimating that 17% of the population experienced a disorder in 2007 (Lund, Kleintjies, Cambell-Hall, Mjadu, Peterson, Bhana, Kakuma, Mlanjeni, Bird, Drew, Faydi, Funk, Green, Omar & Flisher, 2008).

The increasing number of individuals suffering from mental illness both in South African and globally created a need for more mental health professionals who are dedicated to assisting their community members in a more effective way. In South Africa, mental health services are provided by both public and private sector. In these sectors mental health services are provided by the different types of mental health practitioners. The Mental health Care Act (2002) defines mental health practitioners as a psychiatrist, medical practitioner or a nurse, occupational therapist, psychologist or social worker who has been trained to provide prescribed mental health care, treatment and rehabilitation services. These mental health

practitioners are facing numerous problems as the South African mental health system is inadequately staffed and resourced to effectively identify and care for mentally ill patients. Research has suggested that the high workload and lack of support in health institutions may be a root cause of these problems (Safaceno, van Ommeren, Batniji, Cohen, Gureje & Mohoney, 2007; Petersen & Swartz, 2002). Other reasons for the lack of professional assistance include lack of accessibility, lack of funding, stigma, and availability of services (Seedat, Williams, Herman, Moomal, Williams, Jackson, Myer & Stein, 2009). The lack of mental health services was highlighted in a study done by Lund and Fisher (2006) in the Limpopo province. This particular study found that the population to psychiatrist ratio is 0.1 in a population scale of 100 000.

Because of the lack of services from mental health professionals other sectors are also involved in the provision of mental health care services. These sectors include human services like religious or spiritual advisors and complementary medicine sectors like traditional healers, chiropractors and other healers (Seedat, Williams, Herman, Moomal, Williams, Jacksons, Meyer & Stein, 2009). A study done in South Africa in 2009 suggests that only 1 out of 4 respondents with a mental illness received treatment from the official mental health care system. Other respondents had consulted either the complementary medicine sector or the human services sector (Seedat, Williams, Herman, Moomal, Jacksons, Meyer & Stein, 2009). The present study builds on this important contribution by non-health professionals by focusing specifically on the role of the church leaders in the management of mental illness.

1.2 Background to the study

According to Van Niekerk and Prins (2001), every civilization, culture, or nation throughout history has expressed and practiced religious beliefs. Religious beliefs form part of a person's understanding of the world and environment. Religion is an integral part of an individual's life and this becomes even more so when an individual experiences an illness. Religious beliefs play an important part on the perception of mental illness.

The perception of mental illness by religious leaders is very important because these leaders prove to be important sources of information and provide mental care for many people (Oppenheimer, Julia, Kevin, Flannelly & Weaver, 2004; Young, Griffith, & Williams, 2003). Mathews (2008) emphasizes this by stating that the clergy's conception of etiology of mental illness has the ability to influence their congregations' views of the causation of mental illness and has implications for the use of formal mental-health services.

In traditional African religions, treatment for a mental illness correlates directly with the viewed cause of the sickness. Magezi (2006) describes how treatment is given through ritual purification, sacrifices and the search for restoring relationships that has been broken. These relationships can be with relatives, friends and even ancestors. The religious leaders from the Zionist and Apostolic churches seem to follow similar treatment methods. Peltzer (1999) describes common features and healing methods used by religious leaders in these denominations to cure illness including mental illnesses, these may include prayer, holy water, laying on of hands and baptism. Researchers such as Peltzer (1999) and Magezi (2006) have done quite a few studies on views and treatment of mental illness by traditional African churches such as the Zionist and Apostolic churches. There seems to be a

lack of research on mental illness and other religious denominations such as Afrikaans speaking churches.

Traditional western churches seem to follow a very individualistic view of treating mental illness. Religious leaders in these denominations have taken note of the more psychological view of mental illness (Charry, 2001). This has led to religious leaders moving towards a counseling paradigm in their view of treating mental illness. Research has suggested that religious leaders spend 10% to 20% of their time on counseling activities (Weaver, 1995). According to Magezi (2006) this type of pastoral counseling is focused on problems on a spiritual level and goals include faith development and growth. Confessions, repentance and absolutions are seen as essential in treating mental illness (Charry, 2001). Religious leaders already have a relationship with congregation members and this makes rapport building easier than in professional counseling situations. Religious leaders may also use another type of counseling termed salvation therapy (Magezi, 2006).

Explanatory models endorsed by religious leaders and treatment methods can hold valuable information for mental health professionals. A better understanding of views of behaviour of this important group can lead to a better understanding of needs of mental health care users. The present study seeks to make a contribution in this regard by investigating the subjective views of mental illness by Afrikaans speaking church leaders in Polokwane, Limpopo Province.

1.3 Rational for the study

It is important to note how this study resonates with the researcher. The researcher was born in a traditional Afrikaans home, her father is an Afrikaans speaking

church leader. She has seen personally how important the leader of a church's personal and professional views is to his congregation. She has witnessed many individuals suffering from mental illness come and visit a church seeking a solution. Having been trained as a clinical psychologist, the researcher has realised that there is a lack of knowledge about mental illness in the church community. With this study, the researcher hoped that she would be able to encourage better communication and collaboration between mental health professionals and church leaders.

1.4 Aim of the study

The aim of this study is to explore and describe the treatment of mental illness by Afrikaans speaking church leaders in Polokwane, Limpopo Province.

1.5 Objectives of the study

- To explore and provide an interpretation on what Afrikaans speaking church leaders understand to be mental illness;
- To understand and describe Afrikaans speaking church leaders' views about the causes of mental illness;
- To identify and describe the types of interventions that Afrikaans speaking church leaders provide to people who present to them with mental illness.

1.6 Definition of key concepts

- **Mental illness:** The word mental illness is often misleading and used casually. In this study the word mental illness is perceived to be interchangeable with mental disorder. A mental disorder can be defined as a

psychological syndrome associated with distress, impairment, increased risk of death, disability and loss of freedom (APA, 2000).

- **Christian church:** - Driscoll and Breshears (2008) define Christian church as a “community of believers who confess Jesus Christ as Lord... and observe the biblical sacraments of baptism and Communion” (p. 38).
- **Afrikaans speaking:** In this study Afrikaans speaking refers to an individual that speaks Afrikaans as their mother tongue.
- **Church leader:** - In this study church leader is understood to be a leader of a Christian denomination
- **Treatment:** – In this study treatment is defined as care and management of a physical or psychological illness

1.7 Chapter outline

This study comprises of six chapters which are outlined as follows;

- In chapter one, the background to the study, aims and objectives of the study were presented.
- Chapter two discusses the views from other relevant literature. Attention is devoted to explanatory models of mental illness, as well as conceptualization, causations and management of mental illness both from a cultural and religious perspective. The theoretical framework for the present study being the psycho-spiritual theory is also discussed.
- In chapter three, the research methodology is discussed, 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.

- Chapter four depicts the participants' narratives of their experiences and understanding of the research concept. The researcher presented the narratives and extracted the themes and analysed them using the interpretive analysis method.
- In chapter Five, the results of the study are discussed. The researcher deconstructed 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 in order to create a deeper understanding of the data. The research is also discussed within the theoretical framework being the psycho-spiritual model of mental illness.
- Chapter Six 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 2

LITERATURE REVIEW

There is nothing either good or bad, but thinking makes it so.

(Shakespeare, Hamlet, Act 2, Scene 2)

2.1 Introduction

This chapter will discuss different views on mental illness from relevant literature. Attention is devoted to explanatory models of mental illness, as well as conceptualization, causation and management of mental illness both from a cultural and religious perspective. The theoretical framework for the present study being the psycho-spiritual theory is also discussed.

2.2 Western perspective of mental illness

Mental illness is not always clearly defined, and a definition is largely determined by the approach used. According to the Dutch author Kraan (as cited in Theron, 2008) our modern understanding of illness and healing is primarily medical concepts. According to Thompson (2007), mental illness refers to disorders in humans, which can profoundly disrupt a person's thinking, feeling, moods, ability to relate to others, and the capacity for coping with the demands of life. Mental illness is therefore also firstly viewed through a Western perspective. In Western cultures the medical staff is specialists on the specific illness and they are trained to teach the mentally ill person about their disturbance and to help rid that person of their problems. The western perspectives are also very linear in cause and effect. The

whole idea of “healing” a mentally ill person is to remove the cause of the sickness and in essence all causes of illness can be removed if it is specialized.

The definition of mental illness is also influenced by the approach or model used. The approach to defining mental illness that has dominated has been mainly in terms of the evolutionary theory (Bolton, 2010). This evolutionary theory proposes that a mental disorder is a harmful disruption of a natural function, where natural function is to be understood in terms of functioning in the way it has been designed for by evolution (Bolton, 2010). From this approach we can hypothesize that negative social evaluation is necessary for a condition to be a disorder, and if considered from this approach we can then say that a condition can change from being considered a disorder to being considered normal depending on the social norms of society. As an example of this theory we can consider homosexuality that was previously considered a disorder but is currently considered a “normal” accepted way of living in our present society.

Western perspectives on the description of mental illness would largely concentrate on the symptoms and where the specific illness occurs. Mental disorders are a clinically significant behavioral or psychological syndrome that has patterns that occurs within a person and is associated with distress or disability. The Western perspective in its description of mental illness has mostly tried to classify and group mental disorders together. These classification systems include the DSM and ICD-10 classification systems. These classification systems mainly emphasize harm associated with mental disorders, distress or disability and the need to distinguish mental disorders from social deviance.

Two main appropriate explanatory models that have been evident in Western psychiatry from the beginning are the medical and the psychological models. These models differ in several critical aspects, particularly if mental illness and its conditions are meaningful and understandable and whether or not abnormal is clearly differentiated from the normal.

2.2.1 Biological/ medical perspectives on mental illness

The medical or biological model which has its roots in the 19th century has a clear idea of what it describes as an illness and its main feature is its ability to classify abnormal from normal functioning. Arthur Kleinman (as cited in Lynch & Medin, 2006) states that “in the biomedical definition, nature is physical, knowable and independent of perspective, the psychological, social and moral are only superficial layers of epiphenomenal cover that disguise the bedrock of the truth, the real stuff” (p. 257). The biological model proposes that the cause of disorders lie within the body.

The traditional view of mental illness is deeply rooted in the biological/ medical model, and it traditionally describes severe forms of psychological disorders such as schizophrenia, major depressive disorder and mania, this model is less troubled with the less severe psychological disorders such as adjustment disorders, anxiety disorders and mild depression (Millon, Grossman & Meagher as cited in Khan, 2009).

The debate over the causes of mental illness started in the 19th century and German psychiatrist Emil Kraepelin was one of the first to mention the biological causes he proposed. According to German psychiatrist Kraepelin, mental disorder

is a disease that can be classified by physical illness. That is, Kraepelin believed that the fundamental causes of mental illness lay in the psychological and biochemistry of the human brain.

Beginning in the 1960s, the biological perspective became dominant, supported by numerous breakthroughs in psychopharmacology, genetics, neurophysiology, and brain research. For example, scientists discovered many medications that helped to relieve symptoms of certain mental illnesses and demonstrated that people can inherit a vulnerability to some mental illnesses.

Within this framework we can theorize that a patient is a set of assorted organs and physical processes working as a homeostatic unit and can be regulated by physical means: surgery, drugs, hormones and diet. The body is the real and significant part; in contrast the mind and the emotions are merely mechanical functions of the brain and nerve cells (Theron, 2008).

In essence this model theorizes that mental disorder is caused by diseases or damage to the brain, biochemical changes in the brain or heredity genes. For example a study by Nurnberger and Foroud (2000) has found that chromosome 22 is implicated in both bipolar disorder and schizophrenia. Other studies found the hyperarousal symptoms experienced by patients with post traumatic stress disorder may be caused by damage to the hippocampus and anterior gyrus of the brain (Heim & Nemeroff, 2002).

The most notable strength of this model includes the swiftness with which symptoms are reduced even in patients with limited intellectual functioning who cannot benefit from psychotherapy (Preston, O`Neal & Talaga, 2010). This model is also more easily researched than many other models. The most prominent weakness of this model is its reductionist view. Ultimately the symptoms may be reduced but the person may never develop coping skills and problem solving behavior (Preston, O`Neal, & Talaga, 2010). Another weakness of this model is that it has led to health being measured by the absence of illness, thus from this model we can hypothesize that a person with mental health is someone who has no problems or stressors (Theron, 2008).

2.2.2 Psychological perspectives on mental illness

The psychological perspective focuses mostly on observable behavior. The psychological perspective of mental illness includes a diverse range of explanations of mental illness but they all have in common the assumption that mental illness originates from a psychological state that is usually triggered by a change in one`s relationship to the social world (Lynch & Medin, 2006).

Research by Baer (as cited in Lynch & Medin, 2006) has shown that most industrialized societies attribute mental illness to negative thinking and other psychological problems. The treatment for mental illness thus lies in understanding human behavior and emotions.

- *The psychoanalytical theory.* According to this theory which focuses on thoughts both conscious and unconscious, mental illness is seen as being caused by repressed unconscious thoughts and feelings (Van Niekerk & Prins, 2001). The psychoanalytical theory relies heavily on the thinking that there must be a balanced development of the human psyche. According to

this theory the human psyche has three main systems, the id, which comprises the sexual and aggressive drives, the ego, the conscious part of the mind that functions in reality and the superego which controls our moral ideals (Feist & Feist, 2006). Psychoanalysis uses free association, dream analysis, analyzing resistance, analyzing transference and interpretations as major techniques to help the unconscious become conscious (Huffman, 2007). The psychoanalytical theory has been criticized for its limited applicability and for its lack of scientific credibility (Huffman, 2007).

- *The cognitive-behavioural theory:* Cognitive behavioural theory is mainly focused on how faulty thinking and beliefs influence behaviour. This approach has a largely here and now focus and the therapist and the client work together to understand the cognitive and behavioural processes that are maintaining the problem. Improvement comes from gaining insight into negative automatic thoughts, dysfunctional assumptions and negative core beliefs such as “I am unlovable” or “I am not good enough”. Techniques include identifying and challenging negative automatic beliefs and cognitive restructuring (process of changing destructive thoughts or inappropriate interpretations) (Huffman, 2007). This approach has been praised for its success in addressing a range of problems. The cognitive behavioural theory has been criticized for overemphasizing rationality, ignoring unconscious dynamics and minimizing the importance of the past (Huffman, 2007).
- *The humanistic-existential theory:* The humanistic-existential theory relies heavily on the assumption that people all have the potential for growth and change. This theory maximizes that personal growth and mental illness is

believed to be caused by a blockage or disruption of the normal growth potential and this leads to a defective self- concept (Huffman, 2007). One example of this theory is Rogers Client Centred theory that emphasizes the clients' natural tendency to become healthy and productive, techniques used include empathy, unconditional positive regard, genuineness and active listening (Huffman, 2007). This theory has been criticized because of the length of time needed for clients to show improvement and the fact that its basic tenants such as self-actualization is difficult to test scientifically.

The psychological theories are limited by their tendency to oversimplify or over generalize symptoms of mental illness (Van Niekerk & Prins, 2001). Psychological theories have been widely criticized because they are individualistic in nature and these theories tend to emphasize independence, the self and control over one`s life while most African cultures are collective in nature and emphasize interdependence upon one another (Huffman, 2007).

Lack of cultural and biological cause may also cause misinterpretation of symptoms. These theories tend to ignore the spiritual nature of human beings and how these spiritual beliefs influence and affect illnesses. The most notable strength of these theories is that it caused most scientists to consider other causes of mental illness than just the biological.

2.2.3 The biopsychosocial models of mental illness

The biosychosocial model moves away from the reductionistic view of the models discussed above and focuses on a more holistic view of mental illness. According to Engel (as cited in Freedman, 1995) the hallmark of the biopsychosocial model is

its holistic, transactional, probabilistic and analogical view of human beings and their behavior. The biopsychosocial model emphasizes the importance that experience, physiology and anatomy exist in an ever-changing dynamic whole. Research such as those done by Saul Schanberg (as cited in Freedman, 1995) has shown that even short interruption of mother-newborn interaction in the rat is accompanied by changes in the biochemical process in the newborn rat. The study continues by saying that the changes produced can be reversed by tactile stimulation in the form of firm stroking. Thus we can see that even profound biochemical changes in the brain can be prevented or reversed by psychological intervention (Freedman, 1995).

According to van Niekerk and Prins (2001) this model focuses as much on the individual's health as it does on the illness within the individual. This model views the individual in context; this includes various systems or communities wherein the individual functions. Winiarski (as cited in Van Niekerk & Prins, 2001) suggests that every part of an individual and their lives has biomedical, psychological, social and spiritual components, and all of these components influence and interact with one another. From this perspective symptoms of mental illness are believed not to be caused by only one factor but instead are caused by interplay of different components within the individual's life context. This model involves a more positive view by suggesting that the individuals should not only be seen just in terms of their pathologies, but rather also in terms of his/her strengths and weakness as well.

The strength of this model is that it views the causes of the pathology within the individual as arising from a variety of factors. It thus allows for a more comprehensive assessment, both of the individual and the pathology (Van Niekerk & Prins, 2001). The treatment plan is therefore tailored to all areas of the

individual's environment. The weakness of this model is that it can be quite time consuming and thus more expensive. This model also present challenges to research as its effects and outcomes are not easily researchable.

2.3 Cultural perspective on mental illness

Human beings are both creators and products of their culture. Swartz (2002) views culture as

a set of guidelines (both implicit and explicit) which individuals inherit as members of a particular society, and which tells them how to view the world, how to experience it emotionally, and how to behave in it in relation to other people, to supernatural forces or gods and to the natural environment (p. 6).

Hayward (as cited in Ally & Laher, 2008) suggests that culture shapes the expression of mental illness. Consequently, it can be said that an individual will manifest and express his or her psychological ailments in a manner that will be appropriate and allowed in a particular culture. Culture influences the way in which distress is expressed and this in turn could influence diagnostic accuracy in assessment of an illness, which in turn would impact on the reliability to estimate the prevalence of an illness. The beliefs about the causes of one's problems also play a role where one seeks help, and in one's confidence in the treatment provided (Hwang, Meyers, Abe-Kim & Ting, 2008). Drawing on ethnographic evidence from 139 non-industrial societies around the world, Murdock (as cited in Lynch & Medin, 2006) "found that the most prevalent attribution of illness was to psycho-social causes" (p.16).

According to Idemudia (2004), the conception of mental illness is subject to cultural differences. The description of mental illness is also significantly influenced by culture. According to Kleinman (1980) culture determines the transformation from a person to a patient and will influence the decision as to whether to seek help from a medical or non-medical source. For example studies done by Beiser et al. amongst the Sered people of Senegal found that they describe mental illness as “illnesses of the spirit” (Patel, 1995), thus their pathway to care may not necessarily include a medical practitioner. According to a study done by Mateus, Santos and Mari (2005) relatives of patients with schizophrenia in Cape Verde defined mental illness as a “problem with the head”. These relatives explained that they believe the “patients” had been struck on the head with a rock. These examples illustrate that the description of mental illness does not fit into the neatly provided descriptions provided by traditional classification systems such as the DSM IV or ICD-10.

The concept of disease causation and classification are also related to traditional beliefs (Patel, 1995). In many African traditions illness represents an extremely hostile and disruptive force (Manala, 2005). According to Patel (1995) beliefs shared by many traditional African people, include three main fundamental ideas concerning causality; the first being that all things have a cause, and this cause has more power than the effect, secondly that events which seriously affects humans such as birth or death are intentionally caused and thirdly that the cause of any event can be determined through divination, memory, reason and empirical judgment. An example of this includes research done by Comaro (as cited in Lynch & Medin, 2006) mentioning a case where an African community accepted new information that lice caused typhus fever but then demanded to know who sent the lice.

Among traditional Africans there is a general belief that both physical and mental illness originates from various external causes. Traditionally it was thought that cultural beliefs just centered on influences or agents outside the body. These agents might be divinities, demons, spirits, or other phenomenon such as magnetic fields, the moon or the stars is the driving force behind the supernatural model (Barlow & Durand, 2005). Although the above findings reflect professional beliefs, a few other divergent opinions have emerged in recent findings. According to a study conducted by Furnham, Akande and Buguma (1999), most people in the developing world, including South Africa, attribute their distress to both natural and supernatural causes.

African tradition also closely relate to the idea of continuity between the living and the dead. The beliefs centers on the thought that although the body may disintegrate, the spirit lives on and plays an important role in maintaining the health of the living descendants (Patel, 1995). From this belief the concept of spirits can take on different types such as family spirits, community ancestors, alien and evil spirits. The living-dead are known as ancestors, '*badimo*' in Sepedi (gods) or '*abaphansi*' in isiZulu (those from down underground). In traditional African cultures, it is mandatory to maintain a bond with the spirits of the departed (Gumede, 1990). Members of the family perform rituals to maintain the bond with the living-dead. The bond can be maintained by slaughtering a beast or by sprinkling snuff and home brewed beer over the family's sacred place known as '*thokgola*' within the yard as a way of communicating with the ancestors, for example. This ritual is known as '*go phasa*' and can be performed for a variety of reasons. Gumede (1990) believes that a sacrifice such as slaughtering a beast can restore the ontological balance between the living and the departed.

It is believed that the ancestral spirits live invisible in the community close to the area which they inhabited before they died. The ancestral spirits are thought to monitor the activities of the living and these spirits easily take offence at immoral behavior or failure to observe the customary rituals and offerings. Ancestral spirits are also believed to spontaneously develop affection for living individuals and they then want to form close relationships with the living. Since communication between the living and the dead is difficult, these ancestral spirits are thought to produce madness in humans in an attempt to have their presence recognized and to have their wishes granted (Franklin, Sarr, Gueue, Silly & Reni-Collignon, 1996). Thus the cause of mental illness could be considered ancestral wrath. In this case an individual who neglects his ancestors or relatives may make them angry to a point that they may bring illness to him/her.

Van Niekerk and Prins (2001) identified witchcraft as one of the main causes or beliefs about mental illness. Inge (as cited in Ally & Laher, 2008) did research in Nigeria and found that witchcraft is common amongst all the people in Nigeria from different ethnic and religious backgrounds. Inge (as cited in Ally & Laher, 2008) also mentions that these beliefs have a controlling impact on the person's thinking and perceptions of these people and their culture incorporate witchcraft. Witchcraft can be considered an innate power that certain men and women may have, and the witchcraft may cause epileptic fits, excessive weight gain, death, illness, accidents and miscarriages (Eldam, 2003). In this case someone deliberately uses witchcraft to hurt someone else. Bewitchment within this context may be caused by spirits to take possession of the person or by poison being given to the individual (Van Niekerk & Prins, 2001). Research done by Hammond-Tooke, (as cited in Magezi, 2006) on the perceptions of the causes of illness in an African context reveals that 8% of rural and 7% of urban people believe that illness is caused by witchcraft. This perception is not only limited to traditional African cultures. The

perception that mental illness is related to oppression by spirits seems to be common across racial and socioeconomic barriers (Morrison & Thornton, 1999).

2.4 Religious perspectives on mental illness

According to Boyer (as cited in Khan, 2009) religion can be defined as an institution that has a recognized body of followers, who gather for worship and who has a specific set of doctrines that regulate their behavior. O`Hagan (2001) also defines religion as an organized religious group, whose spiritual aspects can be explained in a language, who believe that their practice is sacred and who relates their existence to their creator. Ninian Smart (as cited in Nell, 2009) also gives another definition of religion, stating that religion is a “six dimensional organism, typically containing doctrines, myths, ethical teachings, rituals, and social institutions, animated by religious experiences of various kinds” (p. 564).

According to Van Niekerk and Prins (2001), every civilization, culture, or nation throughout history has expressed and practiced religious beliefs. Even in today’s modern era of technology and advances in secularism, religious and spiritual beliefs, regardless of its form, remain strong (as cited in Leavey, Loewenthal & King, 2007). Religious beliefs form part of a person`s understanding of the world and environment. Religion is an integral part of an individual’s life and this becomes even more so when an individual experiences an illness. Religious beliefs play an important part on the perception of mental illness.

2.4.1 Religious perspectives of causes of illness

Early religious views held that any illness occurred because of sin and breaking of the Biblical law. According to Jones (2001) many religious people still believe that all problems are spiritual and moral problems. An online survey done on Protestants and Catholics with mental illness by Stanford (2007) has found that 21% of responders had been involved in a negative experience where mental illness had been associated with demonic influence, and another 19% had negative experiences in which mental illness had been associated with the sin of the afflicted person.

Several studies (Dain, 1992; Hartog & Gow, 2005) have found that many Christian denominations support psychological explanations for mental illness, but that lay Christians may still view mental illness as a reflection of one's alienation from God, or as a sign of demonic possession. A recent study done on representation of mental illness in Christian self-help bestsellers by Webb, Stetz and Hedden (2008) has found that many of these books contain material that focuses upon a spiritually based appraisal of clinical depression. While a few of the textual units include information about depression from professional mental-health resources, the vast majority of the data stressed an exclusively spiritual interpretation of the basic assumptions, representations, causes and treatments of depression.

The perception of mental illness by religious leaders is very important because these leaders prove to be important sources of information and provide mental care for many people (Oppenheimer, Julia, Kevin, Flannelly & Weaver, 2004; Young, Griffith, & Williams, 2003). Mathews (2008) emphasizes this by stating that the clergy's conception of etiology of mental illness then has the ability to influence

their congregations' views of the causation of mental illness and has implications for the use of formal mental-health services.

A recent study done by Mathews (2008) on explanatory models for mental illness endorsed by Christian clergymen in Singapore found that internal conflicts and poor coping seemed to be the most implicated psychological causes of mental disorders. The study also showed the multiplicity of belief models that were held by Christian clergymen to explain mental illness. While religious beliefs were important, nearly half of the clergy population complemented this belief with a mixture of psychological or organic models. Kim-Goh (1993) also did a small-scale study of 50 Korean pastors in America and found that most pastors indicated a preference for the psychological approach. The treatment methods used by religious leaders are mostly influenced by the views held by that specific denomination.

Religious leaders are often sought in times of emotional difficulty and as seen from research they often function as front-line mental health workers. According to Leavey, Loewenthal, and King (2007) research has shown that community based clergy have considerable contact with people who suffer from mental illness and many of these sufferers prefer the help of clergy rather than health care professionals. These findings are also supported by a study done by Lindgren and Coursey (1995) that surveyed psychiatric patients and their spirituality. They found that over half went to religious services and prayed daily, and that over 80% felt that their spiritual beliefs had a positive impact on their illness, providing them with comfort and the feeling of being cared for and not alone. In stark contrast over a third of the psychiatric patients surveyed did not feel able to discuss such things with their psychiatrists. Other research done by Bergin and Jensen (1990) has shown that in the general population over 80% believe in God or a higher power.

From this research it can be concluded that religion and its influence on mental illness is a very important part of our society and their beliefs as a whole.

Religious beliefs have been shown to play a central role in the perceptions that people have about mental illness (Ally & Laher, 2008). Many religions including the Islamic religion include witchcraft and possession by spirits as causal factors of mental illness. Ally and Laher (2008) conducted a study to explore Muslim Faith Healers perceptions of mental illness in terms of aetiologies and treatment methods. Six Muslim Healers in a Johannesburg community were interviewed and the data was analyzed through thematic content analysis. Their findings concluded that mental illness was seen to be caused by a variety of factors including medical factors and religious factors. Their results also indicated that these faith healers were aware of the distinction between mental and spiritual illness. Treatment methods used were specifically the use of natural products, originating from Islamic (Unani) medicine which has its roots in treatment prescribed in the teachings of the Prophet Mohammed.

2.4.2 Religion and its role in healing

Regardless of form or beliefs, the healing of the individual and of society has always formed part of the central function of religion (Durkheim, 2001). According to Thielman (1998) many of the current health care systems across the world can be traced to religious institutions. Religion has been shown to be a very important factor in health and health related matters. A longitudinal study done in the United States with over 21 000 adults has shown that after controlling for all other factors, attending religious services for more than once a week increased the lifespan of the average adult by between 7 and 14 years (Hummer, Rogers, Nam & Ellison, 1999). Research done by Byrd (1998) also supports the hypothesis about the

importance of religion and its role in health. He researched the effect of intercessory prayer on patients in intensive care units, and a double-blind trial yielded statistically significant results indicated that those patients who were prayed for recovered with fewer complications than the control group (Byrd, 1998).

Religious beliefs have also been shown to positively correlate with mental health. Mohagheghi (as cited in Bonab, Hakimirad & Habibi, 2010) conducted research on the impact of performing religious rituals and mental health and they found that performing religious rituals were associated with better mental health. This is also illustrated by Benson (1996) who found that individuals that use holy words and block intrusion of negative thoughts by repeating these holy words were experiencing a vast amount of tranquility and restfulness. In a study done by Bonab, Hakimirad and Habibi (2010) they interviewed 304 undergraduate college students in Iran in correlation of their mental health and spirituality. The study revealed a significant positive correlation between religious beliefs, being religious and the mental health status of the participants. "More specifically the results of analysis revealed that finding meaning in life, relation with God, spiritual action and actualization, transcendental mystical experiences and religious and social activities have been associated negatively with depression" (Bonab, Hakimirad & Habibi, 2010, p. 890).

Current researchers on the importance of the church in mental health services have found a number of interesting factors. Firstly the head religious figure is an important figure in the church and his leadership and direction is critical for understanding the programs and interventions of the church and is critical for understanding the type of church relationships with formal service agencies in the broader community (Taylor, Ellison, Chatter, Levin & Lincoln, 2000). Secondly the religious leader assumes a variety of roles in relation to church based

interventions, particularly as agents of health-related behavioral and social change (Levin, 1986). Thirdly, religious leaders often function as gatekeepers to mental health services (Veroff, Douvan & Kulka, 1981). Lastly religious leaders are often the first and only mental health professionals that individuals encounter (Taylor, Ellison, Chatter, Levin & Lincoln, 2000).

2.4.3 Religious perspectives in African tradition

African cosmology is centered on religion. Teffo (as cited in Manala, 2005) goes on to say that Africans look at health, illness and death as inextricably linked to religion. Africans are unable to conceive life without religion and African remedies are usually a combination of prayer mixed with medicine (Manala, 2005). Manala (2005) goes on to say that to African cultures “God is the most superior physician” (p. 54). Gibson, Morgado, Brosyle, Mesa and Sanchez (2010) suggest that the fact that Afro-centric religious practices remain relevant despite the influences of centuries of colonization is a testament to the strength of traditional healing. Religion forms a central part that drive people’s lives and it is often called upon to explain personal, social and natural events.

In traditional African religions, treatment for a mental illness correlates directly with the viewed cause of the sickness. Indigenous spiritual healers use spiritual forces to determine the cause of ill health and misfortune (Ensink & Roberson, 1999; Teuton, Bentall & Dowrick, 2007). Within these religious systems diagnosis is often undertaken under the guidance of spiritual forces and mental illness is often attributed to the influence of Satan or the Jinnh (Teuton, Dowrick & Bentall, 2007).

According to research done by Ensink and Robertson (1999) these approaches are becoming increasingly popular in Africa and their research has suggested that religious leaders are often sought out for help in mental health problems. Research done by Jacobsson (2002) in Ethiopia found that in the Coptic Church there are priests and monks that deal with spiritual healing. These spiritual healers prepare amulets with writing from the Bible on animal skins and fold it into small parcels, and these are carried around the neck for protection or for a cure for a problem (Jacobsson, 2002).

Agaral, Makanjuola and Morakinyo (2008) conducted a study in Nigeria to research the management of perceived mental health problems by spiritual healers. They found that these spiritual healers mainly attributed mental illness to pre-natural causes such as witchcraft (93.3%), substance use (86.7%), and punishment for sins (73.3%), supernatural causes such as curses or punishments from gods or ancestors (66.7%), genetic causes (63.3%) and as a complication of physical illness (56.7%).

The religious perspective of healing generally centers on the concept that healing is not only focused on one part of the body such as the medical model but instead the whole person is restored to health. The individual's relationship with God plays a big role in a person's health and in some instances sin against another person or against God can be an underlying factor in the cause of illness. As mentioned natural medicine is used at times but also the laying on of hands and anointing with oil is also mentioned (Theron, 2008). The verbal command such as in the context of raising the dead is also an important part of religious healing.

Most South African people affiliate with different Christian denominations such as the Roman Catholic Church, the Dutch reformed church and the Zion Christian

Church (ZCC). The Zionist Christian church is the largest church in South Africa, with 10-15 million members belonging to the ZCC star and 3-5 million belong to the saint Engenas ZCC (Anderson, 1999). The headquarters of the ZCC is at Zion city Moria in Limpopo province. According to Anderson (1999) the ZCC church believes that the religious leader of the church (or bishop) is an intermediary between the church and God, and just like Jesus Christ he can perform supernatural acts and faith-healing in the name of Jesus Christ. The senior official of the church or 'baruti' can use power of the Holy Spirit to perform healing. Magezi (2006) describes how treatment is given through ritual purification, sacrifices and the search for restoring relationships that has been broken. These relationships can be with relatives, friends and even ancestors. The religious leaders from the Zionist and Apostolic churches seem to follow similar treatment methods. Peltzer (1999) describe common features and healing methods used by religious leaders in these denominations to cure illness including mental illnesses, these may include prayer, holy water, laying on of hands and baptism.

Researchers such as Peltzer (1999) and Magezi (2006) have done quite a few studies on views and treatment of mental illness by traditional African churches such as the Zionist and Apostolic churches. There seems to be a lack of literature on research done by researchers about mental illness and other religious dominations such as Afrikaans speaking churches. The current study aims to highlight the treatment methods and views of the Afrikaans speaking church leader.

According to Hammond-Tooke (1989) churches are viewed as open systems that operate and develop differently and can be seen as therapeutic settings that provide a safe place for emotional expression. The religious leaders in these churches provide mental and emotional nurturance to church members in general.

Religious leaders are consulted for a variety of psychological issues, mostly with death and dying, bereavement, and marriage counseling (Taylor, Ellison, Chatter, Levin & Lincoln, 2000). However, clergy are also asked to address personal crisis and serious mental health problems. Taylor, Ellison, Chatter, Levin and Lincoln (2000), did a study based on an American sample and found that almost half of all consultations with religious leaders were concerned with marital issues, but they also found that many religious leaders do provide help to people with depression or other serious personal problems.

According to Taylor, Ellison, Chatter, Levin and Lincoln (2000) there are several advantages for church members to consult with religious leaders for help with their personal problems. Religious leaders are more economical for the poor. Treatment from traditional mental health professionals is often expensive and many sessions are needed before progress is achieved. Another advantage of consulting with religious leaders is the fact that they are directly approachable by members while most mental health professionals are mostly mediated by a formal or informal referral. Lastly it is expected of religious leaders to make personal visits to those in need, this increases access to them by many with mental health problems.

Traditional Western churches seem to follow a very individualistic view of treating mental illness. This individualistic view of treatment has led to church leaders leaning towards a more psychological way of treating mental illness. This has led to religious leaders moving towards a counseling paradigm as their choice of treatment. The Anglican Church has acknowledged the importance of clergy management of mental illness and has noted the inherent complexity, sensitivity and possible dangers within spiritual healing (Church Review Group, 2000).

Research among clergy has shown that they provide counselling to individuals with a wide range of personal problems, including substance abuse, depression, marital and family conflict, teenage pregnancy, unemployment and legal problems (Taylor, Ellison, Chatter, Levin & Lincoln, 2000). A comparison study done by Larson, Hohmann, Kessler, Meador, Boyd, and Mcsherry (1988) into the different types of clients encountered by religious leaders and mental health professionals found that they encounter similar clients with respect to both type and severity of psychiatric problems they present with. The problem with this study is that religious leaders usually differed with respect to education and training and therefore the type of services they provide would also differ.

Research has suggested that religious leaders spend 10% to 20% of their time on counseling activities (Weaver, 1995). According to Magezi (2006) this type of pastoral counseling is focused on problems on a spiritual level and goals include faith development and growth. Confessions, repentance and absolutions are seen as essential in treating mental illness (Charry, 2001). Religious leaders already have a relationship with congregation members and this makes rapport building easier than in professional counseling situations. Religious leaders may also use another type of counseling termed salvation therapy (Magezi, 2006).

Views of mental illness and the mentally ill held by religious leaders are likely to have important implications in terms of pathways to appropriate care and their relationship with other health professionals, compliance with treatment and outcomes. Despite numerous studies that show the importance of religious leaders in the treatment of mental illness, there is a lack of research concerning the border between religious organizations and formal mental health service delivery. As mentioned before, religious leaders often function as the gatekeepers to the mental health service system and they have traditionally played an important role in the delivery of mental health services. However, little is known about the types of

services they provide, and the specific circumstances surrounding referrals to mental health professionals and the relevant factors associated with these referrals.

Pathways to care are a much needed area that needs more investigation. According to Taylor, Ellison, Chatter, Levin and Lincoln (2000) the quality of mental health services provided by religious leaders is often determined by their ability to identify serious mental health problems and their willingness to refer to professional mental health professionals. Religious leaders are often approached by people with various psychopathologies and they are often unfamiliar with the symptoms of severe mental illness and they may have difficulty in detecting mental illness and emotional distress (Bentz, 1970). This is supported by a study done by Larson (1986) that found that when compared with other professional mental health professionals religious leaders tend to underestimate the severity of psychotic symptoms. This is also supported by another study done by Domina and Sevain (1985) that found that religious leaders are least likely of all providers of mental health providers to recognize suicide lethality. Because of their religious focus and training, religious leaders are more also more likely to interpret mental or emotional problems and symptoms in purely religious term (Hong & Wiehe, 1974). In this study Hong and Wiehe (1974) found that ministers interpret hallucinatory behavior as evidence of religious conflict.

Explanatory models endorsed by religious leaders and treatment methods can hold valuable information for mental health professional. A better understanding of views of behavior of this important group can lead to a better understanding of needs of mental health care users.

2.5 Collaboration of mental health practitioners

There is an increasing call for better collaboration between western and traditional mental health care practitioners. There is a growing interest in the importance of understanding and integrating a patient's culture into therapy. The term cross-cultural counselling has led to a better understanding of how a client's culture can be used as a healing instrument in a therapeutic relationship. Currently the WHO have highlighted this importance by emphasizing the use of traditional medicine and passing a resolution on closer cooperation between traditional and western healthcare systems (Bojuwoye & Sodi, 2010). There is a general agreement between researchers that blending together different cultural healthcare initiatives will be beneficial for patients and would utilize the best features of each cultural system and compensate for weakness in each (Chan, as cited in Bojuwoye & Sodi, 2010).

While this integration might be ideal, there are also some challenges. Firstly there are epistemological challenges, especially relating to the conceptualization of mental illness, this can cause suspicion and lack of communication between mental health practitioners. There also seems to be challenges in terms of practice issues specifically related to respect for methods and beliefs of both western and traditional mental health practitioners. Both western and traditional mental health practitioners need to be educated about cultural perspectives of individuals and how this can be beneficial in psychotherapy.

2.6 Theoretical Framework: Psycho-spiritual theory of mental illness and healing

This study will be guided by the psycho-spiritual theory. Psycho-spiritual healing hypothesizes that every being has an internal life force and that this force gives the body the ability to healing itself instinctively (Integrated Health Service and

Educational Research Center, 2006). This life force can be used to promote true well-being and health. The psycho-spiritual model is based on the individual's experiences of emotional health and the importance of meaning in life and illness (Lin & Bauer-Wu, 2003). According to Lancaster and Palframan (2009) the psycho-spiritual theory is a

constructive paradigm from which to understand the self in transformation because it presents a more holistic model of the self and has developed a large literature on the nature and function of spirituality beyond the context of traditional religion(p. 260).

The psycho-spiritual theory emphasizes that mental health should include both psychological and spiritual dimensions.

The psycho-spiritual theory is based on the concepts of transpersonal psychology. According to Milburn (2011) transpersonal psychology is the fourth force of psychology, the first being the psychoanalytical, the second being behaviorism and the third humanistic. Transpersonal psychology is concerned with the experiences which identify some deeper and more enduring sense of self that is beyond the masks that people present to the outside world and is instead more concerned with the experiences that identify some deeper and more enduring sense of self that is beyond the conditioned ego (Milburn, 2011).

The psycho-spiritual theory can be understood if we look at Carl Jung's understanding of the unconscious and the spiritual dimensions of life (Milburn, 2011). This approach of Jung states that we need to look into the original meaning of the psyche as a soul, according to this approach the psyche is not just a brain

that needs to be fixed or behavior that needs to be re-conditioned instead we must also consider the soul.

The soul is then the immortal aspect of human beings, the part that actually brings meaning and life to us, this is the part that connects us to the divine (Milburn, 2011). This theory believes that the soul compels us to become more conscious of dimensions of awareness and that we are part of a larger framework. The psycho-spiritual theory is very concerned with the holistic view of life and this includes the recognition that people are composed of a physical, mental, emotional and spiritual aspects and each of these aspects interact and affect one another (Milburn, 2011). The focus is then on the wholeness of a person, and how each part functions on its own but again also on how they are one.

This model has a very holistic view of illness which maintains that different factors such as physical, emotional and spiritual aspects all actively contribute to the individual's current state (Integrated Health Services and Educational Research Centre, 2006). The psycho-spiritual theory is concerned with the beliefs and experiences specifically those with spiritual and religious content that regard individual existence as an expression of a larger reality. The psycho-spiritual theory is very concerned with those areas where psychology and spiritual concerns overlap, that are essentially where the mind, body and spirit come together.

This theory views mental illness as a state of imbalance, distortion, and discord within and between the things that constitute and makes up the human person, body, mind, and soul (Integrated Health Service and Educational Research Centre, 2006). This theory views psychology as the process of assisting individuals to

become more self-observing and better equipped to be able to let go of their self-critical judgments (Milburn, 2011).

The psycho-spiritual approach is a very positive approach to psychology and therapy because it values important spiritual principles such as love, happiness, inner peace, presence and well-being. This approach does not ignore the fact that people suffer in the face of trauma but instead it places emphasis on how this suffering may open them up to a reality where their faith can give significant meaning to the trials and tribulations of their lives (Milburn, 2011). In stark contrast to the psychoanalytic approach, the psycho-spiritual theory is very concerned with the presence and the power of presence. This approach emphasizes that when an individual is present they are able to live fully in the moment, and they are then more capable of dealing with life's challenges, and they can then only fully be happy with themselves and others.

Treatment is dependent on restoring balance and order in and between the physical, cognitive, emotional state and spirit. This can only be achieved through self-knowledge, and this self-knowledge will enable the individual to restore the balances that was distorted. Treatment goals within the psycho-spiritual framework would include helping the individual build greater awareness and self-acceptance, changing unsatisfying patterns and behaviors, and developing the necessary skills to meet their life goals. It is therefore essential to the individual's growth that they heal uncomfortable emotions, painful trauma and negative self-beliefs during therapy.

The following example will help to illustrate the treatment for mental illness in this approach. The psycho-spiritual approach would focus on the following three things in the treatment of anxiety (Milburn, 2011);

1. Addressing how anxiety will hold the person back in their present day life such as at work, in relationships and social situations. Addressing how this anxiety will make the person feel about themselves.
2. To shift the negative beliefs that the person holds about himself. In anxiety this would be shifting the negative, fear based beliefs into positive supportive beliefs so that the person might overcome their tendency toward fear and worry and start thinking positively.
3. Finally the focus will be on developing skills and resources to handle present day anxiety provoking situations and to strengthen the person's sense of confidence and empowerment.

In conclusion the psycho-spiritual theory provides this study with a holistic framework that will address the various aspects of individuals including the spiritual aspects of an individual.

2.7 Conclusion

This chapter outlined the literature available on mental illness. The Western perspective on mental illness was discussed including the medical model and the psychological model of mental illness. The chapter continued with providing relevant literature on cultural and religious perspectives on mental illness. The literature reviewed also included studies conducted in South Africa and it highlights the lack of study specifically aimed at understanding mental illness from the perspectives of church leaders. Lastly, the theoretical framework of the study was discussed.

CHAPTER 3

RESEARCH METHODOLOGY

Research is formalized curiosity. It is poking and prying with a purpose.
Zora Neale Hurston

3.1 Introduction

This section will focus on the guiding methodology of the study. The research methodology is the processes that will help the researcher achieve the research aims. This study will be guided by a qualitative research design and the applicability of qualitative research to the present study will be highlighted. The method of selecting relevant participants, data collection techniques and data analysis will also be discussed.

3.2 Research methodology

A qualitative research design was used as the methodological approach of this study. Qualitative research is a subjective, holistic, phenomenological, descriptive and naturalistic research approach that aims to help us to understand the world that we live in and why things are the way they are (Hancock, 2002). According to Babbie and Mouton (2001) the key goal of this approach is to describe and understand the phenomenon in the study. Creswell (1998) supports this by saying qualitative methodology is an inquiry process which is based on distinctive methodological approaches that seek to explore a social or human problem. Qualitative research is dialectic and interpretive. During the interaction between the researcher and the participant, the informant's world was discovered and interpreted by means of qualitative methods (De Vos, 1998).

The qualitative design is more applicable to this study because the researcher sought to investigate a phenomenon using rich, detailed narrations of participants rather than quantifications, thus gaining insight into the complex and 'real life' experiences of particular individuals, rather than the exact verification of a hypothesis in a controlled environment (Liamputtong & Ezzy, 2005). Investigating the views the Afrikaans speaking church leaders have about mental illness using a qualitative design made it possible to open up the life of each participant for exploration and provides the floor in which their views of mental illness can be interpreted, described and understood.

To further explain the applicability of a qualitative design for this study, Rees (1996) notes that qualitative research involves broadly stated questions about human experiences and realities, studied through sustained contact with people in their natural environments, generating rich, descriptive data that helps researchers to understand their experiences and attitudes. This research design allowed the researcher to explore and interpret each church leader's personal opinions about mental illness.

Patton (1990) goes on by saying that qualitative research is well suited for understanding phenomenon within their context, uncovering links among concepts and behavior, and generating refining theory. So by using qualitative research mental illness could be understood from within the context of the church leaders, it was also more practical to uncover links between concepts and behavior such as views about mental illness and causation views held by church leaders. Qualitative research unlike quantitative research have no exclusive categories and therefore the research methodology allowed the researcher to engage participants on a deeper level and to try to fully understand the different views and opinions held by the participants.

3.3 Research Design

The phenomenological method of inquiry was used for the purpose of this study. Phenomenology literally means the study of phenomena. It is a way of describing something that exists as part of the world in which we live. Phenomenological research begins with the acknowledgement that there is a gap in our understanding and that clarification or illumination will be beneficial (Hancock, 2002).

The phenomenological approach intends to illuminate the specific and to identify phenomenon through how they are perceived by participants in a situation. According to Lester (1999) in the human context this normally translates into gathering deep information and perceptions through inductive, qualitative methods such as interviews, discussion and participant observations, and representing it from the perspective of the research participants.

In other words, phenomenology is concerned with the way things appear to us in experience. "Phenomenological methods are particularly effective at bringing to the fore the experience and perceptions of individuals from their own perspectives..." (Lester, 1999, p.1). According to Eatough and Smith (2008) the reality that we live is experienced through practical engagements with things and other individuals in the world, thus making it inherently meaningful.

3.4 Sampling procedure

Themistocleous (2008) describes sampling as a part of research design which is concerned with the selection of participants for the study and involves decisions

about which people, behaviors, events, etc. to observe. Because of the intensive and time consuming nature of data collection in qualitative research it necessitates the use of small samples. Qualitative sampling techniques are concerned with seeking information from specific groups and subgroups in the population (Hancock, 2002). And therefore a very specific group will be targeted for their rich knowledge on the subject.

The Afrikaans speaking church leaders who participated in the study were selected through purposive sampling. According to Patton (1990) all types of sampling in qualitative studies is purposeful sampling. "Qualitative inquiry typically focuses in depth on relatively small samples, even single cases, selected purposefully" (Patton, 1990, p. 169). Purposive sampling is a sampling method which targets a particular group of people and those individuals that do not fit a particular profile are excluded (Trochim, 2006).

Because of the exploratory nature of the study only participants in the city of Polokwane were included in the sample size. Polokwane has a surface area of about 3 775km² (IDP overview 2009/2011). According to a 2007 Community Survey, 561 770 people call the city home (IDP overview 2009/2011). According to a census done in 2001, 2.3% of Limpopo`s population speaks Afrikaans as a home language (Statistics South Africa, 2004). In terms of population groups, Christianity is most common among white and coloured South Africans, being the faith of 86.8% of the people in both groups (Statistics South Africa, 2004). According to Rossouw (2005) there is statistics that indicate that Afrikaners are currently undergoing a drastic religious change, although Christianity is still their main religion. Currently only 50% of all Afrikaners attend the traditional Reformed churches. Currently more Christian Afrikaners are attending Charismatic and Pentecostal churches.

A list of churches was obtained from the Polokwane business directory. From this list, a convenience sample of churches was chosen for the study. Afrikaans speaking church leaders from these churches in the convenience sample were contacted to participate in the study.

Individuals who took part in the study met the inclusion criteria discussed above. A total of ten individuals aged between thirty-two and fifty-nine years agreed to participate in this study. All participants were male, clearly this is indicative of the current gender imbalance in terms of religious leaders. All participants were interviewed in Afrikaans as it was their native language. Anderson and Goolishian`s (1998) idea of the role of language extends beyond its use as a medium of instruction to reflect the role it plays in the process of meaning making when people interact. Participants were offered the opportunity to use their native language to make meanings out of their lived experience. The role of language in meaning making is further emphasized in that the process of talking about certain issues will lead to the development of new themes, new narratives and new histories (Anderson & Goolishian, 1988). Afrikaans is also the researcher`s native language; this enabled an increased understanding of meanings participants attributed to concepts.

3.5 Data collection

In qualitative research data is collected through direct encounters with individuals that can include interviews (Hancock, 2002). This type of data collection is time consuming and intensive, but yields rich data.

A semi structured interview was used to collect data. The benefit of using semi-structured interviews also includes the richness of data that was gathered and the deeper insight into the phenomena under study (Hancock, 2002). Semi-structured interviews are popular in gathering data in qualitative research (Willig, 2001). According to Byrne (as cited in Silverman, 2006), semi-structured interviews are useful in gathering information that cannot just be seen but must be explored and understood in context.

The interview consisted of open ended questions that could lead to more exploration of specific topics. The use of this data collection method is recommended in studies of this nature due to the depth of understanding and detail it obtains (Greenwood, Hussain, Burns & Raphael, 2000). This type of data collection provides a very flexible manner in obtaining data and allows for a large collection of information to be obtained. Another advantage of semi-structured interviews includes the fact that the interviewer has the ability to clarify difficult questions, as well as to further explore issues and to probe as the situation requires.

According to Kelly (1996) the best way to approach data collection with interviews is to prepare your target population about the type of questions they will find in the interview. The respondents were contacted before the interview and the aim and objectives of the study were discussed with the participants.

The questions in the interview schedule were kept short and simple in order to avoid double barreled questions as well as to help the researcher to gather data in a more concrete manner. The questions were designed as not to contain prestige

bias – causing embarrassment or forcing the respondent to give false answers in order to look good. Leading questions were also avoided at all costs, as this can negatively impact on the credibility of the data collected.

3.6 Data analysis

There is a vast diversity in the disciplinary, theoretical orientation, and types of findings generated by qualitative research (Bradley, Curry & Devers, 2007). Data from qualitative research are typically suggestive and rarely but ever conclusive; nevertheless the analysis process must be highly deliberate and systemic.

The interpretive analysis method was used in analyzing the data. According to Geertz (as cited in Terre Blanche, Durrheim & Painter, 2006) interpretive analysis is used to gain a deeper understanding about phenomenon that will be studied. Thorne, Kirkham and O'Flynn-Magee (2004) have also expressed the same view by stating that interpretive analysis can be used to capture the themes and patterns about the phenomenon studied and this enriches the clinical understanding about the phenomenon. The following steps in interpretive analysis as outlined by Terre Blanche, Durrheim and Painter (2006) were used to analyze the data from the interviews:

Step 1: Familiarization and immersion: During this stage the researches spent lot of time in reading and understanding the data collected. The researcher truly immerses herself into the research to understand underlying thoughts and ideas as well as implicated ideas. Immersion in the data to comprehend its meaning in its entirety is an important first step in the analysis (Bradley, Curry & Devers, 2007).

Reviewing the data without coding helps identify emergent themes without losing the connections between concepts and their context.

Step 2: Inducing themes: Themes are primary concepts that characterize specific experiences of individual participants by the more general insights that are apparent from the whole of the data (Bradley, Curry & Devers, 2007). Themes are recurrent concepts that are found throughout the data and can unify statements and concepts about the subject of inquiry.

During this stage the researcher began to sort data into specific themes. Terre Blanche, Durrheim and Painter (2006) point out a few ideas that can be useful during this stage. These are:

- When coding use the language used by the sample population instead of the researchers own theoretical language.
- Inducing themes is not just about repeating what was said but about describing certain underlying processes, conflicts and inconsistencies.
- Try to find a balance between complexity and simplicity. Too little themes may limit understanding of data but too many themes may make the researcher lose sight of the research question.

Step 3: Coding: Coding is about categorizing qualitative data into specific groups. We do this by dividing collected data into labeled, significant pieces with the objection of later dividing these groups into categories under similar headings (Terre Blanche, Durrheim & Painter, 2006). The researcher used coding to break down the data into specific groups. As semi-structured interviews does not have

specific closed-ended questions, and participants discussed topics throughout the interview, it was important to code the data in order to analyze.

Step 4: Elaboration: In this stage, the categories that are constructed in the coding process are now further explored and new meanings are discovered. This leads to a better coding system as well as a richer understanding of how themes fit together (Terre Blanche, Durrheim & Painter, 2006). During the elaboration stage the categories were further explored and read again and again to make sure that the researcher understands what the participant was saying during the interview.

Step 5: Interpretation and checking: During the final step an interpretation of data collected is given. According to Terre Blanche, Durrheim and Painter (2006) interpretation includes writing an account of the occurrence being studied and then categorizing this data into headings and subheadings to enable better understanding.

3.7 Ethical considerations

The following ethical principles were observed by the researcher during the research process:

Informed consent

Research participants have the right to understand the research, to understand how the research will affect them, and to understand the risk and rewards of participation in the research. The participants also have the right to choose to decline to participate in the study. In this regard, the researcher explained the purpose of the study to the participants and advised them on the voluntary nature of their participation, (see Appendix C).

All of the research participants gave written consent for their participation in the study.

Permission to conduct the study

The researcher received written approval by the university research ethics committee before commencing with the study.

Anonymity and confidentiality

Confidentiality and anonymity are ethical requirements in research. Sensitive and personal information provided by participants should not be made available to everyone

The researcher gave assurance to the participants that all information will be kept confidential and that the participants identity will not be revealed.

Respect for participants' rights and dignity

The researcher respected the participant's rights and dignity throughout the research process. Cultural values were respected throughout the research study.

3.8 Reliability, Validity & Objectivity

Reliability and validity questions are difficult to answer in qualitative research. According to Terre Blanche, Durrheim and Painter (2006) qualitative researchers have two problems with validity. First, they find it impossible to identify and rule out specific validity threats before doing the research. Second, social constructionists reject the idea that research findings can be accurate reflections of reality. In the present study, the researcher sought to increase the reliability, validity and objectivity of the findings by addressing the following:

- **Credibility:** Credibility refers to the question on whether the conclusions drawn from the data is valid. In other words the trustworthiness of the research. The researcher ensured the credibility of the study by making detailed notes, and being careful to include primary data into the final report.

- **Transferability:** Transferability refers to the degree to which the research data can be generalized. The researcher ensured transferability by describing the sample population in detail. A demographic profile was included to ensure that the sample population was described in detail. The research context was also discussed.

- **Reliability and validity of interviews:** Validity when seen in the context of research refers to whether or not the correct procedures have been used in order to find the answers to the research question. Reliability refers to the quality of a measurement procedure that provides repeatability and accuracy. In this study semi-structured interviews were used. Semi-structured interviews have the benefit of giving some structure to the interaction with the respondents as well as gaining the information needed. Interviews in themselves have problems with reliability and validity. An interview does not give us facts but instead give us a glimpse of an individual's views and opinions. Because interviews are not quantitative data, reliability and validity is not so obvious. In the present study reliability and validity were maintained by being meticulous in recording the data. . Byrne (as cited in Silverman, 2006) emphasizes this by saying "what an interview produces is a particular representation or account of an individual's views or opinions" (p. 117). An interview is also a discussion between two people which means that there is an exchange of ideas and concepts. The danger in this, according to Rapley (as cited in Silverman, 2006) is that the interview data may be more of a reflection of the

social encounter between the interviewer and the interviewee than it is about the actual topic itself. By being aware of these constraints on interviews the researcher may be better equipped to understand the limitations of the study.

3.9 Conclusion

The guiding methodology and the research design that was followed in the research project were explained in this chapter. By approaching the study qualitatively the researchers obtained a better understanding of each participant's subjective opinions and their lived experiences. The researcher used semi-structured and open-ended questions to ensure that the research descriptions reflect the participants lived experiences. The researcher always has an ethical obligation to ensure anonymity, confidentiality and not to harm any participants involved, and this was upheld during the entire study.

CHAPTER 4

RESULTS

4.1. Introduction

This chapter presents the findings of this study. The researcher investigated Afrikaans speaking church leaders' understanding and treatment of mental illness. Ten participants were interviewed in order to gather sufficient data. In the first part of the chapter, the demographic profile of the participants is presented. This is followed by a section where the church leaders' phenomenological accounts on mental illness and how it is treated are presented. The main themes that emerged from the study were as follows: a). understanding of mental illness; b). causes of mental illness; c). treatment of mental illness; d). prevention of mental illness; and, e). collaboration with mental health care practitioners. The chapter is concluded by giving a summary of the findings of the study.

4.2. Demographic profile of the participants

A total of ten Afrikaans speaking church leaders partook in the study. The participants who took part in the study were male, indicative of the gender inequality in the profession. They were between thirty-two and fifty-nine years of age. The participants mainly referred to themselves as pastors or reverends, irrespective of their qualifications or religious denominations. Only one participant referred to himself differently indicating that his occupation was that of a minister of religion.

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. Three of the participants had obtained a diploma in Theology; another four of the participants had obtained a Bachelor's degree in Theology. Two of the participants had post-graduate qualifications including a masters and a doctor's degree. Half of the participants were from independent churches; the other five participants were from national church denominations.

Table 1

	AGE	GENDER	EDUCATIONAL QUALIFICATIONS	OCCUPATION	RELIGIOUS DEMONINATION
Participant 1	56	Male	Diploma Theology	Head Pastor	Agape Christian Church - Afrikaans Campus
Participant 2	48	Male	Diploma Theology	Pastor	Full Gospel Church
Participant 3	57	Male	BA, BD, Masters Theology	Independent Pastor	Charisma Church
Participant 4	48	Male	Diploma Theology Certificate Pastoral Counseling	Independent Pastor	Kingdom of Life Church
Participant 5	49	Male	BA, BD	Reverend	Nerderduits Reformed Church, Ladanna
Participant 6	59	Male	BA, BD Theology	Minister of Religion	Dutch Reformed Church North
Participant 7	36	Male	BMIN, BTH Theology, Certificate Ethics	Pastor	ASM Church South
Participant 8	32	Male	MA Practical Theology	Pastor	ASM Church Tabernadei Campus
Participant 9	35	Male	Currently studying towards Diploma Theology	Associate Pastor	Agape Christian Church - English Campus
Participant 10	39	Male	PHD Practical Theology PHD Pastoral Psychology	Senior Lector Pastor	Dutch Reformed Church Mother Campus

4.3. Phenomenological explication

4.3.1. Understanding of mental illness

Many of the religious leaders interviewed were of the view that the concept of mental illness as traditionally held by Afrikaans speaking church leaders has changed significantly in the past few years.

As one participant stated;

“it was always psychologists against church leaders” (Participant 9).

Previously religious leaders tended to only consider a spiritual dimension to mental illness and ignore the concept of psychology.

“I think in the past charismatic ministers have not always had empathy and sympathy with church members who had depression. The ministers did not properly understand what it was about. In the first 15 years of my ministry, I thought depression was sin” (Participant 1).

It emerged from the interviews with the participants that there is a realization that, apart from the spiritual dimension, a person's emotional or behavioral world was worth considering. As some of the participants put it:

Man consists of spirit, soul and body;“(Participant 8).

So, to me, it is obvious that there are, that a person consists of a body, and a soul and a spiritual component (Participant 1).

Based on the above extracts, it does appear that there is a need to be in balance with one another for a person to stay healthy. A mental illness therefore occurs when this balance is interrupted for some reason:

“I think, is when we don’t pay attention to our soul dimension or soul level; then it starts to get out of step with the other parts; like their spirit can get out of step with the others and then they spiritualize everything; another guy’s physical part will get out of step and then he becomes this tremendous marathon athlete and everything gets to his body because he doesn’t know how to handle it....”(Participant 9).

The participants reported that mental illness is either a disturbance in the emotional or spiritual component.

“....there can definitely be spiritual complications....” (Participant 2).

Examples that were given of this type of mental illness that is indicated in the spiritual component include; *“demonic influence”* (Participant 2), *“demonically possessed”* (Participant 8) and *“spiritual deviation... willfully continues to live in sin”* (Participant 7).

4.3.2. Causes of mental illness

Religious leaders identified organic causes, learned behavior and traumatic incidents/stressful life events as some of the most likely causes of the onset of a mental illness

Organic causes: Most of the participants considered a biological or medical reason to be the main cause of mental illnesses.

Most participants mentioned a chemical imbalance as the organic cause of mental illness.

“There are really physical causes; that is beyond all doubt; mainly chemical” (Participant 3).

“It is possibly chemical; a chemical imbalance” (Participant 5).

“In general, we think it has something to do with a chemical disturbance. Depression has much to do with a chemical imbalance” (Participant 6).

Learned behavior: Some participants also mentioned that mental illness seems to originate from some type of learning obtained from others, mainly from parents. One participant went on to illustrate this point by mentioning a case of a mother and a child both suffering from depression. When the mother stopped having depression symptoms the child’s depression symptoms also stopped without any treatment. Another participant spoke about how the relationship between children and parents can cause this type of learned behavior:

“She keeps saying mmmm, you’re making me mad; you’re making me mad. So mmmm, the child will learn madness or that behaviour that the mother had because a child of course, wants to identify with the mother, mmmmm, rage outbursts of a father a child will also learn because the child wants to be much like his father, mmmm, so I think coaching is the big thing about it. Don’t do what I do; do what I say; but the child learns that behavior; that’s the one part” (Participant 7).

Trauma and stressful life events: Participants' explanations of the causes of mental illness also seemed to include the view that traumatic experiences and stressful life events do have an impact on the development of mental illnesses. Other participants noted that stressful life events and the way in which people were raised contributed to the development of a mental illness:

".....from wounds that are incurred as a result of wrong upbringing and exposure to wrong information; wrong handling of a child" (Participant 1).

"I often think it's how these people were raised, their background, abuse, rejection.....Those people were rejected by their parents or that type of thing" (Participant 2).

"One of the very biggest reasons is one or other form of emotional pain, which people have experienced in their past. Or currently, in the present....."
(Participant 8).

For example, with regard to trauma, one of the participants said that mental illness could be caused by the following:

"A guy is in an accident and he loses his leg; relationship; we are close to one another and I am close to the girl whom I love or my child; and something happens to them and it has a massive effect on their life"
(Participant 8).

4.3.3. Treatment of mental illness

Participants tended to disagree about whether the church can be helpful to mentally ill individuals. Some participants even went on to say that the church can be dangerous and cause damage to mentally ill individuals;

“I think the average minister is a danger in this territory; that’s my honest opinion, because he just thinks he can fix everything with a Bible verse and a prayer....it doesn’t help if you try a bunch of little texts about being positive, usually judgmental in any case and not supportive” (Participant 3).

“The church doesn’t pray all infections better. Full stop” (Participant 10).

Some participants mentioned that the main role the church has to 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 otherwise;

“But because I told him and because they trusted my bona fides, they could channel the thing” (Participant 1).

On the one hand participants mentioned that the church cannot really play a role in helping mentally ill individuals but on the other hand participants also mention divine healing;

“through the Lord uses people to heal people through His Holy Spirit in church” (Participant 8).

“...then I said do you know something, the gift of healing, of making well; is absolutely possible” (Participant 5).

This contradiction in belief in the role of the church 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.

According to the participants interviewed, since the condition of mental illness manifests with psychological/ or medical symptoms, assistance from a psychologist and/or doctor may help in alleviating the symptoms;

“For that people really need treatment from both sides where medical plays a large role, if not the largest role. And then, of course, all the other things that the help professions offer, psychiatric hospitals, psychiatrists....”
(Participant 3).

This is particularly true if the religious leader believes the condition to be more of a “serious” mental illness or if the religious leader believes the problem to have more of a spiritual nature;

“I identify that a problem lies in the spiritual dimension, I will go to work in a specific manner; and if I think it is a physical problem, I will go to work differently; maybe send him to a doctor” (Participant 8).

If participants considered that an individual might be suffering from a mental illness, the type of behaviour also seems to signify the difference in which they perceive their roles. While dealing with depression was also considered difficult, many religious leaders mentioned that when they do encounter individuals with some depressive symptoms they saw the possibility of reflection and negotiation as well as intervention. One participant mentioned that before he would refer to any other professional, he would first try and change the individual’s way of thinking;

“.....I try to motivate people positively first by saying but that’s how you feel; it’s not necessarily the truth; you feel it, those are your emotions, but let’s look at what reality is. I try to explain to them that thing of what you’re experiencing and what the reality is..... I always try to see the positive in a

matter, so I try to show people what the reality is and what the solution to that problem is and how to act and think differently in their situation” (Participant 2).

Another participant also mentioned that he would first try and change the negative thoughts and replace them with more positive thoughts, but if there is no improvement then he would refer them to a health professional;

“If I can replace the lie with the truth; something empowering, not disempowering. Those two things; sort out the pain and change the thoughts; then you will in all probability get far with the thing. If the guy is so depressed he cannot make sense of what you say, you’re going to have to give him medication” (Participant 8).

One participant mentioned that he would use rather unconventional methods with patients who might be depressed. In this regard, he prescribed two specific exercises to them;

“.....and I encourage guys; you’re going to laugh at me now; about two things; but it is very important to me; the one thing is to go and exercise; listen, because you know I believe with a bit of exercise and being active; you know, if you go and sit on a corner somewhere; if you just go and sit there; you’re going to die; but if you get out of the corner and walk a bit and rediscover you self-worth, then I think you’re going to be okay..... I encourage the guys to eat a banana and an apple on an empty stomach; early in the mornings....” (Participant 5).

The participants also mentioned that their role in supporting mentally ill individuals would also include reducing the stigma that the person might experience by the church itself,

“I think you must also make it clear to your church members; that things like depression, or whatever else, are not a shame, not even for a Christian; then one can know; you are allowed to talk about them” (Participant 6).

4.3.4. Prevention

According to all participants interviewed, prevention of mental illness is believed to be possible.

“Yes, I think prevention is better than cure” (Participant 2).

“You know what, yes, yes, undoubtedly, yes” (Participant 5).

One participant went on to mention that although he believed prevention to be quite possible; it should not be seen as a simplified manner;

“Yes, it is difficult, because most people go to the doctor first when they are sick and many times the same thing yet happens to us. Only when it really gets to a point where the guy doesn’t know where to go any more, then they come and see you” (Participant 6).

Prevention Strategies: Most participants mentioned that psycho-education would be needed for prevention to be successful. Participants went on to provide example of the type of prevention needed;

“Yes, parent guidance like parent child seminars to focus on it; marriage camps and that type of thing helps with healing” (Participant 2).

“I would like to believe that if one could make more of life skills, it would rather be able to help” (Participant 6).

“And it begins with the father and mother figures; to train them so that they can act preventatively, so that when a child ends up in their care they have the ability, even in a broken world, to send this child out into the world reasonably normal and healthy” (Participant 1).

“So information and training or education, psychological education can make a huge difference and proper education” (Participant 10).

According to the religious leaders interviewed, some form of spiritual intervention is also needed in order to prevent mental illness. Much emphasis seemed to be placed by the religious leaders on reading and meditating on the Bible;

“it is when I deposit the Word of God into myself; so that it can bear fruit when it is necessary; so that the Holy Spirit can teach me all things and remind me what you said; so that is the closest to prevention which I can do” (Participant 7).

“I think the Bible says a healthy mind houses a healthy spirit..... the Bible says to be forgiven, you must forgive” (Participant 9).

4.3.5. Collaboration with mental health care practitioners

Although most of the participants acknowledged that they believe that mentally ill individuals need to be referred to mental health professionals such as psychiatrists and psychologists, their own personal referral pathways do not seem to support this notion. Only three participants mentioned mental health professionals including “*psychologist*” (Participant 5), psychiatric institutions such as “*Denmar*”

(Participant 3 and 5) and “*psychiatrists*” (Participant 10). It is interesting to note that all the three participants have some training in various aspects of pastoral counseling, one had a masters and another a doctoral degree in pastoral counseling while a third had some background knowledge in psychology but held a BA degree in Theology.

Most other participants mentioned that they would rather refer to a colleague with more knowledge in the field than to refer to a mental health care practitioner.

“I will then refer to a colleague who will then continue to see the guy”
(Participant 6).

“I will call in a couple of my colleagues and handle it in that way” (Participant 8).

Some participants mentioned that their lack of referral to other mental health care professionals include a variety of reasons including their distrust in some psychological methods or in the reputations of specific individual mental health professionals;

“... the reputation of some psychologists in our town is not very positive”
(Participant 7).

“... and you sometimes hear funny things that these guys have said to people; you realize these things are not fitting; they are just not right; they don't really help”
(Participant 6).

“... but there are things with him that don't completely make sense” (Participant 5).

Other participants mentioned that the lack of collaboration between mental health professionals and church leaders might be caused by a lack of trust;

“I don’t think there is a bridge between the psychological world or counseling and the church; well, not that I know of” (Participant 2).

“The big thing which every minister struggles with, is the trust between them and the psychologists.....is as if a psychologist feels ministers think everything can just be prayed better; and ministers often feel the psychologists just have a lot of theories with which they experiment to see whether they can prove their theories correct. So who suffers under that? It is actually the client or the patient” (Participant 7).

According to Abbott (as cited in Mathews, 2010) this untrusting type of relationship is not uncommon and relationships across professionals are often tense when professional groups have similar domains of care. There is an overlap of duties between religious leaders and mental health.

These statements are problematic to mental health care professionals as referral pathways can be severely hampered by these negative attitudes towards health care professionals. As research has shown religious leaders are usually the first port of call for many mentally ill individuals in their communities, if religious leaders are uncertain about their referrals this may create delays to professional help for individuals.

Most participants seemed to be of the view that the person that they would refer the client to should also be a Christian;

“I would not refer anyone to someone who is not a Christian” (Participant 2).

“I think it still remains important to me that it should be a Christian”
(Participant 6).

“... the first quality, for me, is that the person should see his role as one part of the body of Christ; that means he must also be part of the bride”
(Participant 7).

“... in my opinion they should love the Lord very very much” (Participant 8).

“So my frame of reference always begins in a spiritual and a Christian way. So I will always refer to people who have the same foundation because we believe the same things and I want to be part of life” (Participant 9).

4.4. Summary of findings

The ten individuals that partook in the study were males between thirty-two and fifty-nine years old. Their education qualifications included diplomas, bachelor's degrees and post graduate qualifications. The main themes that emerged from the study were presented. The causes of mental illness mainly identified by the participants were organic causes, stressful life events and trauma. The participants understood mental illness as an imbalance between soul, body and spirit. Most participants believed that prevention of mental illness is possible and that psycho-education is a manner in which mental illness can be prevented. Participants mostly mentioned that they would refer to mental health professionals, but when probed only a few participants were able to mention what mental health professionals they would refer to.

CHAPTER 5

DUSCUSSION

5.1 Introduction

This chapter aims to provide a discussion on themes that emerged from the study. The main themes that are discussed includes; a).understanding of mental illness; b). causes of mental illness; c). treatment of mental illness; d). prevention of mental illness and , e.) collaboration with mental health care practitioners. The results of the study will be discussed with relevant literature to provide a context where the result can be understood. The results of the study are also discussed in relation to the guiding theoretical framework, the psycho-spiritual theory of mental illness and healing.

5.2. Phenomenological explication

5.2.1. Understanding of mental illness

The data obtained from the study indicated that most church leaders understood mental illness to be a condition that is not caused by only one factor but instead to be caused by interplay of different components within the individual's life context. Mental illness is thus understood to be caused by an imbalance within the person`s life. This imbalance between the spiritual, physical and mental dimensions therefore causes the distress normally associated with a mental illness.

This concurs with the conceptualization of the biopsychosocial model of mental illness, that suggest that every part of an individual and their lives has biomedical,

psychological, social and spiritual components, and all of these components influence and interact with one another (van Niekerk & Prins, 2001).

The description of mental illness according to the church leaders interviewed in the study can be said to be linked to how mental illness is conceptualized in the academic literature. The American Psychiatric Association (2000) in particular, conceptualizes mental illness as being a manifestation of a behavioral, psychological or biological dysfunction in the individual.

This model views the individual in context; this includes various systems or communities wherein the individual functions. Winiarski (as cited in Van Niekerk & Prins, 2001) suggests that every part of an individual and their lives has biomedical, psychological, social and spiritual components, and all of these components influence and interact with one another

This attempt of religious leaders to pose both spiritual and psychological components for mental illness might be suggestive of a new path taken by theology to be more integrated with psychology. In a study by Mathews (2008) similar results were found with a study done with Christian clergymen in Singapore. Mathew's research tends to suggest that the reason for this eclectic approach might be religious practitioners who need to "safeguard the sanctity of their unique religious perspective but at the same time appear sophisticated in a world where scientific rationality, with its emphasis on disenchantment, is more the order of the day" (Mathews, 2008, p. 297). He goes on to suggest that it could also be an influence from the modern American movement that supports the integration of

spirituality and psychology to understand and deal with mental illness (Mathews, 2008).

5.2.2 Causes of mental illness

The participants in the study mainly mentioned that organic causes, learned behavior and stressful life events as the main causes of mental illness. This closely resembles the findings of Ally & Laher (2007) in which they found South African Muslim faith healers also identified these as the most likely cause of mental illness.

Organic causes: Many participants identified organic causes as one of the main causes of mental illness. Research done by Mathews (2008) and Samoulihan and Seabi (2010) confirm that an organic cause is the main explanatory model held by both South Africans and many clergy men. This corresponds with the biological model that views the cause of mental illness to lie within the body.

Learned behavior: Some participants also mentioned that mental illness seems to originate from some type of learning obtained from others, mainly from parents. The study by Mathews (2008) on Christian clergy in Singapore found a very small portion of his participants mentioned learned behaviour as possible causes. In the current study it was a theme that was readily mentioned. This could be indicative of the fact that mainly charismatic church leaders were interviewed in contrast to Matthew's study that included other church denominations including catholic and protestant religious denominations.

Trauma and stressful life events: Participants in the study also mentioned stressful life events as a possible cause for mental illness. Research done by Ally and Laher (2007) on perspectives of mental illness held by South African Muslim faith healers also found similar results with many of their participants mentioning that traumatic incidents and childhood trauma was a main cause of mental illness.

5.2.3 Treatment of mental illness

Participants tended to disagree about whether the church can treat someone who is mentally ill, and whether the church is competent in dealing with members who are mentally ill. In a factor analysis study done by Moran, Flannelly, Weaver, Overvold, Hess and Wilson (2005) clergy's beliefs about their competency tends to fall into two categories. On average they found that clergy in their study felt most confident about their ability to deal with traditional kinds of problems most clergy are expected to address such as grief, death, dying, marital problems and family problems. In their study they found that clergy felt less competent when dealing with depression, alcohol, domestic violence and severe mental illness. In the current study this was also found. Participants mentioned that they mostly address problems such as grief, marital conflict, family conflict and trauma. In the current study some participants mentioned that they do address depression but were unsure about the specific treatments they would use. This is supported by research done by Ingram and Lowe (1989) who found that depression is traditionally addressed in pastoral counseling.

Participants in the study mentioned that they are limited in treatment of more severe mental illness but mentioned that they were mainly involved in management of mental illness. Participants mentioned that if they thought the cause of the mental illness was of a spiritual nature they would treat with prayer. This is also

supported by research done by Ally & Laher (2007) that mentioned that Muslim faith healers interviewed in their study mentioned that they believe that spiritual treatment is only necessary in helping to alleviate the symptoms of a spiritual illness. Religious leaders seem to have moved to a more Western view of treating certain mental illnesses especially those they believe to be organic in nature. This also corresponds with research done in South Africa within the general population (Furnham, Pereira & Rawles, 2001) that most people believe that the best way to treat mental illnesses such as depression is to consult a general practitioner, and to enlist the services of a counselor or a psychologist or to discuss the problem with family and friends.

Participants also mentioned that they are often involved in the management of mental illness, including visiting and giving spiritual guidance to mentally ill individuals. This contact with mentally ill individuals encourages church members to also become more tolerant in their management of the mentally ill. Much of the literature suggests that contact with the mentally ill is a key factor for reducing stigmatizing attitudes (Corrigan, 2004). The fact that church leaders mentioned that they often visit and support mentally ill clients, are indicative of a very important service rendered to those in the community. According to research done by Johnson and Spilka (1991) patients often highly value interactions with community based clergy, reporting that pastoral visits brings hope, eases the difficulties they encounter and prepare them for returning back to their normal day to day functioning.

In the study by Moran, Flannelly, Weaver, Overvold, Hess and Wilson (2005) they found that training clergy increased the clergymen's confidence in dealing with both traditional kinds of problems such as grief, death and marital problems as well as depression, suicide and more severe mental illness. In the current study however,

it is noteworthy that the participants with post graduate degrees and some form of training in counseling felt less competent in dealing with severe mental illness and mentioned the dangers of engaging in counseling with such an individual without referral to a psychiatrist and psychologist.

5.2.4 Prevention of mental illness

It is increasingly recognized that producing positive changes in population health, including mental health, requires initiatives that go well beyond the confines of the traditional health sector alone (Braveman & Gruskin, 2003). According to all participants interviewed, prevention of mental illness is believed to be possible. Prevention strategies mentioned included psycho-education and some form of spiritual intervention.

Psycho-education: According to Colom and Lam (2005) psycho-education can be defined as a specific form of education that involves teaching individuals about their symptoms, treatment and signs of relapse so that they can actively seek treatment before the condition worsens. Providing individuals with information and giving education is an important part of any holistic mental health care plan. Well-informed patients are likely to recover faster and play an active role in their own health (Lin, Moyle, Chang, Chou & Hsu, 2008).

Spiritual intervention: Religion plays an important role in the lives of many people coping with illness (Mueller, Plevak & Rummans, 2001). A study done by Koenig (1998) found that religious coping including prayer, depending on God for support and comfort and reading scripture was the most important factor in sustaining many individuals, nearly 90% indicated that religion was used at least moderately to

facilitate coping. Religious believes seems to be valid coping mechanisms for individuals coping with illness, including mental illness (Koenig, Goerge & Peterson, 1998). Having strong religious believes can provide the individual with a sense of control over situations and illness that otherwise seem out of their control. Therefore we can conclude that the prayer and scriptures provided by church leaders to their congregational members can be seen as enforcing a positive coping mechanism.

5.2.5 Collaboration with mental health care practitioners

Referral behaviour is an important consideration in studies of management of health care (Davies, as cited in Mathews, 2010). According to Mathews (2010) clergy are in a very good position to make referrals to mental health professionals as they have high access to church members, they have high regard and trust given to them by the community and there is a public perception that they have high levels of interpersonal skills.

All the participants interviewed were in favour of collaborating with medical and psychological practitioner specifically because they understood that illness could be medical, psychological and/or spiritual. The importance of co-operation between religious leaders and other health professionals is emphasized by the World Health Organization (2001) that mentions in their report that multidisciplinary teams are especially relevant in the management of mental disorders, owing to the complex needs of patients and their families at different points during their illness.

This is also supported by Mathews (2010) that states that

...educational variables such as increased secular and psychological education may lead to clergymen being more familiar with the mental health profession (p. 186).

Mathews (2010) goes on to mention that this type of education might have exposed such religious leaders to other more secular worldviews that is in disagreement with the more spiritual worldviews and thus they may have an increased acceptance of psychological explanations for mental illness.

Participants in the current study mentioned that their lack of knowledge about what services psychologists and psychiatrists render can cause distrust. Participants mentioned that they felt that some mental health professionals might disregard the spiritual importance in counseling and might even influence their church members to become less religiously devout. According to Mathews (2010) a large portion of ministers feel that a wrong referral might lead to professionals who might give church members “bad counsel” and cause more damage than provide help.

The study by Moran et al. (2005) found that on average the clergy they interviewed consulted with pastoral counselors and social workers a “few times a year”. Consultations with psychologists and psychiatrists were found to be less frequent in their study. In the current study a limited number of participants mentioned ever consulting with a psychologist and psychiatrist. One participant in the current study mentioned that there is a need for supervision for church leaders. Many church leaders in the study were independent pastors and had no peers or other colleagues to discuss their cases with. Supervision is a foreign concept to church leaders who on the most part function independently. Johnson (1973) stressed the need for clergy to have clinical supervision, and proposed that they should be supervised on a weekly basis to discuss counseling sessions. The lack of

supervision could account for the habitual 'burn out' experienced by church leaders and their lack referral because they do not receive the necessary supervision to know when and where to refer.

Homophily in referral criteria

Homophily is the tendency to seek out people who are similar to oneself, this is a powerful force in structuring our relationships with others in a variety of social settings (Mathews, 2010). Most people search out someone who is similar in age, sex and race to engage with but this homophily tendency can also be observed in people preferring individuals who have similar beliefs in faith to them (Mathews, 2010). Moreover similarity seems to reduce uncertainty and increases trust between individuals (Bird as cited in Mathews, 2010).

This homophily criterion was observed during the study. With most participants mentioning that they were more likely to refer to someone who is a Christian and who has the same values as they do. A study done by Mathews (2010) on the importance of homophily referral among Christian clergy in Singapore found similar findings with 63.5% of ministers agreeing that the professional they want to refer to must be a Christian. His study also found that it is not important that the professional be from the same denominational background but 30.3% agreed that the professional referred to needs to have some similar values. This is also a very important factor for the participants, which seems to confer that church leaders tend to refer to other Christians or people with the same belief systems.

This tendency of church leaders seem to reflect a belief that mental health practitioners might give their church members "bad counsel" and cause more damage than provide help (Mathews, 2010). There also seems to be competition and mutual suspicion which prevents collaboration among healthcare practitioner.

According to Abbott (as cited in Mathews, 2010) this untrusting type of relationship is not uncommon and relationships across professionals are often tense when professional groups have similar domains of care. There is an overlap of duties between religious leaders and mental health professionals and this can increase this type of competition. Religious leaders who believe that counseling duties are an important part of their role and identity as leader in the church can feel that the intrusion of mental health professionals into their territory might influence their church leaders.

5.3 Discussion of results within the theoretical framework

The study was guided by the psycho-spiritual model on mental health and healing. The psycho-spiritual model is based on the individual's experiences of emotional health and the importance of meaning in life and illness (Lin & Bauer-Wu, 2003).

The psycho-spiritual model emphasized the importance of a holistic view of mental illness. And it therefore emphasized that mental health should include both a psychological and a spiritual dimension. From the results it is evident that most of the participants emphasized the importance of balance between the physical, the psychological and spiritual dimensions. The results also indicate that participants believed that if this balance is disturbed a person may develop a mental illness. This is in agreement with the psycho-spiritual theory that views mental illness as a state of imbalance, distortion, and discord within and between the things that constitute and make up the human person, body, mind, and soul (Integrated Health Service and Educational Research Centre, 2006). Mental illness is thus understood to be caused by an imbalance within the person's life. This imbalance between the spiritual, physical and mental dimensions therefore causes the distress normally associated with a mental illness.

The psycho-spiritual theory also emphasizes that a person is not just a brain or behaviour that needs to be fixed but that an individual also needs to be considered on a deeper level. The results indicate that the participants believed that a person`s soul or inner being is very important and that at times turmoil within this deeper part of the soul can cause a mental illness to emerge. This is in line with the psycho-spiritual theory that emphasizes that an individual should be considered holistically and be treated holistically.

Treatment from the psycho-spiritual theory is dependent on restoring balance and order in and between the physical, cognitive, emotional state and spirit. The participants in the study were very hesitant to give such a clear cut answer to the treatment of mental illness. Participants however mentioned that if they thought the cause of the mental illness was of a spiritual nature they would treat with prayer. Participants also mentioned that they are often involved in the management of mental illness, including visiting and giving spiritual guidance to mentally ill individuals.

The psycho-spiritual approach is a very positive approach to psychology and therapy because it values important spiritual principles such as love, happiness, inner peace, presence and well-being. The results of the study suggests that the participants do believe that a relationship with God and regular visits to church will help the individual stay more positive and help them cope better with the demands of everyday life. The results of the study also suggested that many participants believed that forgiveness of others and the self can have a positive impact of individuals with any type of mental illness. This correlates with the positive approach of the psycho-spiritual approach that emphasizes that inner peace can bring about happiness and a positive approach to life.

The findings of the study suggested that the participants believed that an important part of prevention of mental illness is to psycho-educate church members and to provide them with the necessary skills needed for life. This is in line with the psycho-spiritual theory that suggests that a treatment plan should also include developing skills and obtaining resources for the individual to be able to handle present everyday situations (Milburn, 2011).

5.4 Conclusion

This chapter aimed at providing a discussion on themes that emerged from the study. The themes that emerged from the study were discussed with relevant literature to provide a context where the results were discussed. The main themes that were discussed included understanding of mental illness held by church leaders, causes and treatment models of mental illness held by church leaders. This chapter also provided a discussion on collaboration with other mental health care professionals including hemophilic criteria held by church leaders. The chapter concluded with a discussion of the results in relation to the theoretical framework that guided the study.

CHAPTER 6

CONCLUSION

6.1 Introduction

In this chapter, the researcher provides a brief summary of the findings and reflects on the purpose of this study. In addition, the overall strengths of the study, limitation and recommendations for further research are presented.

6.2 Reflections on the purpose of the study

The first objective of the study was firstly to explore and provide an interpretation of what Afrikaans speaking church leaders understand mental illness to be. Based on the personal opinions of the individuals who agreed to partake in the study, it appeared that participants agreed that there has been a significant shift from the views traditionally held by Afrikaans speaking church leaders. Most participants agreed that mental illness can be understood to be a disorder that disturbs the balance between the physical, spiritual and emotional systems within an individual. Based on these findings, it can be argued that Afrikaans speaking church leaders understand mental illness from within the biosyco-social model perspective.

The second objective of the study was to understand and describe Afrikaans speaking church leaders' views about the causes of mental illness. The findings of this study suggest that most church leaders identified organic causes, learned behaviour and traumatic incidents/stressful life events as the most likely causes of the onset of a mental illness. The researcher is of the opinion that these causes attributed to the onset of a mental illness are legitimate ways in which causes of mental illness are understood within the South African church community. This is

also supported by findings by Ally & Laher (2007) who found that South African Muslim faith healers also identified these as the most likely causes of mental illness.

The third objective was to identify and describe the types of interventions that Afrikaans speaking church leaders provide to individuals who present to them with mental illness. Participants who partook in the study disagreed whether church leaders should provide treatment to mentally ill individuals, and a few participants went on to mention that the main treatment church leaders should provide is referral to other mental health care professionals. Other participants mentioned that they performed some types of support and counseling to individuals. This contradiction in belief about treatment within the church and by church leaders seems to suggest that the church as a Christian theological institution is also not completely sure about their own stance on certain matters especially pertaining to treatment provided to individuals who can be identified as suffering from a mental illness.

6.3 A Brief summary of the findings

The findings of this study suggest that church leaders understood mental illness to be a condition that is not caused by only one factor but instead by an imbalance between the spiritual, physical and emotional dimensions within an individual. The description of mental illness according to the church leaders interviewed in the study can be said to be linked to how mental illness is conceptualized in the academic literature. The American psychiatric association (2000) in particular, conceptualizes mental illness as being a manifestation of a behavioral, psychological or biological dysfunction in the individual.

The findings of the study further suggest that church leaders mainly attribute the cause of mental illness to be due to organic causes, learned behavior and stressful life events. This study confirmed the findings of other studies (Ally & Laher, 2007; Samoulihan & Seabi, 2010) that found these as the main causes attributed to mental illness.

In line with previous findings (Charry, 2001), the present study indicates church leaders have been greatly influenced by the beliefs held by the general South African population. According to Furnham, Pereira & Rawles (2001) the general South African population has taken note of more psychological views of mental illness and this influence their way of seeking treatment for mental illnesses. For instance, the findings reflect that church leaders are more prone to refer individuals with severe mental illness to psychiatrists and psychologists.

The findings also suggested that participants interviewed were in favor of collaborating with medical and psychological practitioners specifically because they understood that illness could be medical, psychological and spiritual. The importance of co-operation between religious leaders and other health professionals is emphasized by the World Health Organization (2001) that mentions that multidisciplinary teams are especially relevant in the management of mental disorders, owing to the complex needs of patients and their families at different points.

There were similarities with the findings of other studies with regard to the importance of hemophilic criteria when referring an individual. With the exception of one participant who felt that educational qualifications was a more important

referral criteria than being a Christian, most participants agreed that they preferred someone who was a Christian and held the same religious beliefs as they did. These findings are supported by a study done by Mathews (2010) that found similar findings with 63.5% of ministers in his study agreeing that the professional they want to refer to must be a Christian.

The study was guided by the psycho-spiritual model on mental health and healing. The results of the study suggested that the participants believed in the importance of a holistic view of mental illness and the imbalance between a person's spiritual, physical and mental dimensions. This is in line with the psycho-spiritual theory that emphasizes the importance of balance and mentions that an imbalance or distortions between an individual's body, mind and soul is the cause of mental illness (Integrated Health Services and Educational Research Centre, 2006).

The results of the study indicate that just like the psycho-spiritual approach the participants believed in a positive approach to psychology, and that inner peace, forgiveness and well-being go hand in hand. .

The findings of the study also suggested that the participants believed that an important part of prevention of mental illness is to psycho-educate church members and to provide them with the necessary skills needed for life. This is in line with the psycho-spiritual theory that suggests that a treatment plan should also include developing skills and obtaining resources for the individual to be able to handle present everyday situations (Milburn, 2011).

6.4 Significance of the study

This study seems to be of value to the field of psychology. Firstly the study has the potential to contribute to a better understanding of mental illness by Afrikaans speaking church leaders. In turn this study can contribute to efforts to encourage collaboration between church leaders and mental health care professionals.

The findings of this study have some implications for mental-health care professionals. Since church leaders are often first-line sources for help for many religious individuals experiencing mental distress (Weaver, Revilla & Koenig, 2002) collaborative efforts with church leaders are potentially useful. It will be realistic to presume that for such collaborative attempts to be possible, mental health care professionals must first acknowledge the importance of religious beliefs held by church leaders. Psychologists and other mental health care professionals should also consider bridging the knowledge gap with church leaders and educating them on the treatment methods used by them for at least some mental illness. This may lead to less distrust between church leaders and mental health professionals and in turn may lead to more collaboration.

Mental health professionals who are concerned about increasing the partnership between church leaders and themselves must consider the needs of such church leaders to maintain some form of control over the referral process. This control is achieved, in part, by searching for partnerships which is deemed as homophily as possible. Mental health care professionals may then need to increase their outreach to church leaders and other traditional health professionals by emphasizing their many similar attitudes and values. It is also worthy to note that

many of the religious leaders were of the view that the concept and understanding of mental illness as traditionally held by Afrikaans speaking church leaders has changed significantly. This attempt of religious leaders to pose both a spiritual and psychological component for mental illness might be suggestive of a new path taken by theology to be more integrated with psychology. This has the potential to minimize the previous individualistic treatment followed by church leaders and instead to embrace a more holistic treatment of an individual with a mental illness.

6.5 Limitations of the study

Regardless of the above contributions, there are several limitations in this study that need consideration. This includes a small sample size since this study focused on perspectives held by ten participants. The results of this study reflect participants' unique subjective opinions. Therefore, the findings drawn from their experiences are not necessarily representative of all Afrikaans speaking church leaders. Therefore, one should exercise caution when generalizing the findings to other individuals.

The purposive sampling strategy used in this study was also limiting. Only individuals who met the inclusion criteria partook in this research endeavor. This sampling strategy excluded individuals who did not meet the inclusion criteria. Furthermore, this study excluded potential participants who met the inclusion criteria based on their place of residency since this study only focused on individuals who reside within Polokwane, Limpopo Province.

Language was a challenge in this study because the interview structure was in English but Afrikaans was used as an interview language. The interview schedule

was translated into Afrikaans but there is still possibility that the intended meanings of the different questions posed to each participant could be lost between translations. In addition, the researcher did not do back translation and this serves as another limitation to this study.

Lastly, the researcher acknowledges her personal influence on the result of this study. Since the researcher maintained a participant-researcher stance during this study, the possibilities are, the findings of this study reflect both the participants' and the researcher's view point. As such, the study does not claim to have made findings of a hard and fast set of facts, but rather it attempted to explore possible ways of understanding the perspectives and opinions held by Afrikaans speaking church leaders by using their narratives and ascribed meanings as a source of information. In addition, since the researcher and her family is a resident of Polokwane and her family is well known within the church community, this could have encouraged or discouraged certain participations, the degree of disclosure and the outcomes of this study.

6.6 Recommendations for follow up studies

Issues raised in this chapter form the basis for further research. It is recommended that future research focus on the following areas;

- Further research into examining homophilic attitudes and variables that enhance trust and collaboration between church leaders and mental health care professionals. This will be crucial if well regarded community helpers such as church leaders are to be better integrated within the formal mental health sector (Mathews, 2010).

- Exploring perspectives and treatment methods for mental illness held by Afrikaans speaking church leaders using a bigger sample size.
- Exploring, in a broader context, the general public's perceptions and attitudes involving hemophilic criteria including traditional doctors, faith healers, etc.

6.7 Concluding Remarks

The researcher hopes that this study will stimulate further research on exploring and describing the treatment of mental illness by Christian church leaders and documentation of the findings of such studies. Perhaps in light of the findings of this study, increased collaboration between mental health professionals and church leaders are observed.

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APPENDIX A: SEMI-STRUCTURED INTERVIEW GUIDE

Interview Guide

1. As an Afrikaans speaking church leader, I would like you to share with me your own understanding of mental illness?
2. Can you share with me your understanding regarding the causes of mental illness?
3. Can you share with me your understanding of possible prevention of mental illness?
4. In view of your own experiences, do you think the church can treat mental illness?
5. In view of your own experience, how do you help or support people who suffer from mental illness?
6. Looking at the condition of mental illness, where would you send church members in need of help or support?

APPENDIX B; TRANSLATED SEMI-STRUCTURED INTERVIEW GUIDE

Onderhoud Gids

1. As `n kerk leier, sal ek graag wil hê u moet u eie begrip oor sielkundige toestande met my deel?
2. Sal u asseblief u siening met my deel oor die oorsake van sielkundige toestande?
3. Sal u asseblief u siening met my deel oor die moontlike voorkoming van sielkundige toestande?
4. In lig van u eie ondervinding, dink u die kerk kan iemand heel wat aan `n sielkundige toestand lei?
5. In lig van u eie ondervinding, hoe sal u iemand wat aan `n sielkundige toestand lei, help of ondersteun?
6. As ons na die kondisie van sielkundige toestande kyk, waarheen sou u kerklidmate stuur wat hulp en ondersteuning nodig het?

APPENDIX C: PARTICIPANT CONSENT LETTER AND FORM

**Department of Psychology
University of Limpopo (Turfloop
Campus)
Private Bag X1106
Sovenga
0727
Date:**

Dear Participant

INFORMED CONSENT

Thank you for demonstrating interest in this study that focuses on the view of mental illness held by Afrikaans speaking church leaders in Polokwane. The purpose of this study is mainly to understand how Afrikaans speaking church leaders view mental illness in terms of cause and treatment.

Your responses to this individual interview will remain strictly confidential. The researcher will not attempt to identify you with your responses to the interview questions or to disclose your name as a participant in the study.

Please be advised that participating in this study is voluntary and that you have the right to terminate your participation at any time.

Kindly answer all the questions and reflect your true reaction. Your participation in this research is very important. Thank you for your time.

Sincerely

Qunessa Kruger
Masters Student

Prof T Sodi
Supervisor

Date

Date

APPENDIX D: TRANSLATED PARTICIPANT CONSENT LETTER & FORM

Departement van Sielkunde

Universiteit van Limpopo (Turfloop Kampus)

Pos Bus X1106

Sovenga

0727

Datum:

Geagte Deelnemer

INGELIGTE TOESTEMMING

Dankie dat u belangstelling toon in hierdie studie wat fokus op kerk leiers en hulle sieninge oor sielkundige toestande in Polokwane. Die doel van hierdie studie is hoofsaaklik om te verstaan wat kerk leiers oor sielkundige toestande verstaan in term van oorsaak en behandeling.

U reaksie op die individuele onderhoud sal streng privaat gehou word. Die navorser sal poog om nie u te indintifiseer deur u antwoorde op die onderhoud nie, en sal nie u naam uitgee as deelnemer aan hierdie studie nie. Neem kennis dat u deelname aan hierdie studie vrywillig is en dat u die reg het om enige tyd te ontrek uit die studie.

Beantwoord asseblief al die vrae met u eerlike opinie. U deelname in hierdie studie word opreg waardeer. Dankie vir u tyd.

Dankie

Qunessa Kruger

Meesters Student

Prof T Sodi

Supervisor

Datum

Datum

APPENDIX E: CONSENT FORM TO BE SIGNED BY PARTICIPANT

CONSENT FORM

I _____ hereby agree to participate in a Masters research project that focuses on Afrikaans speaking church leaders in Polokwane and their treatment of mental illness.

The purpose of the study has been fully explained to me, I further understand that I am participating freely and without being forced in any way to do so. I also understand that I can terminate my participation in this study at any point should I not want to continue and that this decision will not in any way affect me negatively.

I understand that this is a research project, whose purpose is not necessarily to benefit me personally. I understand that my details as they appear in this consent form will not be linked to the interview schedule, and that my answers will remain confidential.

Signature: _____

Date: _____

APPENDIX F: TRANSLATED CONSENT FORM TO BE SIGNED BY PARTICIPANT

TOESTEMMINGS VORM

Ek _____ gee hiermee toestemming om deel te neem aan die Meesters studie projek wat fokus op kerk leiers in Polokwane en hulle sieninge oor sielkundige toestande.

Die doel van hierdie studie is deeglik aan my verduidelik, ek verstaan verder dat ek vrywillig aan hierdie studie deelneem en dat ek in geen manier geforseer word nie. Ek verstaan ook dat ek my deelname aan hierdie studie enige tyd kan termineer sou ek wou en dat hierdie keuse my in geen manier negatief sal beïnvloed nie.

Ek verstaan dat hierdie `n studie projek is, en dat die doel van hierdie studie nie noodwendig is om my persoonlik te bevoordeel nie. Ek verstaan ook dat my besonderhede soos dit op hierdie vorm verskyn, nie sal gekoppel word aan my antwoorde op die onderhoud skedule nie, en dat hierdie antwoorde vertroulik gehou sal word.

Handtekening: _____

Datum: _____